HEALTH COST CONTAINMENT

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

NINETY-SIXTH CONGRESS

FIRST SESSION

ON

S. 505

A BILL TO PROVIDE FOR THE REFORM OF THE ADMINISTRATIVE AND REIMBURSEMENT PROCEDURES CURRENTLY EMPLOYED UNDER THE MEDICARE AND MEDICAID PROGRAMS, AND FOR OTHER PURPOSES

S. 570

A BILL TO ESTABLISH VOLUNTARY LIMITS ON THE ANNUAL INCREASES IN TOTAL HOSPITAL EXPENSES, AND TO PROVIDE FOR MANDATORY LIMITS ON THE ANNUAL INCREASES IN HOSPITAL INPATIENT REVENUES TO THE EXTENT THAT THE VOLUNTARY LIMITS ARE NOT EFFECTIVE

MARCH 13 AND 14, 1979

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

45-558 O WASHINGTON : 1979 HG 96-16

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

COMMITTEE ON FINANCE

RUSSELL B. LONG, Louisiana, *Chairman*

HERMAN E. TALMADGE, Georgia
ABRAHAM RIBICOFF, Connecticut
HARRY F. BYRD, JR., Virginia
GAYLORD NELSON, Wisconsin
MIKE GRAVEL, Alaska
LLOYD BENTSEN, Texas
SPARK M. MATSUNAGA, Hawaii
DANIEL PATRICK MOYNIHAN, New York
MAX BAUCUS, Montana
DAVID L. BOREN, Oklahoma
BILL BRADLEY, New Jersey

ROBERT DOLE, Kansas
BOB PACKWOOD, Oregon
WILLIAM V. ROTH, JR., Delaware
JOHN C. DANFORTH, Missouri
JOHN H. CHAFEE, Rhode Island
JOHN HEINZ, Pennsylvania
MALCOLM WALLOP, Wyoming
DAVID DURENBERGER, Minnesota

MICHAEL STERN, *Staff Director*
ROBERT E. LIGHTHIZER, *Chief Minority Counsel*

SUBCOMMITTEE ON HEALTH

HERMAN E. TALMADGE, Georgia, *Chairman*

ABRAHAM RIBICOFF, Connecticut
GAYLORD NELSON, Wisconsin
SPARK M. MATSUNAGA, Hawaii

ROBERT DOLE, Kansas
DAVID DURENBERGER, Minnesota
WILLIAM V. ROTH, JR., Delaware

CONTENTS

ADMINISTRATION WITNESSES

PUBLIC WITNESSES

COMMUNICATIONS

APPENDIX

ADDITIONAL INFORMATION

HEALTH COST CONTAINMENT

TUESDAY, MARCH 13, 1979

U.S. SENATE,
COMMITTEE ON FINANCE,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met at 9 a.m., pursuant to notice, in room 2221, Dirksen Senate Office Building, Hon. Herman E. Talmadge (chairman of the subcommittee) presiding.

Present: Senators Long, Talmadge, Nelson, Baucus, Boren, Bradley, Dole, Roth, Jr., Heinz, Wallop, and Durenberger.

[The press release announcing these hearings and the bills S. 505 and S. 570 follow:]

Press Release #H-6

P R E S S R E L E A S E

FOR IMMEDIATE RELEASE
February 12, 1979

UNITED STATES SENATE
COMMITTEE ON FINANCE
SUBCOMMITTEE ON HEALTH
2227 Dirksen Senate Office Bldg.

FINANCE COMMITTEE SCHEDULES HEARINGS ON HEALTH COST CONTAINMENT AND CATASTROPHIC HEALTH INSURANCE PROTECTION

Senator Russell B. Long (D., La.), Chairman of the Senate Committee on Finance, announced today the scheduling of hearings and "markup" sessions in two significant areas of health costs concern.

"Beginning on March 12," said Long, "the Subcommittee on Health, chaired by Senator Herman Talmadge, will hold hearings on pending cost control and reimbursement reform legislation--including the Medicare and Medicaid reform bill which Senators Talmadge and Dole expect to reintroduce shortly."

"At that hearing," Long indicated, "we would anticipate testimony being received concerning the Administration's proposal to constrain increases in hospital revenues generally--not just for Medicare and Medicaid."

"I expect that the full Finance Committee would, during the week of March 19 engage in a markup of health care cost control legislation," said Long.

"During the last week in March," stated the Committee Chairman, "we will hear testimony on pending catastrophic health insurance and medical assistance reform proposals (S. 350 and S. 351)." That would include, Long noted, the catastrophic health insurance bill which Senator Robert Dole is expected to introduce in the near future.

The Louisiana Democrat anticipates scheduling full Committee markup sessions on catastrophic health insurance and related provisions to take place prior to the Congressional Easter recess.

Senator Long stressed that those requesting an opportunity to testify should specify whether they wish to testify on: (a) the hearing on cost controls; or (b) the hearing on catastrophic health insurance.

The Chairman said that because an unusually large number of requests to testify are anticipated, the Committee will not be able to schedule all those who request to testify. Those persons who are not scheduled to appear in person to present oral testimony are invited to submit written statements. The Chairman emphasized that the views presented in such written statements will be as carefully considered by the Committee as if they were presented orally.

Witnesses who desire to testify at the hearings should submit a written request to Michael Stern, Staff Director, Committee on Finance, Room 2227 Dirksen Senate Office Building, Washington, D. C. 20510 by no later than the close of business on March 1, 1979 in the case of cost containment and March 15, 1979 in the case of catastrophic health insurance.

All parties who are scheduled to testify orally are urged to comply with the guidelines below:

Notification of witnesses. -- Parties who have submitted written requests to testify will be notified as soon as possible as to the time and date they are scheduled to appear. Once a witness has been advised of the time and date of his appearance, rescheduling will not be permitted. If a witness is unable to testify at the time he is scheduled to appear, he may file a written statement for the record of the hearing.

Consolidated testimony. -- The Chairman also stated that the Committee urges all witnesses who have a common position or with the same general interest to consolidate their testimony and designate a single spokesman to present their common viewpoint orally to the Committee. This procedure will enable the Committee to receive a wider expression of views on the total bill than it might otherwise obtain. The Chairman praised witnesses who in the past have combined their statements in order to conserve the time of the Committee.

Panel groups. -- Groups with similar viewpoints but who cannot designate a single spokesman will be encouraged to form panels. Each panelist will be required to restrict his or her comments to no longer than a ten-minute summation of the principal points of the written statements. The panelists are urged to avoid repetition whenever possible in their presentations.

Legislative Reorganization Act. -- The Chairman observed that the Legislative Reogranization Act of 1946, as amended, requires all witnesses appearing before the Committees of Congress to file in advance written statements of their proposed testimony, and to limit their oral presentations to brief summaries of their argument. The statute also directs the staff of each Committee to prepare digests of all testimony for the use of Committee Members.

Chairman Long stated that in light of this statute and in view of the large number of witnesses who desire to appear before the Committee in the limited time available for the hearing, all witnesses must comply with the following rules:

(1) All statements must be filed with the Committee at least one day in advance of the day on which the witness is to appear. If a witness is scheduled to testify on a Monday or Tuesday, he must file his written statement with the Committee by the Friday preceding his appearance.

(2) All witnesses must include with their written statements a summary of the principal points included in the statement.

(3) The written statements must be typed on letter-size paper (not legal size) and at least 100 copies must be submitted to the Committee.

(4) Witnesses are not to read their written statements to the Committee, but are to confine their ten-minute oral presentations to a summary of the points included in the statement.

(5) Not more than ten minutes will be allowed for the oral summary.

Witnesses who fail to comply with these rules will forfeit their privilege to testify.

Written statements. -- Witnesses who are not scheduled for oral presentation, and others who desire to present a statement to the Committee, are urged to prepare a written position of their views for submission and inclusion in the record of the hearings. He emphasized that these written statements would also be digested by the staff for presentation to the Committee during its executive sessions and that they would receive the same careful consideration by the Committee as though they had been delivered orally. These written statements should be submitted to Michael Stern, Staff Director, Committee on Finance, Room 2227 Dirksen Senate Office Building by March 11, 1979 in the case of cost containment and April 5, 1979 in the case of catastrophic health insurance.

P.R. #H-6

96TH CONGRESS
1ST SESSION

S. 505

To provide for the reform of the administrative and reimbursement procedures currently employed under the medicare and medicaid programs, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MARCH 1 (legislative day, FEBRUARY 22), 1979

Mr. TALMADGE (for himself and Mr. DOLE) introduced the following bill; which was read twice and referred to the Committee on Finance

---

A BILL

To provide for the reform of the administrative and reimbursement procedures currently employed under the medicare and medicaid programs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Medicare-Medicaid Administrative and Reimbursement Reform Act of 1979".

TABLE OF CONTENTS

TABLE OF CONTENTS—Continued

CRITERIA FOR DETERMINING REASONABLE COST OF HOSPITAL SERVICES

SEC. 2. (a)(1) The first sentence of section 1861(v)(1)(A) of the Social Security Act is amended by striking out "The" and inserting "Subject to subsection (bb), the".

(2) Section 1861(v) of such Act is further amended by adding at the end thereof the following new paragraph:

"(8) For additional requirements applicable to determination of reasonable cost for services provided by hospitals, see subsection (bb) and section 1127(c)(3).".

(b) Section 1861 of such Act is amended by adding after subsection (aa) the following new subsection:

"Criteria for Determining Reasonable Cost of Hospital Services

"(bb)(1) In order more fairly and effectively to determine reasonable costs incurred in providing hospital services, the Secretary shall, not later than April 1, 1980, after consulting with appropriate national organizations, establish a system of hospital classification under which hospitals furnishing services initially will be classified—

"(A) by size, with each of the following groups of hospitals being classified in separate categories: (i) those having more than 5, but fewer than 25, beds, (ii) those having more than 24, but fewer than 50, beds, (iii) those having more than 49, but fewer than 100,

beds, (iv) those having more than 99, but fewer than 200, beds, (v) those having more than 199, but fewer than 300, beds, (vi) those having more than 299, but fewer than 400, beds, (vii) those having more than 399, but fewer than 500, beds, and (viii) those having more than 499 beds;

"(B) by type of hospital, with (i) short-term general hospitals being in a separate category, (ii) hospitals which are primary affiliates of accredited medical schools being in one separate category (without regard to bed size), and (iii) psychiatric, geriatric, maternity, pediatric, or other specialty hospitals being in the same or separate categories, as the Secretary may determine appropriate, in light of any differences in specialty which significantly affect the routine costs of the different types of hospitals;

"(C) as rural or urban; and

"(D) according to such other criteria as the Secretary finds appropriate, including modification of bed-size categories;

but the system of hospital classification shall not differentiate between hospitals on the basis of ownership.

"(2) The term 'routine operating costs' used in this subsection does not include—

"(A) capital and related costs,

"(B) direct personnel and supply costs of hospital education and training programs,

"(C) costs of interns, residents, and nonadministrative physicians,

"(D) energy costs,

"(E) malpractice insurance expense, or

"(F) ancillary service costs.

"(3)(A) During the calendar quarter beginning on January 1 of each year, beginning with 1980, the Secretary shall determine, for the hospitals in each category of the system established under paragraph (1), an average per diem routine operating cost amount which shall (except as otherwise provided in this subsection) be used in determining payments to hospitals.

"(B) The determination shall be based upon the amount of the hospitals' routine operating costs for the most recent accounting year ending prior to October 1 of the calendar year preceding the calendar year in which the determination is made. If, for any accounting year which starts on or after July 1, 1980, a hospital's actual routine operating costs are in excess of the amount allowed for purposes of determining payment to the hospital pursuant to this subsection and subsection (v), only one-half of such excess shall be taken into account in making any determination which the Secretary shall make under this paragraph.

"(C) In making a determination, the routine operating costs of hospitals in each category shall be divided into personnel and nonpersonnel components.

"(D)(i) The personnel and nonpersonnel components of routine operating costs for hospitals in each category (other than for those excluded under clause (ii)) shall be divided by the total number of days of routine care provided by such hospitals to determine the average per diem routine operating cost for such category.

"(ii) In making the calculations required by subparagraph (A) the Secretary shall exclude any newly opened hospital (as defined in the second sentence of paragraph (4)(F)), and any hospital which he determines is experiencing significant cost differentials resulting from failure of the hospital fully to meet the standards and conditions of participation as a provider of services.

"(E) There shall be determined for each hospital in each category a per diem target rate for routine operating costs. Such target rate shall equal the average per diem routine operating cost amount for the category in which the hospital is expected to be classified during the subsequent accounting year, except that the personnel component shall be adjusted using a wage index based upon general wage levels for reasonably comparable work in the areas in which the hospitals are located. If the Secretary finds that, in an area where a

hospital in any category is located for the most recent twelve-month period for which data with respect to such wage levels are available, the wage level for such hospital is significantly higher than such general wage level in that area (relative to the relationship within the same hospital group between hospital wages and such general wages in other areas), then such general wage level in the area shall be deemed equal to the wage level for such hospital, only with respect to the hospital's first accounting year beginning on or after July 1, 1980.

"(4)(A)(i) The term 'adjusted per diem target rate for routine operating costs' means the per diem target rate for routine operating costs plus the percentage increase in costs determined under the succeeding provisions of this subparagraph.

"(ii) In determining the adjusted per diem target rate, the Secretary shall add an annual projected percentage increase in the cost of the mix of goods and services (including personnel and nonpersonnel costs) comprising routine operating costs, based on an index composed of appropriately weighted indicators of changes in the economy in wages and prices which are representative of services and goods included in routine operating costs. Where actual changes in such weighted index are significantly different (at least one-half of 1 percentage point) from those projected, the Secretary shall

issue corrected target rates on a quarterly basis. At the end of the hospital's accounting year, the target rate shall be adjusted to reflect the actual changes in such weighted index. Adjustments shall also be made to take account of changes in the hospital's classification.

"(B) For purposes of payment the amount of routine operating cost incurred by a hospital for any accounting year which begins on or after July 1, 1980, shall be deemed to be equal—

"(i) in the case of a hospital which has actual routine operating costs equal to or greater than that hospital's adjusted per diem target rate for routine operating costs, to the greater of—

"(I) the hospital's actual routine operating costs, but not exceeding—

"(a) in the case of the first accounting year of any hospital which begins on or after July 1, 1980, and prior to July 1, 1981, an amount equal to the aggregate of (1) 100 percent of the hospital's adjusted per diem target rate for routine operating costs, plus (2) 15 percent of the amount described in clause (1), and

"(b) in the case of any accounting year after the accounting year described in clause

(a), an amount equal to the aggregate of (1) 100 percent of the hospital's adjusted per diem target rate for routine operating costs for such year, plus (2) a dollar amount equal to the dollar amount determined under clause (a)(2) for the category of such hospital, or

"(II) the amounts determined for the hospital under division (I) if it had been classified in the bed-size category which contains hospitals closest in bed-size to such hospital's bed-size (with a hospital which has a bed-size that falls halfway between two such categories being considered in the category which contains hospitals with the greater number of beds), but not exceeding the hospital's actual routine operating costs; and

"(ii) in the case of a hospital which has actual routine operating costs which are less than that hospital's adjusted per diem target rate for routine operating costs, to (I) the amount of the hospital's actual routine operating costs, plus (II) the smaller of (a) 5 percent of the hospital's adjusted per diem target rate for routine operating costs, or (b) 50 percent of the amount by which the hospital's adjusted per diem target rate for routine operating costs exceeds the hospital's actual routine operating costs.

"(C) Any hospital (other than a newly opened hospital) excluded by the Secretary under paragraph (3)(D)(ii), shall be reimbursed for routine operating costs on the basis of the lesser of (i) actual costs or (ii) the reimbursement determined under this subsection.

"(D) On or before April 1 of the year in which the Secretary determines the amount of the average per diem operating cost for each hospital category and the adjusted per diem target rate for each hospital, the Secretary shall publish the determinations, and he shall notify the hospital administrator and the administrative governing body of each hospital with respect to all aspects of the determination which affect the hospital.

"(E) If a hospital is determined by the Secretary to be—

"(i) located in an underserved area where hospital services are not otherwise available,

"(ii) certified as being currently necessary by an appropriate planning agency, and

"(iii) underutilized,

the adjusted per diem target rate shall not apply to that portion of the hospital's routine operating costs attributable to the underutilized capacity.

"(F) If a newly opened hospital is determined by the Secretary to have greater routine operating costs as a result

of the cost patterns associated with newly opened hospitals, the adjusted per diem target rate shall not apply to that portion of the hospital's routine operating costs attributable to such patterns. For purposes of this subparagraph a 'newly opened hospital' means a hospital which has not satisfied the requirements of paragraphs (1) and (7) of subsection (e) of this section (under present or previous ownership) for at least twenty-four months prior to the start of such hospital's accounting year.

"(G) If a hospital is determined by the Secretary to have greater routine operating costs as a result of changes in service on account of consolidation, sharing, or addition of services, where such consolidation, sharing, or addition has been approved by the appropriate State Health Planning and Development Agency or Agencies, the adjusted per diem target rate shall not apply to that portion of the hospital's routine operating costs attributable to such changes in service.

"(H)(i) If a hospital satisfactorily demonstrates to the Secretary that, in the aggregate, its patients require a substantially greater intensity of care than generally is provided by the other hospitals in the same category, resulting in unusually greater routine operating costs, then the adjusted per diem target rate shall not apply to that portion of the hospi-

tal's routine operating costs attributable to the greater intensity of care required.

"(ii) To the extent that a hospital can demonstrate that it experiences routine operating costs in excess of such costs for hospitals having a reasonably similar mix of patients on account of consistently shorter lengths-of-stay in such hospital, which result from the greater intensity of care provided by such hospital, the excess routine operating costs shall be considered attributable to the greater intensity of care required.

"(I) The Secretary may further increase the adjusted per diem target rate applicable in Alaska and Hawaii to reflect the higher prices prevailing in such States.

"(J) Where the Secretary finds that a hospital has manipulated its patient mix, or patient flow, or provides less than the normal range and extent of patient services, or that an unusually large proportion of routine nursing service is provided by private-duty nurses, the routine operating costs of that hospital shall be deemed equal to the lesser of (i) the amount determined without regard to this subsection, or (ii) the amount determined under subparagraph (B).

"(5) Where any provisions of this subsection are inconsistent with section 1861(v), this subsection supersedes section 1861(v).

"(6)(A) Notwithstanding any other provision of this Act, in the case of any State which has established a reimbursement system for hospitals, hospital reimbursement in that State under this title and under the State plan approved under title XIX shall, with respect to the services covered by such system, be based on that State system, if the Secretary finds that—

"(i) the State has mandated the reimbursement system and it at least applies to the same hospitals in the State, and to the same costs, as the Federal reimbursement reform program established by this subsection;

"(ii) every hospital in the State with which there is a provider agreement under this title or under the State plan approved under title XIX conforms to the accounting and uniform reporting requirements of section 1121 of this Act, and furnishes any appropriate reports that the Secretary may require; and

"(iii) such State demonstrates to his satisfaction that the total amount payable, with respect to inpatient hospital costs, in the State under this title and under the State plan approved under title XIX will be equal to or less than an amount equal to (i) the amount which would otherwise be payable for such costs under this title and such State plan without regard to the in-

centive payments provided by subparagraph (B)(ii) of paragraph (4), less (ii) the amount of any incentive payments which are allowed under the State's reimbursement system in recognition of demonstrated efficiencies.

If the Secretary finds that any of the above conditions in a State which previously met them have not been met for a two-year period, the Secretary shall, after due notice, reimburse hospitals in that State according to the provisions of this Act (other than this paragraph) unless he finds that unusual, justifiable, and nonrecurring circumstances led to the failure to comply.

"(B) If the Secretary finds that, during any two-year period during which hospital reimbursement under this title and under the State plan approved under title XIX was based on a State system as provided in subparagraph (A), the amount payable by the Federal Government under such titles for inpatient hospital costs in such State was in excess of the amount which would have been payable for such costs in such State if reimbursement had not been based on the State system (as estimated by the Secretary), the adjusted per diem target rate for routine operating costs (as determined under the preceding paragraphs of this subsection) for hospitals in such State shall be reduced (by not more than 1 percent in

any year) until the Federal Government has recouped an amount equal to such excess payment amount.

"(C)(i) The Secretary shall pay to any State in which hospital reimbursement under this title is based on a State system as provided in subparagraph (A), an amount which bears the same ratio to the total cost of administering the State system (including the cost of initially putting the system into operation) as the amount paid by the Federal Government under this title in such State for inpatient hospital costs bears to the total amount of inpatient hospital costs in such State which are subject to the State system.

"(ii) Payments under clause (i) shall be made from funds in the Federal Hospital Insurance Trust Fund.

"(iii) An amount which bears the same ratio to the total cost of administering the State system (including the cost of initially putting the system into operation) as the amount paid under the State plan approved under title XIX in such State for inpatient hospital costs bears to the total amount of inpatient hospital costs in such State which are subject to the State system, shall, for purposes of title XIX, be considered to be an amount expended for the administration of such State plan.".

(c) Part A of title XI of the Social Security Act is amended by adding after section 1126 the following new section:

"HEALTH FACILITIES COSTS COMMISSION

"SEC. 1127. (a) There is established a commission to be known as the Health Facilities Costs Commission (hereinafter in this section referred to as the 'Commission').

"(b)(1) The Commission shall be composed of fifteen members appointed by the Secretary—

"(A) at least three of whom shall be individuals who are representatives of hospitals;

"(B) at least eight of whom shall be individuals who represent public (including Federal, State, and local) health benefit programs; and

"(C) the remainder of whom shall be, as a result of training experience or attainments, particularly and exceptionally well qualified to assist in serving and carrying out the functions of the Commission.

One of the members of the Commission, at the time of appointment, shall be designated as Chairman of the Commission. The Secretary shall first appoint members to the Commission not later than January 1, 1980.

"(2) The Chairman of the Commission shall designate a member of the Commission to act as Vice Chairman of the Commission.

"(3) A majority of the members of the Commission shall constitute a quorum, but a lesser number may conduct hearings.

"(4) A vacancy in the Commission shall not affect its powers, but shall be filled in the same manner as that herein provided for the appointment of the member first appointed to the vacant position.

"(5) Members of the Commission shall be appointed for a term of four years, except that the Secretary shall provide for such shorter terms for some of the members first appointed so as to stagger the date of expiration of members' terms of office.

"(6) No individual may be appointed to serve more than two terms as a member of the Commission.

"(7) Each member of the Commission shall be entitled to per diem compensation at rates fixed by the Secretary, but not more than the current per diem equivalent of the annual rate of basic pay in effect for grade GS–18 of the General Schedule for each day (including travel time) during which the member is engaged in the actual performance of duties vested in the Commission, and all members of the Commission shall be allowed, while away from their homes or regular places of business in the performance of service for the Commission, travel expenses (including per diem in lieu of subsistence) in the same manner as persons employed intermittently in the Government service are allowed expenses under section 5703 of title 5, United States Code.

"(8) The Commission shall meet at the call of the Chairman, or at the call of a majority of the members of the Commission; but meetings of the Commission shall be held not less frequently than once in each calendar month which begins after a majority of the authorized membership of the Commission has first been appointed.

"(c)(1) It shall be the duty and function of the Commission to conduct a continuing study, investigation, and review of the reimbursement of hospitals for care provided by them to individuals covered under title XVIII or under State plans approved under title XIX, with particular attention to the criteria established by section 1861(bb) with a view to devising additional methods for reimbursing hospitals for all other costs, and for reimbursing all other entities which are reimbursed on the basis of reasonable cost. These methods shall provide for appropriate classification and reimbursement systems designed to ordinarily permit comparisons (A) of the cost centers of one entity, either individually or in the aggregate, with cost centers similar in terms of size and scale of operation, (B) prevailing wage levels, (C) the nature, extent, and appropriate volume of the services furnished, and (D) other factors which have a substantial impact on hospital costs. The Commission shall also develop procedures for appropriate exceptions. The Commission shall submit to the Congress reports on its progress in addressing these issues at

least once every six months during the three-year period following the date of the enactment of this section.

"(2) The Commission shall study appropriate methods for classifying and comparing hospitals which, with respect to any accounting year, derive 75 percent or more (as estimated by the Secretary) of their inpatient care revenues from one or more health maintenance organizations. The Commission shall consider recommending the classification and comparison of such hospitals as a separate category in recognition of the differences in the nature of their operations as compared with other hospitals.

"(3) The Secretary, taking account of the proposals and advice of the Commission, shall by regulation make appropriate modifications in the method of reimbursement under titles V, XVIII, and XIX for routine hospital costs, other hospital costs, and costs of other entities which are reimbursed on the basis of reasonable costs.

"(d) The Secretary shall provide such technical, secretarial, clerical, and other assistance as the Commission may need.

"(e) The Commission may secure directly from any department or agency of the United States such data and information as may be necessary to enable it to carry out its duties under this section. Upon request of the Chairman of

the Commission, any such department or agency shall furnish any such data or information to the Commission.

"(f) There are hereby authorized to be appropriated such sums as may be necessary to carry out this section.

"(g) Section 14 of the Federal Advisory Committee Act shall not apply to the Commission.".

(d)(1) Section 1866(a)(1) of the Social Security Act is amended—

(A) by striking out the period at the end of subparagraph (D) and inserting in lieu thereof ", and"; and

(B) by inserting after subparagraph (D) the following new subparagraph:

"(E) not to increase amounts due from any individual, organization, or agency in order to offset reductions made under section 1861(bb) in the amount paid, or expected to be paid, under this title.".

(2) Section 1902(a)(27) of the Social Security Act is amended by striking out "and" at the end of clause (A) and by inserting before the semicolon at the end of clause (B) the following: ", and (C) not to increase amounts due from any individual, organization, or agency in order to offset reductions made pursuant to the requirements contained in section 1902(a)(13)(D) in the amount paid, or expected to be paid under the State plan".

(e) Section 1902(a)(13)(D) of the Social Security Act is amended to read as follows:

"(D) for payment of the reasonable cost of inpatient hospital services provided under the plan, applying the methods specified in section 1861(v) and section 1861(bb), which are consistent with section 1122; and".

PAYMENTS TO PROMOTE CLOSING AND CONVERSION OF UNDERUTILIZED FACILITIES

SEC. 3. (a) Part A of title XI of the Social Security Act is amended by adding after section 1127 (as added by section 2 of this Act) the following new section:

"PAYMENTS TO PROMOTE CLOSING AND CONVERSION OF UNDERUTILIZED FACILITIES

"SEC. 1128. (a)(1)(A) Before the end of the third full month following the month in which this section is enacted, the Secretary shall establish a Hospital Transitional Allowance Board (hereinafter in this section referred to as the 'Board'). The Board shall have five members, appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, who are knowledgeable about hospital planning and hospital operations.

"(B) Members of the Board shall be appointed for three-year terms, except some initial members shall be appointed for shorter terms to permit staggered terms of office.

"(C) Members of the Board shall be entitled to per diem compensation at rates fixed by the Secretary, but not more than the current per diem equivalent at the time the service involved is rendered for grade GS-18 under section 5332 of title 5, United States Code.

"(D) The Secretary shall provide such technical, secretarial, clerical, and other assistance as the Board may need.

"(2) The Board shall receive and act upon applications by hospitals, certified for participation (other than as 'emergency hospitals') under titles XVIII and XIX, for transitional allowances.

"(b) For purposes of this section—

"(1) The term 'transitional allowance' means an amount which—

"(A) shall, solely by reason of this section, be included in a hospital's reasonable cost for purposes of calculating payments under the programs authorized by titles V, XVIII, and XIX of this Act; and

"(B) in accordance with this section, is established by the Secretary for a hospital in recognition of a reimbursement detriment (as defined in

paragraph (3)) experienced because of a qualified facility conversion (as defined in paragraph (2)).

"(2) The term 'qualified facility conversion' means closing, modifying, or changing the usage of an underutilized hospital facility which is expected to benefit the programs authorized under title V, title XVIII, and title XIX by (A) eliminating excess bed capacity, (B) discontinuing an underutilized service for which there are adequate alternative sources, or (C) substituting for the underutilized service some other service which is needed in the area and which is consistent with the findings of an appropriate health planning agency.

"(3) A hospital which has carried out a qualified facility conversion and which continues in operation will be regarded as having experienced a 'reimbursement detriment'—

"(A) to the extent that, solely because of the conversion, there is a reduction in that portion of the hospital's costs attributable to capital assets which are taken into account in determining reasonable cost for purposes of determining amount of payment to the hospital under title V, title XVIII, or a State plan approved under title XIX;

"(B) if the conversion results, on an interim basis, in increased operating costs, to the extent that operating costs exceed amounts ordinarily reimbursable under title V, title XVIII, and the State plan approved under title XIX; or

"(C) in the case of complete closure of a private nonprofit hospital, or local governmental hospital, other than for replacement of the hospital, to the extent of actual debt obligations previously recognized as reasonable for reimbursement, where the debt remains outstanding, less any salvage value.

"(c)(1) Any hospital may file an application with the Board (in a form and including data and information as the Board, with the approval of the Secretary, may require) for a transitional allowance with respect to any qualified conversion which was formally initiated after December 31, 1979. The Board, with the approval of the Secretary, may also establish procedures, consistent with this section, by means of which a finding of a reimbursement detriment may be made prior to the actual conversion.

"(2) The Board shall consider any application filed by a hospital, and if the Board finds that—

"(A) the facility conversion is a qualified facility conversion, and

"(B) the hospital is experiencing or will experience a reimbursement detriment because it carried out the qualified facility conversion,

the Board shall transmit to the Secretary its recommendation that the Secretary establish a transitional allowance for the hospital in amounts reasonably related to prior or prospective use of the facility under titles V and XVIII and the State plan approved under title XIX, for a period, not to exceed twenty years as specified by the Board, and, if the Board finds that the criteria in subparagraphs (A) and (B) are not met, it shall advise the Secretary not to establish a transitional allowance for that hospital. For an approved closure under subsection (b)(3)(C) the Board may recommend or the Secretary may approve, a lump-sum payment in lieu of periodic allowances, where such payment would constitute a more efficient and economic alternative.

"(3)(A) The Board shall notify a hospital of its findings and recommendations.

"(B) A hospital dissatisfied with a recommendation may obtain an informal or formal hearing, at the discretion of the Secretary by filing (in the form and within a time period established by the Secretary) a request for a hearing.

"(4)(A) Within thirty days after receiving a recommendation from the Board respecting a transitional allowance or, if later, within thirty days after a hearing, the Secretary shall

make a final determination whether, and if so in what amount and for what period of time, a transitional allowance will be granted to a hospital. A final determination of the Secretary shall not be subject to judicial review.

"(B) The Secretary shall notify a hospital and any other appropriate parties of the determination.

"(C) Any transitional allowance shall take effect on a date prescribed by the Secretary, but not earlier than the date of completion of the qualified facility conversion. A transitional allowance shall be included as an allowable cost item in determining the reasonable cost incurred by the hospital in providing services for which payment is authorized under this Act, except that the transitional allowance shall not be considered in applying limits to costs recognized as reasonable pursuant to the third sentence of section 1861(v)(1) and section 1861(bb) of this Act, or in determining the amount to be paid to a provider pursuant to section 1814(b), section 1933(a)(2), section 1910(i)(3), and section 506(f)(3) of this Act.

"(d) In determining the reasonable cost incurred by a hospital with respect to which payment is authorized under a State plan approved under title V or title XIX, any transitional allowance shall be included as an allowable cost item.

"(e)(1) The Secretary is authorized to establish transitional allowances only as provided in paragraphs (2) and (3).

"(2) Prior to January 1, 1983, the Secretary is authorized to establish a transitional allowance for not more than fifty hospitals.

"(3) On and after January 1, 1983, the Secretary is authorized to establish a transitional allowance for any hospital which qualifies for such an allowance under the provisions of this section.

"(4) On or before January 1, 1982, the Secretary shall report to the Congress evaluating the effectiveness of the program established under this section including appropriate recommendations.".

(b) The amendments made by subsection (a) shall apply only to services furnished by a hospital during any accounting year beginning on or after October 1, 1979.

FEDERAL PARTICIPATION IN HOSPITAL CAPITAL EXPENDITURES

SEC. 4. (a) Section 1122 of the Social Security Act is amended to read as follows:

"(a) The purpose of this section is to assure that Federal funds appropriated under titles V, XVIII, and XIX are not used to support unnecessary capital expenditures made by or on behalf of health care facilities (including those of health maintenance organizations) and home health agencies which are reimbursed under any of such titles and that, to the extent possible, reimbursement under such titles shall support

planning activities with respect to health services and facilities in the various States.".

(b) Section 1122(b) of the Social Security Act is amended by striking out "(which shall be an agency described in clause (ii) of subsection (d)(1)(B) that has a governing body or advisory board at least half of whose members represent consumer interests)" and inserting in lieu thereof "(the agency designated under section 1521 of the Public Health Service Act)".

(c) Paragraphs (1) and (2) of section 1122(b) are amended to read as follows:

"(1) make, and submit to the secretary together with such supporting materials as he may find necessary, findings and recommendations with respect to capital expenditures proposed by or on behalf of any health care facility (including those of a health maintenance organization) or home health agency in such State within the field of its responsibilities.

"(2) receive from the Health Systems Agencies designated under title XV of the Public Health Service Act, and submit to the Secretary together with such supporting material as he may find necessary, the findings and recommendations of such agencies with respect to capital expenditures proposed by or on behalf of health care facilities (including those of health main-

tenance organizations) or home health agencies in such State within the fields of their respective responsibilities, and".

(d) Section 1122(c) of the Social Security Act is amended to read as follows:

"(c) The reasonable expenses incurred in carrying out the activities referred to in subsection (b) by the designated planning agencies (disregarding any expenses for which the agency is authorized to be reimbursed from other sources) shall be payable from—

"(1) funds in the Federal Hospital Insurance Trust Fund,

"(2) funds in the Federal Supplementary Medical Insurance Trust Fund, and

"(3) funds appropriated to carry out the health care provisions of the several titles of this Act,

in such amounts as the Secretary finds result in a proper allocation. The Secretary shall transfer money between the funds as may be appropriate to settle accounts between them. The Secretary shall pay the designated planning agencies without requiring contribution of funds by any State or political subdivision thereof.".

(e) Section 1122(d) of such Act is amended to read as follows:

"(d)(1) Except as provided in paragraph (2), if the Secretary determines that—

"(A) the designated planning agency had not approved the proposed expenditure; and

"(B) the designated planning agency had granted to the person proposing the capital expenditure an opportunity for a fair hearing with respect to the findings;

then, in determining Federal payments under titles V, XVIII, and XIX for services furnished in the health care facility for which the capital expenditure is made, the Secretary shall not include any amount attributable to depreciation, interest on borrowed funds, a return on equity capital (in the case of proprietary facilities), other expenses related to the capital expenditure, or for direct operating costs, to the extent that they can be directly associated with the capital expenditures, unless the designated planning agency for the States determines, in accordance with an agreement entered into under subsection (b) or under a certificate of need program which is applicable to such expenditure and which meets the requirements of title XV of the Public Health Service Act, that such capital expenditures are needed and meet criteria adopted by such agency. In the case of a proposed capital expenditure in a standard metropolitan statistical area which encompasses more than one jurisdiction, that

expenditure shall require approval of the designated planning agency of each jurisdiction, which shall jointly review the proposal. Where the designated planning agencies do not unanimously agree, the proposed expenditures shall be deemed disapproved. Where the designated planning agencies do not act to approve or disapprove the proposed expenditure within one hundred and eighty days after the submission of the request for approval, the proposed expenditure shall be deemed approved. Any deemed approval or disapproval shall be subject to review and reversal by the Secretary following a request, submitted to him within sixty days of the deemed approval or disapproval, for a review and reconsideration based upon the record. With respect to any organization which is reimbursed on a per capita, fixed fee, or negotiated rate basis, in determining the Federal payments to be made under titles V, XVIII, and XIX, the Secretary shall exclude an amount reasonably equivalent to the amount which would otherwise be excluded under this subsection if payment were made on other than a per capita, fixed fee, or negotiated rate basis.

"(2) If the Secretary, after submitting the matters involved to the advisory council established under subsection (i), determines that an exclusion of expenses related to any capital expenditure would discourage the operation or expansion of any health care facility or health maintenance organi-

zation which has demonstrated to his satisfaction proof of its capability to provide comprehensive health care services (including institutional services) effectively and economically, or would be inconsistent with effective organization and delivery of health services, or the effective administration of title V, XVIII, or XIX), he shall not exclude the expenses pursuant to paragraph (1).".

(f) Section 1122(g) of the Social Security Act is amended to read as follows:

"(g) For purposes of this section, a 'capital expenditure' is an expenditure which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance and which (1) exceeds $150,000, (2) changes the bed capacity of the facility, or (3) substantially changes the services of the facility, including conversion of existing beds to higher cost usage. The cost of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of the plant and equipment shall be included in determining whether the expenditure exceeds $150,000. For purposes of this section, 'capital expenditure' does not include an expenditure for the purpose of acquiring (either by purchase or under lease or comparable arrangement) an existing health care facility, the utilized services

and bed capacity of which are not increased as a result of the acquisition.".

(g) Section 1861(z) of the Social Security Act is amended to read as follows:

"Institutional Planning

"(z) An overall plan and budget of a hospital, skilled nursing facility, or home health agency shall—

"(1) provide for an annual operating budget which includes all anticipated income and expenses related to items which would, under generally accepted accounting principles, be considered income and expense items (except that nothing in this paragraph shall require that there be prepared in connection with any budget an item-by-item identification of the components of each type of anticipated expenditure or income);

"(2) provide for a capital expenditures plan for at least a five-year period (including the year to which the operating budget applies) which identifies in detail the sources of financing and the objectives of each anticipated expenditure in excess of $150,000 related to the acquisition of land, improvement of land, buildings, or equipment, and the replacement, modernization, or expansion of the buildings and equipment, and which would, under generally accepted accounting principles, be considered capital items, and such capital expendi-

tures plan shall be a matter of public record and available in readily accessible form and fashion;

"(3) provide for annual review and updating; and

"(4) be prepared, under the direction of the governing body of the institution or agency, by a committee consisting of representatives of the governing body, administrative staff, and medical staff (if any) of the institution or agency.".

(h) The amendments made by this section shall become effective on January 1, 1980, and shall be effective with respect to determinations made by the Secretary on or after such date.

AGREEMENTS WITH PHYSICIANS TO ACCEPT ASSIGNMENTS

SEC. 5. (a) Title XVIII of the Social Security Act is amended by adding the following new section:

"AGREEMENTS WITH PHYSICIANS TO ACCEPT ASSIGNMENTS

"SEC. 1868. (a) For purposes of this section the term 'participating physician' means a doctor of medicine or osteopathy who has in effect an agreement with the Secretary by which he agrees to accept an assignment of claim (as provided for in section 1842(b)(3)(B)(ii)) for each physicians' service (other than those excluded from coverage by section 1862) performed by him in the United States for an indi-

vidual enrolled under part B. The assignment shall be in a form prescribed by the Secretary. The agreement may be terminated by either party upon 30-days' notice to the other, filed in a manner prescribed by the Secretary.

"(b) To expedite processing of claims from participating physicians, the Secretary shall establish procedures and develop appropriate forms under which—

"(1) each physician will submit his claims on one of alternative simplified approved bases including multiple listing of patients, and the Secretary shall act to assure that these claims are processed expeditiously, and

"(2) the physician shall obtain from each patient enrolled under part B (except in cases where the Secretary finds it impractical for the patient to furnish it) and shall make available at the Secretary's request, a signed statement by which the patient (A) agrees to make an assignment with respect to all services furnished by the physician and (B) authorizes the release of any medical information needed to review claims submitted by the physician.

"(c)(1) Participating physicians shall be paid administrative cost-savings allowances (as determined under paragraph (2)) in addition to the reasonable charges that are payable.

"(2) The administrative cost-savings allowance shall be $1 for each claim the participating physician submits in accordance with the simplified billing procedure referred to in subsection (b) and these payments shall be treated as an administrative expense to the medical insurance program, except that—

"(A) not more than $1 shall be payable to a physician for claims for services furnished to any particular patient within any 7-day period;

"(B) no administrative cost-savings allowance shall be payable for services performed for a hospital inpatient or outpatient unless:

"(i) the services are surgical services, anesthesia services, or services performed by a physician who, as an attending or consulting physician, personally examined the patient and whose office or regular place of practice is located outside a hospital, and

"(ii) the physician ordinarily bills directly (and not through such hospital) for his services; and

"(C) no administrative cost-savings allowance shall be payable for services which consist solely of laboratory or X-ray services which are for hospital in-

patients or outpatients or are performed outside the office of the participating physician.".

(b) The amendments made by subsection (a) shall become effective on July 1, 1980.

HOSPITAL-ASSOCIATED PHYSICIANS

SEC. 6. (a)(1) Section 1861(q) of the Social Security Act is amended by adding "(1)" immediately after "(q)" and by adding, immediately before the period at the end thereof, the following: "; except that the term does not include any service that a physician may perform as an educator, an executive, or a researcher; or any professional patient care service unless the service (A) is personally performed by or personally directed by a physician for the benefit of the patient and (B) is of such nature that its performance by a physician is appropriate".

(2) Section 1861(q) is amended by adding the following paragraphs at the end:

"(2) In the case of anesthesiology services related to the surgical or obstetrical care of a patient, a procedure shall be considered to be 'personally performed' in its entirety by a physician where a physician performs for the benefit of the patient the following activities:

"(A) preanesthetic evaluation of the patient;

"(B) prescription of the anesthesia plan;

"(C) personal participation in the most demanding procedures in this plan, including those of induction and emergence and assuring that a qualified individual, who need not be his employee, acting under such physician's direction, performs any of the less demanding procedures which the physician does not personally perform;

"(D) following the course of anesthesia administration at frequent intervals;

"(E) remaining physically available for the immediate diagnosis and treatment of emergencies; and

"(F) providing indicated postanesthesia care:

Provided, however, That during the performance of the activities described in subparagraphs (C), (D), and (E), the physician is not responsible for the care of more than one other patient. Where a physician performs the activities described in subparagraphs (A), (B), (D), and (E) and another individual performs the activities described in subparagraph (C), the physician will be deemed to have personally directed the services if he was responsible for no more than four patients while performing the activities described in subparagraphs (D) and (E), and the reasonable charge for his personal direction shall not exceed one-half the amount that would have been payable if he had personally performed the procedure in its entirety.

"(3) Pathology services shall be considered 'physicians' services' to patients only where the physician personally performs acts or makes decisions with respect to a patient's diagnosis or treatment which require the exercise of medical judgment. These include operating room and clinical consultations, the required interpretation of the significance of any material or data derived from a human being, the aspiration or removal of marrow or other materials, and the administration of test materials or isotopes. Such professional services shall not include professional services such as the performance of autopsies, and services performed in carrying out responsibilities for supervision, quality control, and for various other aspects of a clinical laboratory's operations that are appropriately performed by nonphysician personnel.".

(3) Section 1861(b) of such Act is amended—

(A) by striking out "or" at the end of paragraph (6),

(B) by striking out the period at the end of paragraph (7) and inserting "; or", and

(C) by adding at the end the following paragraph:

"(8) a physician, if the services provided are not physicians' services (within the meaning of subsection (q)).".

(b)(1) Section 1861(s) of the Social Security Act is amended by adding at the end: "The term 'medical and other

health services' shall not include services described in paragraphs (2)(A) and (3) if furnished to inpatients of a provider of services unless the Secretary finds that, because of the size of the hospital and the part-time nature of the services or for some other reason acceptable to him, it would be less efficient to have the services furnished by the hospital (or by others under arrangement with them made by the hospital) than to have them furnished by another party.".

(2) Section 1842(b)(4) of such Act, as added by section 10 of this Act, is amended by adding at the end thereof the following subparagraph:

"(G) The charge for a physician's or other person's services and items which are related to the income or receipts of a hospital or hospital subdivision shall not be considered in determining his customary charge to the extent that the charge exceeds an amount equal to the salary which would reasonably have been paid for the service (together with any additional costs that would have been incurred by the hospital) to the physician performing it if it had been performed in an employment relationship with the hospital plus the cost of other expenses (including a reasonable allowance for traveltime and other reasonable types of expense related to any differences in acceptable methods of organization for the provision of services) in-

curred by the physician, as the Secretary may determine to be appropriate.".

(c) Section 1861(v) of such Act is amended by adding after paragraph (8) (as added by section 2 of this Act) the following new paragraph:

"(9)(A) Where services are furnished by a physician under an arrangement (including an arrangement under which the physician performing the services is compensated on a basis related to the amount of the income or receipts of the hospital or any department or other subdivision) with a hospital or medical school, the amount included in any payment to the hospital under this title as the reasonable cost of the services (as furnished under the arrangement) shall not exceed an amount equal to the salary which would reasonably have been paid for the services (together with any additional costs that would have been incurred by the hospital) to the physician performing them if they had been performed in an employment relationship with the hospital (rather than under such arrangement) plus the cost of other expenses (including a reasonable allowance for traveltime and other reasonable types of expense related to any differences in acceptable methods of organization for the provision of the services) incurred by the physician, as the Secretary may determine to be appropriate.".

(d)(1) Section 1833(a)(1)(B) of the Social Security Act is amended by inserting "(except as provided in subsection (i))" immediately after "amounts paid shall".

(2) Section 1833(b)(2) of such Act is amended by inserting "(except as otherwise provided in subsection (i))" immediately after "amount paid shall".

(3) Section 1833 of such Act is amended by redesignating the second subsection (g) thereof as subsection (h) and by adding the following new subsection:

"(i) The provisions of subsection (a)(1)(B) and clause (2) of the first sentence of subsection (b) shall not apply to any physician unless he has entered into an agreement with the Secretary under which he agrees to be compensated for all such services on the basis of an assignment the terms of which are described in section 1842(b)(3)(B)(ii).".

(e) The amendments made by this section shall, except those made by subsection (d), apply to services furnished in accounting periods of the hospital which begin after the month following the month of enactment of this Act. The amendment made by subsection (d) shall be effective July 1, 1979.

USE OF APPROVED RELATIVE VALUE SCHEDULE

SEC. 7. Part A of title XI of the Social Security Act is amended by adding after section 1128 (as added by section 3 of this Act) the following new section:

"USE OF APPROVED RELATIVE VALUE SCHEDULE

"SEC. 1129. (a) To provide common language describing the various kinds and levels of medical services which may be reimbursed under titles V, XVIII, and XIX of this Act, the Secretary shall establish a system of procedural terminology, including definitions of terms. The system shall be developed by the Health Care Financing Administration with the advice of other large health care purchasers, representatives of professional groups and other interested parties. In developing the system, the Health Care Financing Administration shall consider among other things, the experience of third parties in using existing terminology systems in terms of implications for administrative and program costs, simplicity and lack of ambiguity, and the degree of acceptance and use.

"(b) Upon development of a proposed system of procedural terminology and its approval by the Secretary the system shall be published in the Federal Register. Interested parties shall have not less than six months in which to comment on the proposed system and to recommend relative values to the Secretary for the procedures and services designated by the terms. Comments and proposals shall be supported by information and documentation specified by the Secretary.

"(c) The good faith preparation of a relative value schedule or its submission to the Secretary by an association of health practitioners solely in response to a request of the Secretary as authorized under this section shall not in itself be considered a violation of any consent decree by which an association has waived its right to make recommendations concerning fees. The proposed relative value schedule shall not be disclosed to anyone other than those persons actually preparing it or their counsel until it is made public by the Secretary.

"(d) The Health Care Financing Administration shall review materials submitted under this section and shall recommend that the Secretary adopt a specific terminology system and its relative values for use by carriers in calculating reasonable charges under title XVIII of this Act, but only after—

"(1) interested parties have been given an opportunity to comment and any comments have been considered;

"(2) statistical analyses have been conducted assessing the economic impact of the relative values on the physicians in various specialties, geographic areas and types of practice, and on the potential liability of the program established by part B of title XVIII of this Act;

"(3) it has been determined that the proposed terminology and related definitions are unambiguous, practical, and easy to evaluate in actual clinical situations and that the unit values assigned generally reflect the relative time and effort required to perform various procedures and services; and

"(4) it has been determined that the use of the proposed system will enhance the administration of the Federal health care financing programs.

"(e) A system of terminology, definitions, and their relative values, as approved by the Secretary, shall be periodically reviewed by him and may be modified. An approved system (as amended by any modification of the Secretary) may subsequently be used by any organization or person for purposes other than those of this Act. Nothing in this section shall be considered to bar the Secretary from adopting a uniform system of procedural terminology in situations where a relative value schedule has not been approved.".

TEACHING PHYSICIANS

SEC. 8. Section 15(d) of Public Law 93-233 (as amended by section 7(c) of Public Law 93-368, the first section of Public Law 94-368, and section 7 of Public Law 95-292) is amended by striking out "October 1, 1978" and inserting in lieu thereof "October 1, 1979".

CERTAIN SURGICAL PROCEDURES PERFORMED ON AN AMBULATORY BASIS

SEC. 9. Part B of title XVIII of the Social Security Act is amended by adding at the end thereof the following new section:

"SPECIAL PROVISIONS RELATING TO CERTAIN SURGICAL PROCEDURES PERFORMED ON AN AMBULATORY BASIS

"SEC. 1845. (a) The Secretary shall, in consultation with the National Professional Standards Review Council and appropriate medical organizations, specify those surgical procedures which can be safely and appropriately performed either in a hospital on an inpatient basis or on an ambulatory basis—

"(1) in a physician's office; or

"(2) in an ambulatory surgical center or hospital.

"(b)(1) If a physician performs in his office a surgical procedure specified by the Secretary pursuant to subsection (a)(1) on an individual insured for benefits under this part, he shall, notwithstanding any other provision of this part, be entitled to have payment made under this part equal to—

"(A) 100 percent of the reasonable charge for the services involved with the performance of such procedure (including all pre- and post-operative physicians' services performed in connection therewith), plus

"(B) the amount established by the Secretary pursuant to paragraph (2),

but only if the physician agrees with such individual to be paid on the basis of an assignment under the terms of which the reasonable charge for such services is the full charge therefor.

"(2) The Secretary shall establish with respect to each surgical procedure specified pursuant to subsection (a)(1), an amount established with a view to according recognition to the special costs, in excess of usual overhead, which physicians incur which are attributable to securing, maintaining, and staffing the facilities and ancillary services appropriate for the performance of such procedure in the physician's office, and to assuring that the performance of such procedure in the physician's office will involve substantially less total cost than would be involved if the procedure were performed on an inpatient basis in a hospital. The amount so established with respect to any surgical procedure periodically shall be reviewed and revised and may be adjusted, when appropriate, by the Secretary to take account of varying conditions in different areas.

"(c)(1) Payment under this part may be made to an ambulatory surgical center for ambulatory facility services furnished in connection with any surgical procedure, specified by the Secretary pursuant to subsection (a)(2), which is per-

formed on an individual insured for benefits under this part in an ambulatory surgical center, which meets such health, safety, and other standards as the Secretary shall by regulations prescribe, if such surgical center agrees to accept, in full payment of all services furnished by it in connection with such procedure, the amount established for such procedure pursuant to paragraph (2).

"(2) The Secretary shall establish with respect to each surgical procedure specified pursuant to subsection (a)(2), a reimbursement amount which is payable to an ambulatory surgical center for its services furnished in connection with such procedure. The amount established for any such surgical procedure shall be established with a view to according recognition to the costs incurred by such centers generally in providing the services involved in connection with such procedure, and to assuring that the performance of such procedure in such a center involves less cost than would be involved if such procedure were performed on an inpatient basis in a hospital. The amount so established with respect to any surgical procedure shall periodically be reviewed and revised and may be adjusted by the Secretary, when appropriate, to take account of varying conditions in different areas.

"(3) If the physician, performing a surgical procedure (specified by the Secretary under subsection (a)(2)), in a hospital on an outpatient basis or in an ambulatory surgical

center with respect to which payment is authorized under the preceding provisions of this subsection, or a physician performing physicians' services in such center or hospital directly related to such surgical procedure, agrees to accept as full payment for all services performed by him in connection with such procedure (including pre- and post-operative services) an amount equal to 100 percent of the reasonable charge for such services, he shall be paid under this part for such services an amount equal to 100 percent of the reasonable charge for such services.

"(d)(1) The Secretary is authorized by regulations to provide that in case a surgical procedure specified by the Secretary pursuant to subsection (a)(2) is performed on an individual insured for benefits under this part in an ambulatory surgical center which meets such health, safety, and other standards as the Secretary shall by regulations prescribe, there shall be paid with respect to the services furnished by such center and with respect to all related services (including physicians' services, laboratory, X-ray, and diagnostic services) a single all-inclusive fee established pursuant to paragraph (2), if all parties furnishing all such services agree to accept such fee (to be divided among the parties involved in such manner as they shall have previously agreed upon) as full payment for the services furnished.

"(2) In implementing this subsection, the Secretary shall establish with respect to each surgical procedure specified pursuant to subsection (a)(2) the amount of the all-inclusive fee for such procedure, taking into account such factors as may be appropriate. The amount so established with respect to any surgical procedure shall periodically be reviewed and revised and may be adjusted, when appropriate, to take account of varying conditions in different areas.

"(e) The provisions of section 1833 (a) and (b) shall not be applicable to expenses attributable to services to which subsection (b) is applicable, to ambulatory facility services (furnished by an ambulatory surgical center) to which the provisions of subsection (c) (1) and (2) are applicable, to physicians' services to which the provisions of subsection (c)(3) are applicable, or to services to which the provisions of subsection (d) are applicable.".

CRITERIA FOR DETERMINING REASONABLE CHARGE FOR PHYSICIANS' SERVICES

SEC. 10. (a) Section 1842(b) of the Social Security Act is amended—

(1) by redesignating paragraphs (4) and (5) as paragraphs (5) and (6);

(2) by striking out so much of paragraph (3) as follows the first sentence; and

(3) by inserting after paragraph (3) the following new paragraph:

"(4)(A) In determining the reasonable charge for services for purposes of paragraph (3) (including the services of any hospital-associated physicians), there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services.

"(B)(i) Except as otherwise provided in clause (iii), no charge may be determined to be reasonable in the case of bills submitted or requests for payment made under this part after December 31, 1970, if it exceeds the higher of (I) the prevailing charge recognized by the carrier and found acceptable by the Secretary for similar services in the same locality in administering this part on December 31, 1970, or (II) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the last preceding calendar year elapsing prior to the start of the fiscal year in which the bill is submitted or the request for payment is made.

"(ii) In the case of physician services, the prevailing charge level determined for purposes of clause (i)(II) for any fiscal year beginning after June 30, 1973, may not (except as

otherwise provided in clause (iii)) exceed (in the aggregate) the level determined under such clause for the fiscal year ending June 30, 1973, except to the extent that the Secretary finds, on the basis of appropriate economic index data, that such higher level is justified by economic changes. Moreover, for any twelve-month period beginning on July 1 of any year (beginning with 1980), no prevailing charge level for physicians' services shall be increased to the extent that it would exceed by more than one-third the statewide prevailing charge level (as determined under subparagraph (E)) for that service.

"(iii) Notwithstanding the provisions of clauses (i) and (ii) of this subparagraph, the prevailing charge level in the case of a physician service in a particular locality determined pursuant to such clauses for the fiscal year beginning July 1, 1975, shall, if lower than the prevailing charge level for the fiscal year ending June 30, 1975, in the case of a similar physician service in the same locality by reason of the application of economic index data, be raised to such prevailing charge level for the fiscal year ending June 30, 1975.

"(C) In the case of medical services, supplies, and equipment (including equipment servicing) that, in the judgment of the Secretary, do not generally vary significantly in quality from one supplier to another, the charges incurred after December 31, 1972, determined to be reasonable may

not exceed the lowest charge levels at which such services, supplies, and equipment are widely and consistently available in a locality except to the extent and under circumstances specified by the Secretary. With respect to power-operated wheelchairs for which payment may be made in accordance with section 1861(s)(6), charges determined to be reasonable may not exceed the lowest charge at which power-operated wheelchairs are available in the locality.

"(D) The requirement in paragraph (3)(B) that a bill be submitted or request for payment be made by the close of the following calendar year shall not apply if (i) failure to submit the bill or request the payment by the close of such year is due to the error or misrepresentation of an officer, employee, fiscal intermediary, carrier, or agent of the Department of Health, Education, and Welfare performing functions under this title and acting within the scope of his or its authority, and (ii) the bill is submitted or the payment is requested promptly after such error or misrepresentation is eliminated or corrected.

"(E) The Secretary shall determine separate statewide prevailing charge levels for each State that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 50 percent of the customary charges made for similar services in the State during the last preceding calendar year elapsing prior to the start of the fiscal year in which

the bill is submitted or the request for payment is made. In States with more than one carrier, the statewide prevailing charge level shall be the weighted average of the fiftieth percentiles of the customary charges of each carrier.

"(F) Notwithstanding any other provision of this paragraph, any charge for any particular service or procedure performed by a doctor of medicine or osteopathy shall be regarded as a reasonable charge if—

"(i) the service or procedure is performed in an area which the Secretary has designated as a physician shortage area,

"(ii) the physician has a regular practice in the physician shortage area,

"(iii) the charge does not exceed the prevailing charge level as determined under subparagraph (B), and

"(iv) the charge does not exceed the amount generally charged by such physician for similar services.".

(b) Sections 506(f)(1) and 1903(i)(1) of the Social Security Act are each amended by striking out "the fourth and fifth sentences of section 1842(b)(3)" and inserting in lieu thereof in each instance "subparagraphs (B)(ii), (B)(iii), (C), and (F) of section 1842(b)(4)".

(c) The amendments made by this section shall become effective on July 1, 1980.

PAYMENT FOR CERTAIN ANTIGENS UNDER PART B OF MEDICARE

SEC. 11. (a) Section 1861(s)(2) of the Social Security Act is amended—

(1) by striking out "and" at the end of clause (E),

(2) by inserting "and" at the end of clause (F), and

(3) by adding after clause (F) the following new clause:

"(G) antigens (subject to reasonable quantity limitations determined by the Secretary) prepared by an allergist for a particular patient, including antigens he prepares which are forwarded to another qualified person for administration to the patient by or under the supervision of a physician;".

(b) The amendments made by subsection (a) shall apply to items furnished after the month of enactment of this Act.

PAYMENT UNDER MEDICARE OF CERTAIN PHYSICIANS' FEES ON ACCOUNT OF SERVICES FURNISHED TO A DECEASED INDIVIDUAL

SEC. 12. (a) Section 1870(f) of the Social Security Act is amended by striking out the matter following clause (2) thereof and inserting in lieu thereof the following: "payment for such services shall be made (but only in such amount and

subject to such conditions as would have been applicable if the individual who received the services had not died) to—

"(A) the physician or other person who provided such services, but only on the condition that such physician or person agrees that the reasonable charge is the full charge for the services, or

"(B) the spouse or other legally designated representative of such individual, but only if (i) the condition specified in subparagraph (A) is not met, and (ii) such spouse or representative requests (in such form and manner as the Secretary shall by regulations prescribe) that payment be made under this subparagraph.".

(b) The amendment made by subsection (a) shall apply only to payments made after the month of enactment of this Act.

HOSPITAL PROVIDERS OF LONG-TERM CARE SERVICES

SEC. 13. (a) Section 1861 of the Social Security Act is amended by adding after subsection (bb) (as added by section 2 of this Act) the following:

"Hospital Providers of Extended Care Services

"(cc)(1)(A) Any hospital (other than a hospital which has in effect a waiver of the requirement imposed by subsection (e)(5)) which has an agreement under section 1866 may (subject to paragraph (2)) enter into an agreement with the Secretary under which its inpatient hospital facilities may be

used for the furnishing of services of the type which, if furnished by a skilled nursing facility, would constitute post-hospital extended care services.

"(B)(i) Notwithstanding any other provision of this title, payment to any hospital for services furnished under an agreement entered into under this subsection shall be based upon the reasonable cost of the services as determined under this subparagraph.

"(ii) The reasonable cost of the services shall consist of the reasonable cost of routine services and ancillary services. The reasonable cost of routine services furnished during any calendar year by a hospital under an agreement under this subsection shall equal the product of the number of patient-days during the year for which the services were furnished and the average reasonable cost per patient-day. The average reasonable cost per patient-day shall be established as the average rate per patient-day paid for routine services during the previous calendar year under the State plan (of the State in which the hospital is located) approved under title XIX to skilled nursing facilities located in such State and which meet the requirements specified in section 1902(a)(28). The reasonable cost of ancillary services shall be determined in the same manner as the reasonable cost of ancillary services provided as inpatient hospital services.

"(2) The Secretary shall not enter into an agreement under this subsection with any hospital unless—

"(A) the hospital is located in a rural area and has less than 50 beds, and

"(B) the hospital has been granted a certificate of need for the provision of long-term care services from the agency of the State (which has been designated as the State health planning and development agency under an agreement pursuant to section 1521 of the Public Health Service Act) in which the hospital is located.

"(3) An agreement with a hospital entered into under this section shall, except as otherwise provided under regulations of the Secretary, be of the same duration and subject to termination on the same conditions as are agreements with skilled nursing facilities under section 1866, and shall, where not inconsistent with any provision of this subsection, impose the same duties, responsibilities, conditions, and limitations, as those imposed under such agreements entered into under section 1866; except that no such agreement with any hospital shall be in effect for any period during which the hospital does not have in effect an agreement under section 1866, or during which there is in effect for the hospital a waiver of the requirement imposed by subsection (e)(5). A hospital with respect to which an agreement has been terminated shall not

be eligible to undertake a new agreement until a two-year period has elapsed from the termination date.

"(4) Any agreement with a hospital under this subsection shall provide that payment for services will be made only for services for which payment would be made as posthospital extended care services if those services had been furnished by a skilled nursing facility under an agreement entered into under section 1866, and any individual who is furnished services for which payment may be made under and agreement shall, for purposes of this title (other than this subsection), be deemed to have received posthospital extended care services in like manner and to the same extent as if the services furnished to him had been posthospital extended care services furnished by a skilled nursing facility under an agreement under section 1866.

"(5) During a period for which a hospital has in effect an agreement under this subsection, in order to allocate routine costs between hospital and long-term care services for purposes of determining payment for inpatient hospital services (including the application of reimbursement limits specified in section 1861 (bb)), the total reimbursement due for routine services from all classes of long-term care patients, including title XVIII, the State plan approved under title XIX, and private pay patients, shall be subtracted from the hospitals total routine costs before calculations are made to

determine title XVIII reimbursement for routine hospital services.

"(6) During any period during which an agreement is in effect with a hospital under this subsection, the hospital shall, for services furnished by it under the agreement, be considered to satisfy the requirements, otherwise required, of a skilled nursing facility for purposes of the following provisions: sections 1814(a)(2)(C), 1814(a)(6), 1814(a)(7), 1814(h), 1861(a)(2), 1861(i), 1861(j) (except 1861(j)(12)), and 1861(n); and the Secretary shall specify any other provisions of this Act under which the hospital may be considered as a skilled nursing facility.

"(7) The Secretary may enter into an agreement under this subsection on a demonstration basis with any hospital having more than 49 beds, but less than 101 beds, if such hospital otherwise meets the requirements of this subsection.

"(8) Within three years after the date of enactment of this subsection, the Secretary shall provide a report to the Congress containing an evaluation of the program established under this subsection concerning—

"(A) the effect of the agreements on availability and effective and economical provision of long-term care services;

"(B) whether the program should be continued; and

"(C) whether eligibility should be extended to other hospitals, regardless of bed size or geographic location, where there is a shortage of long-term care beds.".

(b) Title XIX of such Act is amended by adding at the end thereof the following new section:

"HOSPITAL PROVIDERS OF SKILLED NURSING AND INTERMEDIATE CARE SERVICES

SEC. 1913. (a) Notwithstanding any other provision of this title, payment may be made, in accordance with this section, under an approved State plan for skilled nursing services and intermediate care services furnished by a hospital which has in effect an agreement under section 1861(cc).

"(b)(1) Payment to any such hospital, for any skilled nursing or intermediate care services furnished pursuant to subsection (a), shall be at a rate equal to the average rate per patient-day paid for routine services during the previous calendar year under the State plan to skilled nursing and intermediate care facilties located in the State in which the hospital is located. The reasonable cost of ancillary services shall be determined in the same manner as the reasonable cost of ancillary services provided for inpatient hospital services.

"(2) With respect to any period for which a hospital has in effect an agreement under section 1861(cc), in order to allocate routine costs between hospital and long-term care

services, the total reimbursement for routine services due from all classes of long-term care patients, including title XVIII, the State plan, and private pay patients, shall be subtracted from the hospital total routine costs before calculations are made to determine reimbursement for routine hospital services under the State plan.".

(c) Section 1861(j) is amended by inserting "and except as provided in subsection (cc)" after "subsection (a)(2)".

(d) The amendments made by this section shall become effective on the date on which final regulations, promulgated by the Secretary to implement the amendments, are issued; and those regulations shall be issued not later than the first day of the sixth month following the month in which this Act is enacted.

REIMBURSEMENT RATES UNDER MEDICAID FOR SKILLED NURSING AND INTERMEDIATE CARE FACILITIES

SEC. 14. (a) Section 1902(a)(13)(E) of the Social Security Act is amended by inserting "(and which may, at the option of the State, include reasonable allowances for the facilities in the form of incentive payments related to efficient performance)" after "cost related basis".

(b) The amendment made by subsection (a) shall become effective on October 1, 1979.

MEDICAID CERTIFICATION AND APPROVAL OF SKILLED NURSING AND INTERMEDIATE CARE FACILITIES

SEC. 15. (a) Section 1910 of the Social Security Act is amended to read as follows:

"CERTIFICATION AND APPROVAL OF SKILLED NURSING AND INTERMEDIATE CARE FACILITIES

"SEC. 1910. (a) The Secretary shall make an agreement with any State which is willing and able to do so whereby the State health agency or other appropriate State or local agencies (whichever are utilized by the Secretary pursuant to section 1864(a)) will be utilized to recommend to him whether an institution in the State qualifies as a skilled nursing facility (for purposes of section 1902(a)(28)) or an intermediate care facility (for purposes of section 1905(c)).

"(b) The Secretary shall advise the State agency administering the medical assistance plan of his approval or disapproval of any institution certified to him as a qualified skilled nursing or intermediate care facility for purposes of section 1902(a)(28) or section 1905(c) and specify for each institution the period (not to exceed twelve months) for which approval is granted, except that the Secretary may extend that term for up to two months, provided the health and safety of patients will not be jeopardized, if he finds that an extension is necessary to prevent irreparable harm to the facility or hardship to the facility's patients or if he finds it impracticable

within the twelve-month period to determine whether the facility is complying with the provisions of this title and applicable regulations. The State agency may, upon approval of the Secretary, enter into an agreement with any skilled nursing or intermediate care facility for the specified approval period.

"(c) The Secretary may cancel approval of any skilled nursing or intermediate care facility at any time if he finds that a facility fails to meet the requirements contained in section 1902(a)(28) or section 1905(c), or if he finds grounds for termination of his agreement with the facility pursuant to section 1866(b). In that event the Secretary shall notify the State agency and the skilled nursing or intermediate care facility that approval of eligibility of the facility to participate in the programs established by this title and title XVIII shall be terminated at a time specified by the Secretary. The approval of eligibility of any such facility to participate in the programs may not be reinstated unless the Secretary finds that the reason for termination has been removed and there is reasonable assurance that it will not recur.

"(d) Effective July 1, 1980, no payment may be made to any State under this title for skilled nursing or intermediate care facility services furnished by any facility—

"(1) which does not have in effect an agreement with the State agency pursuant to subsection (b), or

"(2) with respect to which approval of eligibility to participate in the programs established by this title or title XVIII has been terminated by the Secretary and has not been reinstated, except that payment may be made for up to thirty days for skilled nursing or intermediate care facility services furnished to any eligible individual who was admitted to the facility prior to the effective date of the termination.

"(e) Any skilled nursing facility or intermediate care facility which is dissatisfied with any determination by the Secretary that it no longer qualifies as a skilled nursing facility or intermediate care facility for purposes of this title shall be entitled to a hearing by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g). Any agreement between such facility and the State agency shall remain in effect until the period for filing a request for a hearing has expired or, if a request has been filed, until a decision has been made by the Secretary; except that the agreement shall not be extended if the Secretary makes a written determination, specifying the reasons therefor, that the continuation of provider status constitutes an immediate and serious threat to the health and safety of patients, and the Secretary certifies that the facility has been notified of its deficiencies and has failed to correct them.".

(b) Section 1869(c) of the Social Security Act is amended by adding at the end thereof the following sentence: "If the Secretary's determination terminates a provider with an existing agreement pursuant to section 1866(b)(2), or if such determination consists of a refusal to renew an existing provider agreement, the provider's agreement shall remain in effect until the period for filing a request for a hearing has expired or, if a request has been filed, until a final decision has been made by the Secretary; except that the agreement shall not be extended if the Secretary makes a written determination, specifying the reasons therefor, that the continuation of provider status constitutes an immediate and serious threat to the health and safety of patients and if the Secretary certifies that the provider has been notified of such deficiencies and has failed to correct them.".

(c) The amendments made by the preceding provisions of this section shall become effective on the date on which final regulations, promulgated by the Secretary to implement the amendments, are issued; and those regulations shall be issued not later than the first day of the sixth month following the month in which this Act is enacted.

(d) Title XIX of the Social Security Act is amended by adding after section 1910 thereof the following new section:

"CERTIFICATION AND APPROVAL OF RURAL HEALTH CLINICS

"SEC. 1910A. (a) Whenever the Secretary certifies a facility in a State to be a qualified rural health clinic under title XVIII, such facility shall be deemed to meet the standards for certification as a rural health clinic for purposes of providing rural health clinic services under this title.

"(b) The Secretary shall notify the State agency administering the medical assistance plan of his approval or disapproval of any facility in that State which has applied for certification by him as a qualified rural health clinic.".

(e) Section 1866(c)(2) of the Social Security Act is amended by striking out "1910(a)" and inserting in lieu thereof "1910".

VISITS AWAY FROM INSTITUTION BY PATIENTS OF SKILLED NURSING OR INTERMEDIATE CARE FACILITY

SEC. 16. (a) Section 1903 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(r) In the administration of this title, the fact that an individual who is an inpatient of a skilled nursing or intermediate care facility leaves to make visits outside the facility shall not conclusively indicate that he does not need services which the facility is designed to provide; however, the frequency and length of such visits shall be considered, together

with other evidence, in determining whether the individual is in need of the facility's services.".

(b) The amendment made by subsection (a) shall become effective on October 1, 1979.

NOTIFICATION TO STATE OFFICIALS

SEC. 17. Part A of title XI of the Social Security Act is amended by adding after section 1129 (as added by section 7 of this Act) the following new section:

"NOTIFICATION TO STATE OFFICIALS

"SEC. 1130. If the Secretary notifies a State of any audit, quality control performance report, deficiency, or any reduction, termination, or increase in Federal matching, under the State plan for any program for which Federal payments are made under this Act, simultaneous notification shall also be made to the Governor of the State and the respective chairmen of the legislative and appropriation committees of that State's legislature having jurisdiction over the program affected.".

REPEAL OF SECTION 1867

SEC. 18. Section 1867 of the Social Security Act is repealed.

PROCEDURES FOR DETERMINING REASONABLE COST AND REASONABLE CHARGE

SEC. 19. (a) Part A of title XI of the Social Security Act is amended by adding after section 1131 the following new section:

"EXCLUSION OF CERTAIN ITEMS IN DETERMINING REASONABLE COST AND REASONABLE CHARGE

"SEC. 1132. (a) Except as otherwise provided in subsection (b), in determining the amount of any payment under title XVIII, under a program established under title V, or under a State plan approved under title XIX of this Act, when the payment is based upon the reasonable cost or reasonable charge, no element comprising any part of the cost or charge shall be considered to be reasonable if, and to the extent that, such element is—

"(1) a commission, finder's fee, or for a similar arrangement, or

"(2) an amount payable for any facility (or part or activity thereof) under any rental or lease arrangement, which is, directly or indirectly, determined, wholly or in part as a percentage, fraction, or portion of the charge or cost attributed to any health service (other than the element) or any health service including, but not limited to, the element.

"(b) The Secretary shall by regulations establish exceptions to the provisions of subsection (a) with respect to any element of cost or charge which consists of payments based on a percentage arrangement, if such element is otherwise reasonable and the percentage arrangement—

"(1) is a customary commercial business practice, or

"(2) provides incentives for the efficient and economical operation of the health service.".

(b) Section 506 of such Act is amended by adding at the end thereof the following new subsection:

"(h) For additional exclusions from reasonable cost and reasonable charge see section 1132.".

(c) Section 1842(b)(4) of such Act (as amended by sections 6 and 10 of this Act) is further amended by adding at the end thereof the following new subparagraph:

"(H) For additional exclusions from reasonable cost and reasonable charge see section 1132.".

(d) Section 1861(v) of such Act is amended by adding after paragraph (9) (as added by section 6 of this Act) the following new paragraph:

"(10) For additional exclusions from reasonable cost and reasonable charge see section 1132.".

(e) Section 1903 of such Act is amended by adding after subsection (r) (as added by section 16 of this Act) the following new subsection:

"(s) For additional exclusions from reasonable cost and reasonable charge see section 1130.".

AMBULANCE SERVICE

SEC. 20. (a) Section 1861(s)(7) of the Social Security Act is amended by inserting after "ambulance service" the following: "(including ambulance service to the nearest hospital which is (A) adequately equipped, and (B) has medical personnel qualified to deal with, and available for the treatment of, the individual's illness, injury, or condition)".

(b) The amendment made by subsection (a) shall apply to services furnished on or after the first day of the first month which begins more than 180 days after the date of the enactment of this Act, or, if earlier, the effective date of regulations promulgated by the Secretary to implement such amendment.

GRANTS TO REGIONAL PEDIATRIC PULMONARY CENTERS

SEC. 21. (a) Section 511 of the Social Security Act is amended—

(1) by inserting "(a)" after "SEC. 511.", and

(2) by adding at the end thereof the following new subsection:

"(b)(1) From the sums available under paragraph (2) the Secretary is authorized to make grants to public or nonprofit private regional pediatric pulmonary centers, which are a part of (or are affiliated with) an institution of higher learning, to assist them in carrying out a program for the training and instruction (through demonstrations and otherwise) of health care personnel in the prevention, diagnosis, and treatment of respiratory diseases in children and young adults, and in providing (through such program) needed health care services to children and young adults suffering from such diseases.

"(2) For the purpose of making grants under this subsection, there are authorized to be appropriated, for the fiscal year ending September 30, 1980, and each of the next four succeeding fiscal years, such sums (not in excess of $5,000,000 for any fiscal year) as may be necessary. Sums authorized to be appropriated for any fiscal year under this subsection for making grants for the purposes referred to in paragraph (1) shall be in addition to any sums authorized to be appropriated for such fiscal year for similar purposes under other provisions of this title.".

(b) Section 502(2) of such Act is amended by inserting "(a)" after "511".

WAIVER OF HUMAN EXPERIMENTATION PROVISION FOR MEDICARE AND MEDICAID

SEC. 22. Any requirements of title II of Public Law 93-348 otherwise held applicable are hereby waived with respect to coverage, or copayments, deductibles, or other limitations on payment for services (whether of general application or in effect only on a trial or demonstration basis) under programs established under titles XVIII and XIX of the Social Security Act. Notwithstanding the first sentence of this section, the Secretary in reviewing any application for any experimental, pilot or demonstration project pursuant to the Social Security Act shall apply any appropriate requirements of title II of Public Law 93-348 and any regulations promulgated thereunder in making his decision on whether to approve such application.

DISCLOSURE OF AGGREGATE PAYMENTS TO PHYSICIANS

SEC. 23. Section 1106 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(f) The Secretary shall not make available, nor shall the State title XIX agency be required to make available to the public, information relating to the amounts that have been paid to individual doctors of medicine or osteopathy by or on behalf of beneficiaries of the health programs established by title XVIII or XIX, as the case may be, except as

may be necessary to carry out the purposes of those titles or as may be specifically required by the provisions of other Federal law.".

RESOURCES OF MEDICAID APPLICANT TO INCLUDE CERTAIN ASSETS PREVIOUSLY DISPOSED OF FOR SUBSTANTIALLY LESS THAN MARKET VALUE

SEC. 24. (a) Section 1904 of the Social Security Act is amended by adding at the end thereof the following sentence: "The Secretary shall not find that a State has failed to comply with the requirements of this title solely because it denies medical assistance to an individual who would be ineligible for such assistance if, in determining whether he is eligible for benefits under title XVI of this Act, or, in the case of an individual who is not included under section 1902(a)(13)(B), in determining whether he is eligible for medical assistance under the State plan, there was included in his resources any asset owned by him within the preceding twelve months to the extent that he gave or sold that asset to any person for substantially less than its fair market value for the purpose of establishing eligibility for medical assistance under the State plan (and any such transaction shall be presumed to have been for such purpose unless such individual furnishes convincing evidence to establish that the transaction was for some other purpose).".

(b) Section 1902(a) of the Social Security Act is amended—

(1) by striking out "and" at the end of paragraph (39);

(2) by striking out the period at the end of paragraph (40) and inserting in lieu thereof "; and"; and

(3) by adding at the end thereof the following new paragraph:

"(41) contain provisions reasonably directed at the denial of eligibility for medical assistance under the State plan to an individual who would be ineligible for such assistance except for the transfer of assets, for substantially less than fair market value; except that such denial shall be made only to the extent authorized under the last sentence of section 1904 or under other provisions of this title.".

(c)(1) The amendment made by subsection (a) shall become effective on October 1, 1979.

(2)(A) The amendment made by subsection (b) shall, except as otherwise is provided in subparagraph (B), become effective on July 1, 1980.

(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the

amendments made by subsection (b), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature which begins after the date of enactment of this Act.

RATE OF RETURN ON NET EQUITY FOR FOR-PROFIT HOSPITALS

SEC. 25. Section 1861(v)(1)(B) of the Social Security Act is amended—

(1) in the first sentence thereof, by inserting "a hospital or" immediately after "Such regulations in the case of";

(2) in the second sentence thereof, by striking out "one and one-half times" and inserting in lieu thereof "the percentages, specified in the next sentence, of"; and

(3) by inserting after the last sentence thereof the following new sentence: "For hospital and skilled nursing facility accounting years beginning before July 1, 1980, the percentage referred to in the previous sentence is 150 percent and for subsequent accounting years, the percentage is—

"(i) 150 percent with respect to a skilled nursing facility;

"(ii) 150 percent with respect to a hospital which, during such accounting year, has actual routine operating costs which were greater than the maximum allowable routine operating costs of such hospital as determined under section 1861(bb)(4)(B)(i);

"(iii) 250 percent with respect to a hospital which, during such accounting year had actual routine operating costs which were less than the hospital's adjusted per diem target rate for routine operating costs as determined under section 1861(bb)(4); and

"(iv) 200 percent with respect to other hospitals.".

DEDUCTIBLE NOT APPLICABLE TO EXPENSES FOR CERTAIN INDEPENDENT LABORATORY TESTS

SEC. 26. (a) The first sentence of section 1833(b) of the Social Security Act is amended—

(1) by striking out "and" at the end of clause (1), and

(2) by inserting immediately before the period the following: ", and (3) such total amount shall not include expenses incurred for diagnostic tests with re-

spect to which the provisions of subsection (a)(1)(D) are applicable".

(b) The amendments made by subsection (a) shall be applicable with respect to services provided on or after the first day of the first calendar month which begins more than 60 days after the date of enactment of this Act.

PAYMENT FOR LABORATORY SERVICES UNDER MEDICAID

SEC. 27. (a)(1) Section 1902(a)(23) of the Social Security Act is amended by inserting "(A)" before "has entered into" and by inserting before the semicolon at the end the following: ", or (B) during the three-year period beginning on the date of enactment of the Medicare-Medicaid Administrative and Reimbursement Reform Act, has made arrangements through a competitive bidding process or otherwise for the purchase of laboratory services referred to in section 1905(a)(3), if the Secretary has found that (i) adequate services will be available under such arrangements, (ii) such laboratory services will be provided only through laboratories (I) which meet the requirements of section 1861(e)(9), paragraphs (10) and (11) of section 1861(s), and such additional requirements as the Secretary may require, and (II) no more than 75 per centum of whose charges for such services are for services provided to individuals who are entitled to benefits under this title or under part A or part B of title XVIII, and (iii) charges for services provided under such arrange-

ments are made at the lowest rate charged (determined without regard to administrative costs which are related solely to the method of reimbursement for such services) for comparable services by the provider of such services, or, if charged for on a unit price basis, such charges result in aggregate expenditures not in excess of expenditures that would be made if charges were at the lowest rate charged for comparable services by the provider of such services".

(2) The Secretary shall evaluate arrangements made for the purchase of laboratory services under section 1902(a)(23)(B) of the Social Security Act and shall transmit that evaluation to the Congress, together with recommendations as to whether such section 1902(a)(23)(B) should be extended or modified, no later than twenty-four months after the date of enactment of this Act.

(b) Section 1902(a)(28) of such Act is amended by inserting before the semicolon the following: ", and provide that any laboratory services (other than such services provided in a physician's office) paid for under such plan must be provided by a laboratory which during the three-year period beginning on the date of enactment of the Medicare-Medicaid Administrative and Reimbursement Reform Act meets the requirements of section 1861(e)(9), paragraphs (10) and (11) of section 1861(s) or, in the case of a rural health clinic, subsection 1861(aa)(2)(G)".

(c) Section 1902(a)(30) of such Act is amended by inserting before the semicolon the following: "; and, in the case of laboratory services referred to in section 1905(a)(3), such payments do not exceed the lowest amount charged (determined without regard to administrative costs which are related solely to the method of reimbursement for such services) to any person or entity for such services by that provider of laboratory services".

(d)(1) The amendments made by subsections (b) and (c) shall (except as otherwise provided in paragraph (2)) apply to medical assistance provided, under a State plan approved under title XIX of the Social Security Act, on or after the first day of the first calendar quarter that begins more than 30 days after the date of enactment of this Act.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by paragraph (b) or (c), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act.

CONFIDENTIALITY OF PSRO DATA

SEC. 28. Section 1166(a) of the Social Security Act is amended by inserting "which identifies (either by name or by inference) an individual patient, practitioner, provider, supplier or reviewer" immediately after "functions".

REMOVAL OF THREE-DAY HOSPITALIZATION REQUIREMENT AND ONE HUNDRED-VISIT LIMITATION FOR HOME HEALTH SERVICES

SEC. 29. (a) Section 1811 of the Social Security Act is amended by striking out "post-hospital".

(b) Section 1812(a)(3) of such Act is amended to read as follows:

"(3) home health services.".

(c) Section 1812(d) of such Act is repealed.

(d) Section 1812(e) of such Act is amended—

(1) by striking out "(c), and (d)" and inserting in lieu thereof "and (c)"; and

(2) by striking out "post-hospital extended care services, and post-hospital home health services" and inserting in lieu thereof "and post-hospital extended care services".

(e) Section 1814(a)(2)(D) of such Act is amended—

(1) by striking out "post-hospital"; and

(2) by striking out "for any of the conditions with respect to which he was receiving inpatient hospital

services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) and (9) of section 1861(e)) or post-hospital extended care services".

(f) Section 1814(i) of such Act is amended—

(1) by striking out "Posthospital" in the heading thereof; and

(2) by striking out "posthospital" in paragraph (1).

(g) Section 1832(a)(2)(A) of such Act is amended by striking out "for up to 100 visits during a calendar year".

(h) Section 1834 of such Act is repealed.

(i) Section 1861(n) of such Act is repealed.

(j) Section 1861(e) of such Act is amended—

(1) by striking out "subsections (i) and (n)" in the matter preceding paragraph (1) and inserting in lieu thereof "subsection (i)"; and

(2) by striking out "subsections (i) and (n)" in the third sentence and inserting in lieu thereof "subsection (i)".

(k) Section 226(c)(1) of such Act is amended—

(1) by striking out "and post-hospital home health services" and inserting in lieu thereof "and home health services"; and

(2) by striking out "or post-hospital home health services" in clause (B).

(l) Section 7(d)(1) of the Railroad Retirement Act is amended by striking out "posthospital home health services" and inserting in lieu thereof "home health services".

(m) The amendments made by this section shall be effective with respect to services provided on or after July 1, 1980.

PAYMENT FOR DURABLE MEDICAL EQUIPMENT

SEC. 30. Section 1833(f)(3) of the Social Security Act is amended to read as follows:

"(3) For purposes of determining the amount payable with respect to durable medical equipment furnished an individual as described in section 1861(s)(6), the Secretary shall, to the extent feasible, calculate at least annually the reasonable charge on a prospective basis and shall take into account, in addition to the customary charges for such equipment, the acquisition costs of such equipment, appropriate overhead (taking into consideration the level of delivery services and other necessary services actually provided by the supplier), and a reasonable margin of profit.".

DEVELOPMENT OF UNIFORM CLAIMS FORMS FOR USE UNDER HEALTH CARE PROGRAMS

SEC. 31. (a) Part A of title XI of the Social Security Act is amended by adding after section 1132 (as added by section 19 of this Act) the following new section:

"DEVELOPMENT OF UNIFORM CLAIMS FORMS

"SEC. 1133. (a) Within the 2-year period commencing on the date of the enactment of this section, the Secretary shall, to the maximum extent feasible, develop and require to be employed, in the administration of the health insurance for the aged and disabled program established by title XVIII and the medical assistance programs approved under title XIX, uniform claims forms which shall be utilized in making payment for health services under such programs. Such claims forms may vary in form and content, but only to the extent clearly required.

"(b) The Secretary shall require forms developed pursuant to subsection (a) to be utilized in the administration of health care programs (other than those referred to in subsection (a)) but over which he has administrative responsibility, if he determines that such use is in the interest of effective administration of such programs.

"(c) The Secretary, in carrying out the provisions of subsection (a) shall consult with those charged with the administration of Federal programs (other than those referred

to in subsections (a) and (b)) and with other organizations and persons that pay for health care, and with the concerned providers of health care services, with the objective of having a broad representation of such programs and plans to facilitate and encourage maximum use by other programs of such uniform claims forms.".

(b) The Secretary shall make a report to the Congress, within 21 months after the enactment of this Act, covering the following points:

(1) his assessment of what his actions will be in carrying out the provisions of section 1133 of the Social Security Act,

(2) the success or lack of success in encouraging third-party payors generally to adopt the uniform claims forms required under such section, and

(3) his recommendations as to what action, legislative or otherwise, needs to be taken in order to maximize the use of such uniform claims forms.

COORDINATED AUDITS UNDER THE SOCIAL SECURITY ACT

SEC. 32. (a) Title XI of the Social Security Act is amended by inserting after section 1133 (as added by section 31 of this Act) the following new section:

"COORDINATED AUDITS

"SEC. 1134. If an entity provides services reimbursable on a cost-related basis under title V or XIX, as well as serv-

ices reimbursable on such a basis under title XVIII, the Secretary shall require, as a condition for payment to any State under title V or XIX with respect to administrative costs incurred in the performance of audits of the books, accounts, and records of that entity, that these audits be coordinated through common audit procedures with audits performed with respect to the entity for purposes of title XVIII. The Secretary shall apportion to the program established under title V or XIX that part of the cost of coordinated audits which is attributable to each such program and which would not have otherwise been incurred in an audit of the program established under title XVIII. Where the Secretary finds that a State has declined to participate in such a common audit with respect to title V or XIX, he shall reduce the payments otherwise due such State under such title by an amount which he estimates to be the amount that represents the duplication of costs resulting from such State's failure to participate in the common audit.".

(b)(1) Section 1902(a) of the Social Security Act (as amended by section 24 of this Act) is further amended—

(A) by striking out "and" at the end of paragraph (40);

(B) by striking out the period at the end of paragraph (41) and inserting in lieu thereof "; and"; and

(C) by inserting after paragraph (41) the following new paragraph:

"(42) provide (A) that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan, (B) that such audits, for such entities also providing services under part A of title XVIII, will be coordinated and conducted jointly (to such extent and in such manner as the Secretary shall prescribe) with audits conducted for purposes of such title, and (C) for payment of the portion of the costs of each such common audit of such an entity equal to the portion of the cost of the common audit which is attributable to the program established under this title and which would not have otherwise been incurred in an audit of the program established under title XVIII.".

(2)(A) The amendments made by paragraph (1) shall (except as otherwise is provided in subparagraph (B)) apply to medical assistance provided, under a State plan approved under title XIX of the Social Security Act, on or after the first day of the first calendar quarter which begins more than 30 days after the date of enactment of this Act.

(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by subsection (b), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature which begins after the date of enactment of this Act.

(c)(1) Section 505(a) of the Social Security Act is amended—

(A) by striking out "and" at the end of paragraph (14);

(B) by striking out the period at the end of paragraph (15) and inserting in lieu thereof "; and"; and

(C) by inserting after paragraph (15) the following new paragraph:

"(16) provides (A) that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan, (B) that such audits, for such entities also providing services

under part A of title XVIII, will be coordinated and conducted jointly (to such extent and in such manner as the Secretary shall prescribe) with audits conducted for purposes of such part, and (C) for payment of the portion of costs of each such common audit of such an entity equal to the portion of the cost of the common audit which is attributable to the program established under this title and which would not have otherwise been incurred in an audit of the program established under title XVIII.".

(2) The amendments made by paragraph (1) shall apply to services provided, under a State plan approved under title V of the Social Security Act, on or after the first day of the first calendar quarter which begins more than 30 days after the date of enactment of this Act.

(d) The Secretary shall report to Congress, not later than March 31, 1981, on actions the Secretary has taken (1) to coordinate the conduct of institutional audits and inspections which are required under the programs funded under title V, XVIII, or XIX of the Social Security Act and (2) to coordinate such audits and inspections with those conducted by other cost payers, and he shall include in such report recommendations for such legislation as he deems appropriate to assure the maximum feasible coordination of such institutional audits and inspections.

ENCOURAGEMENT OF PHILANTHROPIC SUPPORT FOR HEALTH CARE

SEC. 33. Title XI of the Social Security Act is amended by inserting after section 1134 (as added by section 32 of this Act) the following new section:

"ENCOURAGEMENT OF PHILANTHROPIC SUPPORT FOR HEALTH CARE

"SEC. 1135. (a) It is the policy of the Congress that philanthropic support for health care be encouraged and expanded, especially in support of experimental and innovative efforts to improve the health care delivery system and access to health care services.

"(b)(1) For purposes of determining, under title XVIII or XIX, the reasonable costs of any service furnished by a provider of health services—

"(A) except as provided in paragraph (2), unrestricted grants, gifts, and endowments and income therefrom, shall not be deducted from the operating costs of such provider, and

"(B) grants, gifts, and endowment income designated by a donor for paying specific operating costs of such provider shall be deducted from the particular operating costs or group of costs involved.

"(2) Income from endowments and investments may be used to reduce interest expense, if such income is from an

unrestricted gift or grant and is commingled with other funds, except that in no event shall any such interest expense be reduced below zero by any such income.".

STUDY OF AVAILABILITY AND NEED FOR SKILLED NURSING FACILITY SERVICES UNDER MEDICARE AND MEDICAID

SEC. 34. (a)(1) The Secretary of Health, Education, and Welfare (hereinafter in this section referred to as the "Secretary") shall conduct a thorough study and investigation of the availability and need for skilled nursing facility services covered under part A of title XVIII of the Social Security Act and under State plans approved under title XIX of such Act.

(2) Such study shall include—

(A) an investigation of the desirability and feasibility of imposing a requirement that skilled nursing facilities (i) which furnish services to patients covered under State plans approved under title XIX of the Social Security Act also furnish such services to patients covered under part A of title XVIII of such Act, and (ii) which furnish services to patients covered under such title XVIII also to furnish such services to patients covered under such State plans,

(B) an evaluation of the impact of existing laws and regulations on skilled nursing facilities and individuals covered under such State plans and under part A

of such title XVIII, and an evaluation of the extent to which existing laws and regulations encourage skilled nursing facilities to accept only title XVIII beneficiaries or title XIX recipients, and

(C) an investigation of possible changes in regulations and legislation which would result in encouraging a greater availability of skilled nursing services.

(3) In developing such study, the Secretary shall consult with professional organizations, health experts, private insurers, nursing home providers, and consumers of skilled nursing facility services.

(b) Within 6 months after the date of enactment of this Act the Secretary shall complete such study and investigation and shall submit a full and complete report thereon, together with recommendations with respect to the matters covered by such study and investigation (including any recommendations for administrative or legislative changes), to the Committee on Finance of the Senate and to the Committee on Ways and Means and the Committee on Interstate and Foreign Commerce of the House of Representatives.

COVERAGE UNDER MEDICARE OF CERTAIN DENTISTS' SERVICES

SEC. 35. (a) Clause (2) of the first sentence of section 1861(r) of the Social Security Act is amended to read as follows: "(2) a doctor of dentistry or of dental or oral surgery

who is legally authorized to practice dentistry by the State in which he performs such function, but only with respect to (A) a function (i) which he is legally authorized to perform as such by the State in which he performs such function, and (ii) which, if performed by an individual described in clause (1), would constitute physicians' services, or (B) the certification required by section 1814(a)(2)(E) of this Act,".

(b) The amendment made by subsection (a) shall be effective with respect to service provided on or after October 1, 1979.

COVERAGE UNDER MEDICARE OF OPTOMETRISTS' SERVICES WITH RESPECT TO APHAKIA

SEC. 36. (a) The first sentence of section 1861(r) of the Social Security Act is amended, in clause (4) thereof, by—

(1) inserting "(i)" immediately after "with respect to", and

(2) inserting immediately after "lenses," the following: ", and (ii) any function with respect to aphakia which he is legally authorized to perform as such by the State in which he performs such function,".

(b) The amendments made by subsection (a) shall be effective with respect to services provided on or after October 1, 1979.

STUDY OF CRITERIA EMPLOYED FOR CLASSIFYING A FACILITY AS A SKILLED NURSING FACILITY

SEC. 37. (a) The Secretary of Health, Education, and Welfare (hereinafter in this section referred to as the "Secretary") shall conduct a special study, investigation, and review of the criteria presently employed in determining whether a facility is a "skilled nursing facility" as that term is used in paragraph (2) of section 1861(a) of the Social Security Act (relating to definition of "spell of illness"), with a view to determining, and recommending to the Congress, such modifications in such criteria as he may consider appropriate.

(b) The Secretary shall not later than December 31, 1980, submit to the Congress a full and complete report on such study, investigation, and review, together with his recommendations for any modification in the criteria referred to in subsection (a).

AUTHORITY FOR CERTAIN STATES TO BUY-IN COVERAGE UNDER PART B OF MEDICARE FOR CERTAIN MEDICAID RECIPIENTS

SEC. 38. Section 1843 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(i) Any State, which prior to the date of enactment of this subsection—

"(A) has not entered into an agreement under the preceding provisions of this section, may enter into such an agreement at any time within the twelve-month period which begins with the month following the month in which this subsection is enacted, and any such agreement shall conform to the modifications prescribed by the Secretary (as referred to in the third sentence of subsection (b)) and may, at the option of the State, contain any provision authorized under subsections (g) and (h) with respect to modifications of agreements with States entered into under the preceding provisons of this section; or

"(B) has entered into an agreement under the preceding provisions of this section which has not been modified pursuant to the authority contained in subsection (g) or (h), may within the twelve-month period which begins with the month following the month in which this subsection is enacted modify such agreement in like manner as if the date referred to in subsections (g)(1) and (h)(1) were the day following the close of such twelve-month period.".

HEALTH MAINTENANCE ORGANIZATIONS ENROLLING OVER 50 PERCENT MEDICARE OR MEDICAID RECIPIENTS

SEC. 39. Section 1903(m)(2)(C) of the Social Security Act is amended by striking out "the date the entity enters into a

contract with the State under this title for the provision of health services on a prepaid risk basis" and inserting in lieu thereof "the date the entity qualifies as as health maintenance organization (as determined by the Secretary)".

O

96TH CONGRESS
1ST SESSION

S. 570

To establish voluntary limits on the annual increases in total hospital expenses, and to provide for mandatory limits on the annual increases in hospital inpatient revenues to the extent that the voluntary limits are not effective.

IN THE SENATE OF THE UNITED STATES

MARCH 7 (legislative day, FEBRUARY 22), 1979

Mr. NELSON (for himself, Mr. WILLIAMS, Mr. KENNEDY, Mr. JAVITS, Mr. RIBICOFF, Mr. PELL, Mr. MOYNIHAN, Mr. TSONGAS, and Mr. RIEGLE) introduced the following bill; which was read twice and referred jointly by unanimous consent to the Committees on Finance and Human Resources

---

A BILL

To establish voluntary limits on the annual increases in total hospital expenses, and to provide for mandatory limits on the annual increases in hospital inpatient revenues to the extent that the voluntary limits are not effective.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Hospital Cost Containment Act of 1979".

ESTABLISHMENT OF VOLUNTARY LIMITS

SEC. 2. (a) The Secretary, during January of 1980, and during January of each succeeding year, shall promulgate a national voluntary percentage limit. That limit shall consist of the sum of the following amounts (as determined or estimated by the Secretary):

(1) the average percentage increase in wages paid in the preceding year over wages paid in the second preceding year per employee per hour to employees (other than to doctors of medicine or osteopathy and to supervisors) of hospitals in the United States, multiplied by the average fraction (as determined or estimated by the Secretary from time to time) of the expenses of hospitals in the United States attributable to such wages,

(2) the greater of—

(A) the sum of the products of the average percentage increase in the United States in the price of each appropriate class (as determined by the Secretary) of goods or services (other than those covered by paragraph (1)) in the preceding year over the price in the second preceding year per unit of the class and the average fraction (as determined or estimated by the Secretary from

time to time) of the expenses of hospitals in the United States attributable to that class, and

(B)(i) in 1980, 5.12 per centum, or

(ii) in any succeeding year, the amount determined in the previous year under subsection (d)(2),

(3) the percentage increase in the population in the United States in the preceding year over the population in the second preceding year, and

(4) 1 per centum (as an allowance for the net increase in service intensity in hospitals).

(b) The Secretary, during January of 1980, and during January of each succeeding year, shall promulgate a voluntary percentage limit for each State. The limit for each State shall consist of the sum of the following amounts (as determined or estimated by the Secretary):

(1) the sum of the amounts determined or estimated by the Secretary under paragraphs (2) and (4) of subsection (a),

(2) the average percentage increase in wages paid in the preceding year over wages paid in the second preceding year per employee per hour to employees (other than to doctors of medicine or osteopathy and to supervisors) of hospitals in the State (or zero, if the Secretary finds that there are not sufficient data to

make a reasonable estimate), multiplied by the average fraction (as determined by the Secretary from time to time) of the expenses of hospitals in the United States attributable to such wages, and

(3) the percentage increase (including a negative increase) in the population in the State in the preceding year over the population in the second preceding year.

(c)(1) The Secretary, during January of 1980, shall promulgate a voluntary percentage limit for each hospital for the hospital's accounting period ending in 1979. That limit shall consist of the sum of the following amounts (as determined or estimated by the Secretary):

(A) the sum of —

(i) the sum of the amounts determined or estimated by the Secretary under paragraphs (1) and (3) of subsection (b) for the State in which the hospital is located, and

(ii) the average percentage increase in wages paid in the hospital's accounting period ending in 1978 over wages paid in the preceding accounting period per employee per hour to employees (other than to doctors of medicine or osteopathy and to supervisors) of the hospital (or zero, if the Secretary finds that there are not sufficient data to

make a reasonable estimate), multiplied by the average fraction (as determined by the Secretary from time to time) of the expenses of hospitals in the United States attributable to such wages,

multiplied by the fraction of the accounting period occurring in 1979, and

(B) the percentage increase in the hospital's expenses in the accounting period ending in 1978 over those expenses in the accounting period ending in 1977, multiplied by the fraction of the accounting period that ends in 1979 occurring in 1978.

(2) The Secretary, during January of 1981, and January of each succeeding year, shall promulgate a voluntary percentage limit for each relevant hospital for the hospital's accounting period ending in the preceding year. That limit shall consist of the sum of the following amounts (as determined by the Secretary):

(A) the sum of —

(i) the sum of the amounts determined or estimated by the Secretary under paragraphs (1) and (3) of subsection (b) for the State in which the hospital is located, and

(ii) the average percentage increase in wages paid in the hospital's accounting period ending in the preceding year over wages paid in the preced-

ing accounting period per employee per hour to employees (other than to doctors of medicine or osteopathy and to supervisors) of the hospital (or zero, if the Secretary finds that there are not sufficient data to make a reasonable estimate), multiplied by the average fraction (as determined by the Secretary from time to time) of the expenses of hospitals in the United States attributable to such wages,

multiplied by the fraction of the accounting period occurring in the preceding year, and

(B) the amount determined under subparagraph (A) or paragraph (1)(A) during the previous January for the hospital, multiplied by the fraction of the accounting period occurring in the second preceding year.

(3) For purposes of paragraph (2), a "relevant hospital" means a hospital not subject to a mandatory limit under section (3)(d) for the hospital's accounting period ending in the year preceding the year in which the Secretary is promulgating limits under this subsection.

(d)(1) The Secretary, during January of 1980, and during January of each succeeding year, shall estimate and announce the average percentage increase in the United States in the price of each appropriate class (as determined by the Secretary) of goods or services (other than those cov-

ered by subsection (a)(1)) in the year over the price in the preceding year per unit of the class.

(2) The Secretary, during January of 1980, and during January of each succeeding year, shall determine and announce the sum of the products of the average percentage increase (as estimated by the Secretary under paragraph (1)) in the United States in the price of each appropriate class (as determined by the Secretary under paragraph (1)) of goods or services (other than those covered by subsection (a)(1)) in the year over the price in the preceding year per unit of the class and the average fraction (as determined or estimated by the Secretary from time to time) of the expenses of hospitals in the United States attributable to that class.

APPLICABILITY OF MANDATORY LIMITS

SEC. 3. (a)(1) The Secretary, before July 1, 1980, and before July 1 of each succeeding year, shall determine or estimate the dollar amount by which the percentage increase in the expenses of each relevant hospital in the accounting period of the hospital ending in the preceding year over its expenses in the preceding accounting period exceeded (or was less than) the voluntary percentage limit for the hospital for the accounting period (as promulgated under section 2(c)).

(2) For purposes of paragraph (1), a "relevant hospital" means a hospital not subject to a mandatory limit under subsection (d) for the hospital's accounting period ending in the

year preceding the year in which the Secretary is making the determinations or estimates under this subsection.

(b)(1) The Secretary, before July 1, 1980, and before July 1 of each succeeding relevant year, shall determine the sum of the differences determined or estimated under subsection (a). If the Secretary determines that the sum is equal to or less than zero, no hospital shall be subject to a mandatory limit under this Act for its accounting period ending in the year.

(2) For purposes of paragraph (1), a "relevant year" means a year following a year in which the Secretary determined that the sum of the differences under this subsection was equal to or less than zero.

(c)(1) The Secretary, before July 1, 1980, and before July 1 of each succeeding year, shall, if he has determined under subsection (b) that the sum of the differences is greater than zero, determine the sum of the differences determined or estimated under subsection (a) for hospitals in each relevant State. If the Secretary determines for a particular State that the sum is equal to or less than zero, no hospital in that State shall be subject to a mandatory limit under this Act for its accounting period ending in the year.

(2) For purposes of paragraph (1), a "relevant State" means a State for which the Secretary determined in the previous year that the sum of the differences under this sub-

section was equal to or less than zero, except that, for determinations being made in 1980, or in any year following a year in which the Secretary determined under subsection (b) that the sum of the differences was equal to or less than zero, every State is a relevant State.

(d) Every hospital, for each accounting period beginning after January 1, 1979, and for each succeeding accounting period, shall be subject to a mandatory limit as prescribed by this Act, unless (1) subsection (b) or (c) provides that the hospital, for that accounting period, is not subject to a mandatory limit, (2) the amount determined by the Secretary for the hospital for that accounting period under subsection (a) is equal to or less than zero, or (3) the hospital has been excluded under section 4 or 5 from the application of a mandatory limit.

EXEMPTION FOR HOSPITALS IN CERTAIN STATES

SEC. 4. At the request of the chief executive of any State, the Secretary shall exclude the hospitals in that State from the application of the mandatory limits established under this Act—

(1) if and so long as the Secretary determines that the State has in effect a State mandatory hospital cost containment program applicable to all hospitals in the State and to all revenues or expenses for inpatient hospital services,

(2) if and so long as the Secretary receives satisfactory assurances as to the equitable treatment under the State mandatory hospital cost containment program of all entities (including Federal and State programs) that pay hospitals for inpatient hospital services, of hospital employees, and of hospital patients, and

(3)(A) if the Secretary determines that the average rate of increase in hospital expenses in the State in the preceding year did not exceed the voluntary percentage limit for the State by more than one per centum, or

(B) if and for so long as the Secretary—

(i) receives satisfactory assurances that the average rate of increase in hospital expenses in the State will not exceed the voluntary percentage limit for the State, and

(ii) determines that the State mandatory hospital cost containment program meets such other conditions as he may establish.

EXEMPTION FOR HOSPITALS ENGAGED IN CERTAIN EXPERIMENTS OR DEMONSTRATIONS

SEC. 5. The Secretary may exclude a hospital from the application of a mandatory limit established under this Act if he determines that—

(1) the exclusion is necessary to facilitate an experiment or demonstration entered into under section 402 of the Social Security Amendments of 1967, section 222 of the Social Security Amendments of 1972, or section 1526 of the Public Health Service Act, and

(2) the experiment or demonstration is consistent with the purposes of this Act.

APPLICATION OF MANDATORY LIMIT

SEC. 6. (a) The average reimbursement payable to a hospital by a cost payer per admission, and the average inpatient charges per admission of a hospital, for any accounting period of the hospital subject to a mandatory limit under section 3(d), exceed the mandatory limit if such reimbursement or charges exceed the average reimbursement payable to the hospital by the cost payer per admission, or the average inpatient charges per admission of the hospital, respectively, for the base accounting period of the hospital, by a percentage which is greater than the compounded sum of the percentage limits promulgated by the Secretary under section 7 (d) or (e) for that accounting period and previous accounting periods of the hospital.

(b)(1) For purposes of calculating under subsection (a) for the base accounting period the average inpatient charges per admission of a hospital and the average reimbursement payable to the hospital by each cost payer per admission, the

inpatient charges of the hospital (and the reimbursement payable to the hospital by each cost payer) for the base accounting period shall (except as provided in paragraph (2)) be reduced by an amount equal to any inpatient charges (in the case of a cost payer, any such inpatient charges attributable to that cost payer) for the base accounting period for elements of inpatient hospital services that cease to be furnished in the accounting period subject to subsection (a), multiplied by the fraction of the accounting period during which those services are not furnished.

(2) Paragraph (1) shall not apply with respect to inpatient hospital services that have been found inappropriate by the State health planning and development agency designated under section 1521 of the Public Health Service Act for the State in which the hospital is located.

(3) Upon request by a hospital, the State health planning and development agency designated under section 1521 of the Public Health Service Act for the State in which the hospital is located shall make a finding as to the appropriateness of specific institutional health services for purposes of paragraph (2), after requesting the recommendations of the appropriate health systems agency. The finding of a State health planning and development agency under this paragraph shall not be subject to further review.

CALCULATION OF MANDATORY LIMITS

SEC. 7. (a)(1) The Secretary shall determine a percentage with respect to each hospital's accounting period subject to section 3(d). The percentage shall consist of the sum of the following amounts (as determined or estimated by the Secretary), except as otherwise provided in paragraph (2):

(A) the average percentage increase in wages paid in the accounting period over wages paid in the preceding accounting period per employee per hour to employees (other than to doctors of medicine or osteopathy and to supervisors) of the hospital (or zero, if the Secretary finds that there are not sufficient data to make a reasonable estimate), multiplied by the fraction (as determined or estimated by the Secretary from time to time) of the expenses of the hospital attributable to such wages, and

(B) the greater of—

(i) the sum of the products of the average percentage increase in the United States in the price of each appropriate class (as determined by the Secretary) of goods or services (other than those covered by subparagraph (A)) in the year in which the accounting period ends over the price in the preceding year per unit of the class and the fraction (as determined or estimated by the Secre-

tary from time to time) of the expenses of the hospital attributable to that class, and

(ii) for an accounting period ending after 1980, the sum of the products of the average percentage increase (as estimated by the Secretary under section 2(d)(1) in January of the year preceding the year in which the accounting period ends) in the United States in the price of each appropriation class (as determined by the Secretary) of goods or services (other than those covered by subparagraph (A)) in the year preceding the year in which the accounting period ends over the price in the year preceding that year per unit of the class and the fraction (as determined or estimated by the Secretary from time to time) of the expenses of the hospital attributable to that class.

(2) At the request of a hospital, the Secretary, in determining the percentage under paragraph (1) for the first accounting period of a hospital subject to section 3(d), shall substitute the average fraction of the expenses of hospitals in the United States for the fraction of the expenses of that hospital, with respect to each class of goods or services under subparagraphs (A) or (B) of paragraph (1). The amount determined under this paragraph as a substitute for the amount that would be determined under paragraph (1)(B) may not,

for an accounting period ending in 1980, be less than 5.12 per centum.

(b) The Secretary shall develop (and may from time to time revise) a system of grouping hospitals by appropriate characteristics, such as patient case mix and metropolitan or nonmetropolitan setting. He shall establish (and may from time to time revise) a method of measuring efficiency within each group that provides for setting a group norm, defined in terms of all or certain hospital expenses (adjusted for area wage differentials). The Secretary shall assign to each hospital in a group, with respect to each accounting period subject to section 3(d), a percentage bonus (or penalty) related to the extent to which the hospital's expenses (adjusted for area wage differentials) of the kind utilized in defining the group norm are less than (or exceed) the group norm, as follows:

(1) If the adjusted expenses are less than 90 per centum of the group norm, the bonus shall be 1 per centum.

(2) If the adjusted expenses are 90 per centum of the group norm or greater, and are less than the group norm, the bonus shall be one-half of 1 per centum.

(3) If the adjusted expenses equal or exceed the group norm, and equal or are less than 115 per centum of the group norm, the bonus shall be zero per centum.

(4) If the adjusted expenses exceed 115 per centum of the group norm, and equal or are less than 130 per centum of the group norm, the penalty shall be 1 per centum.

(5) If the adjusted expenses exceed 130 per centum of the group norm, the penalty shall be 2 per centum.

The Secretary shall add the percentage bonus to (or subtract the percentage penalty from) the percentage determined or estimated for the hospital under subsection (a).

(c)(1) The Secretary may make further additions to, or subtractions from, the percentage determined with respect to a hospital's accounting period under the preceding subsections to allow for—

(A) changes in admissions, or

(B) such other factors as the Secretary may find warrant special consideration.

The Secretary may make such additions or subtractions on his own motion, or on request of a hospital as provided in paragraph (2).

(2) If a hospital wishes to request the Secretary to exercise his discretion under paragraph (1), the hospital shall file a request, in the manner and form prescribed by the Secretary, with the appropriate agency or organization with which the Secretary has entered into an agreement under section

1816 of the Social Security Act. If a hospital files a request as provided in the preceding sentence, and the Secretary has not acted on the request within sixty days of its filing, the request shall be treated as granted.

(d) The Secretary shall promulgate for purposes of section 6 a percentage limit for each hospital's accounting period subject to section 3(d) that follows an accounting period that was not subject to that section. That percentage shall consist of the sum of the following amounts (as determined or estimated by the Secretary):

(1) the difference between—

(A) the percentage determined under the preceding subsections, and

(B) the lesser of—

(i) the sum of—

(I) one-half the amount by which the percentage increase in the hospital's expenses in its preceding accounting period over those expenses in the second preceding accounting period exceeded (if at all) the voluntary percentage limit promulgated by the Secretary under section 2(c) for the hospital's preceding accounting period, and

(II) one-half the amount by which the percentage increase in the hospital's expenses in its preceding accounting period over those expenses in the second preceding period exceeded (if at all) the greater of—

(α) the percentage increase in the hospital's expenses in its second preceding accounting period over those expenses in the third preceding accounting period, and

(β) the average of the percentage increase under clause (α) and the percentage increase in the hospital's expenses in its third preceding accounting period over those expenses in the fourth preceding accounting period, and

(ii) the difference between—

(I) one-half of the percentage determined or estimated under subsection (a), and

(II) the percentage penalty (if any) assigned to the hospital under subsection (b),

multiplied by the fraction of the accounting period occurring in the year in which the accounting period ends, and

(2) the percentage increase in the hospital's expenses in the accounting period over those expenses in the preceding accounting period, multiplied by the fraction of the accounting period occurring in the preceding year.

(e) The Secretary shall promulgate for purposes of section 6 a percentage limit for each hospital's accounting period subject to section 3(d) that follows an accounting period that was subject to that section. That percentage shall consist of the sum of the following amounts (as determined by the Secretary):

(1) the difference between—

(A) the percentage determined under subsections (a) through (c), and

(B) the lesser of—

(i) the amount (if any) by which the percentage previously determined or estimated for the hospital under subsection (d)(1)(B)(i) exceeded the percentage previously determined for the hospital under subsection (d)(1)(B)(ii), less any portion of that amount previously utilized under this clause, and

(ii) the difference between—

(I) one-half of the percentage determined or estimated under subsection (a), and

(II) the percentage penalty (if any) assigned to the hospital under subsection (b),

multiplied by the fraction of the accounting period occurring in the year in which the accounting period ends, and

(2) the percentage determined under paragraph (1) or subsection (d)(1) for the previous accounting year, multiplied by the fraction of the accounting period occurring in the preceding year.

CONFORMANCE BY CERTAIN FEDERAL AND STATE PROGRAMS

SEC. 8. (a) Notwithstanding any provision of title XVIII of the Social Security Act, reimbursement for inpatient hospital services under the program established by that title shall not be payable, on an interim basis or in final settlement, to the extent that it exceeds the applicable mandatory limits established under this Act or under a State mandatory hospital cost containment program of a State whose hospitals have been excluded under section 4 from the application of the mandatory limits established under this Act.

(b) Notwithstanding any provision of title V or XIX of that Act, payment shall not be required to be made by any State under either of those titles with respect to any amount paid for inpatient hospital services in excess of the applicable mandatory limits established under this Act; nor shall payment be made to any State under either of those titles with respect to any amount paid for inpatient hospital services in excess of those limits.

EXCISE TAXES

SEC. 9. Chapter 36 of the Internal Revenue Code of 1954 (relating to certain other excise taxes) is amended by adding at the end the following new subchapter:

"Subchapter F—Taxes on Certain Excess Reimbursement and Charges for Inpatient Hospital Services

"SEC. 4495. IMPOSITION OF TAXES.

"(a) TAXES ON EXCESS REIMBURSEMENT.—

"(1) TAX ON HOSPITAL.—If a hospital has excess reimbursement with respect to a cost payer for an accounting period subject to a mandatory limit, there is hereby imposed on the hospital a tax equal to 150 percent of the amount of excess reimbursement.

"(2) TAX ON PRIVATE COST PAYER.—If a hospital has excess reimbursement with respect to a private cost payer for an accounting period subject to a man-

datory limit, there is hereby imposed on the private cost payer a tax equal to 150 percent of the amount of excess reimbursement.

"(b) TAX ON EXCESS HOSPITAL INPATIENT CHARGES.—If a hospital has excess inpatient charges for an accounting period subject to a mandatory limit, there is hereby imposed on the hospital a tax equal to the product of 150 percent of the amount of excess inpatient charges of the hospital for the accounting period and the fraction (as determined by the Secretary of Health, Education, and Welfare) of those charges not attributable to cost payers.

"(c) PAYMENT OF TAXES.—

"(1) TAX ON EXCESS REIMBURSEMENT.—Any tax imposed by paragraph (1) or (2) of subsection (a) on any hospital or private cost payer, respectively, for any accounting period shall be paid not later than 30 days after the date the Secretary of Health, Education, and Welfare notifies the Secretary—

"(A) of the excess reimbursement, and

"(B) of the amount of tax which is due from the hospital or private cost payer under paragraph (1) or (2), respectively, of subsection (a).

"(2) TAX ON EXCESS INPATIENT CHARGES.—

"(A) IN GENERAL.—Any tax imposed by subsection (b) on any hospital for any accounting

period shall be paid not later than 30 days after the date the Secretary of Health, Education, and Welfare notifies the Secretary—

"(i) of the excess inpatient charges, and

"(ii) of the amount of tax that is due from the hospital under subsection (b).

"(B) DEFERRAL AND ABATEMENT.—If the Secretary of Health, Education, and Welfare certifies to the Secretary that a hospital has an approved escrow account and certifies the cumulative amount deposited into the account, then—

"(i) an amount of the tax imposed on the hospital by subsection (b) for the accounting period, equal to 150 percent of the cumulative amount deposited (but not greater than that tax), shall be deferred,

"(ii) the amount of any tax previously imposed on the hospital by subsection (b) and deferred under this subparagraph shall be abated, and

"(iii) the hospital may withdraw from the escrow account the amount (if any) by which the cumulative amount exceeds 66⅔ percent of the tax imposed by subsection (b) for the accounting period. The deferral shall

continue so long as the remaining amount remains in that account.

"(C) WITHDRAWALS FROM APPROVED ESCROW ACCOUNT.—Amounts deposited into an approved escrow account shall be treated as withdrawn from the account in the order in which they were deposited into the account.

"(d) DEFINITIONS.—For purposes of this section—

"(1) HOSPITAL.—The term 'hospital' has the meaning assigned by section 14(5) of the Hospital Cost Containment Act of 1979.

"(2) ACCOUNTING PERIOD SUBJECT TO A MANDATORY LIMIT.—The term 'accounting period subject to a mandatory limit' means an accounting period (as defined in section 14(6) of that Act) that is subject to a mandatory limit under section 3(d) of that Act.

"(3) COST PAYER.—The term 'cost payer' has the meaning assigned by section 14(9) of that Act.

"(4) PRIVATE COST PAYER.—The term 'private cost payer' has the meaning assigned by section 14(9)(B) of that Act.

"(5) INPATIENT CHARGES.—The term 'inpatient charges' has the meaning assigned by section 14(8) of that Act.

"(6) REIMBURSEMENT PAYABLE TO A HOSPITAL BY A COST PAYER.—The term 'reimbursement payable to a hospital by a cost payer' has the meaning assigned by section 14(10) of that Act.

"(7) EXCESS REIMBURSEMENT.—A hospital has excess reimbursement with respect to a cost payer for an accounting period subject to a mandatory limit if the Secretary of Health, Education, and Welfare determines that the average reimbursement payable to the hospital by the cost payer per admission for that accounting period exceeds the mandatory limit under section 6 of that Act for that accounting period.

"(8) EXCESS INPATIENT CHARGES.—A hospital has excess inpatient charges for an accounting period subject to a mandatory limit if the Secretary of Health, Education, and Welfare determines that the average inpatient charges per admission of the hospital for that accounting period exceeds the mandatory limit under section 6 of that Act of that accounting period.

"(9) AMOUNT OF EXCESS REIMBURSEMENT.—The amount of excess reimbursement with respect to a cost payer for a hospital's accounting period subject to a mandatory limit shall be the amount determined by the Secretary of Health, Education, and Welfare to be equal to the amount by which the reimbursement pay-

able to the hospital by the cost payer for the accounting period would have to be reduced so that the average reimbursement payable to the hospital by the cost payer for that accounting period would not exceed the mandatory limit for that accounting period under section 6 of that Act.

"(10) AMOUNT OF EXCESS INPATIENT CHARGES.—The amount of excess inpatient charges of a hospital for an accounting period subject to a mandatory limit shall be the amount determined by the Secretary of Health, Education, and Welfare to be equal to the amount by which the inpatient charges of the hospital would have to be reduced so that the average inpatient charges per admission of the hospital for the accounting period would not exceed the mandatory limit for that accounting period under section 6 of that Act.

"(11) APPROVED ESCROW ACCOUNT.—The term 'approved escrow account' means an escrow account which is established and maintained by a hospital in a manner approved by the Secretary of Health, Education, and Welfare.".

IMPROPER CHANGES IN ADMISSION PRACTICES

SEC. 10. Upon written complaint by any institution that satisfies paragraphs (1) and (7) of section 1861(e) of the

Social Security Act that a hospital has changed its admission practices in a manner that would tend to reduce the proportion of inpatients of the hospital for whom reimbursement is less than the anticipated inpatient charges applicable to them, the Secretary shall investigate the complaint and, upon a finding by him that the complaint is justified, he may exclude the hospital from participation in any or all of the programs established by title V, XVIII, or XIX of the Social Security Act.

NATIONAL COMMISSION ON HOSPITAL COST CONTAINMENT

SEC. 11. (a) The Secretary shall establish a National Commission on Hospital Cost Containment.

(b) The Commission shall consist of fifteen members appointed by the Secretary. Of those members—

(1) five shall be individuals representative of hospitals,

(2) five shall be individuals representative of entities that reimburse hospitals, of whom one shall be the Administrator, Health Care Financing Administration, and

(3) five shall be individuals who are not representative of either hospitals or of entities that reimburse hospitals.

(c)(1) Except as provided in paragraphs (2) and (3), members shall be appointed for three years.

(2) Of the members first appointed—

(A) five shall be appointed for a term of two years, and

(B) five shall be appointed for a term of one year.

(3) Any member appointed to fill a vacancy occurring before the expiration of the term for which his predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of his term until his successor has taken office.

(d) The Secretary shall appoint one of the members as Chairman, to serve until the expiration of the member's term.

(e) Eight members of the Commission shall constitute a quorum to do business. The Commission shall meet at the call of the Chairman or at the call of a majority of its members.

(f) The Commission shall advise, consult with, and make recommendations to, the Secretary with respect to—

(1) the implementation of this Act,

(2) proposed modifications to the provisions of this Act, and

(3) any other matters that may affect hospital expenses or revenues.

(g)(1) Except as provided in paragraph (2), members of the Commission shall each be entitled to receive the daily equivalent of the annual rate of basic pay in effect for grade

GS-18 of the General Schedule for each day (including traveltime) during which they are engaged in the actual performance of Commission duties.

(2) Members of the Commission who are full-time officers or employees of the United States shall receive no additional pay on account of their service on the Commission.

(3) While away from their homes or regular places of business in the performance of services for the Commission, members of the Commission shall be allowed travel expenses, including per diem in lieu of subsistence, in the same manner as persons employed intermittently in the Government service are allowed expenses under section 5703 of title 5, United States Code.

(h) The Commission may, subject to the provisions of part III of title 5, United States Code, as they apply to the civil service, appoint, fix the pay of, and prescribe the functions of such personnel as are necessary to carry out its functions. In addition, the Commission may procure the services of experts and consultants as authorized by section 3109 of title 5, United States Code.

(i) The provisions of section 14(a) of the Federal Advisory Committee Act shall not apply with respect to the Commission.

SHORT ACCOUNTING PERIODS

SEC. 12. The Secretary may make appropriate adjustments in the application of the provisions of this Act with respect to short accounting periods (as defined in section 14(6)(B)).

REGULATIONS

SEC. 13. The Secretary may prescribe regulations to implement the provisions of this Act.

DEFINITIONS AND RELATED MATTERS

SEC. 14. For purposes of this Act, the term—

(1) "Secretary" means the Secretary of Health, Education, and Welfare,

(2) "State" means each of the fifty States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands,

(3) "United States" means the geographic area consisting of all the States,

(4) "admission" means the formal acceptance by an institution of an inpatient, excluding newborn children (unless retained after discharge of the mother) or a transfer within or among inpatient units of the institution,

(5) "hospital", with respect to any period, means an institution (or distinct part of an institution if the

distinct part participates in the program established by title XVIII of the Social Security Act) that—

(A) satisfies paragraphs (1) and (7) of section 1861(e) of the Social Security Act during all of the period and has satisfied those conditions during the preceding thirty-six months,

(B) had an average duration of stay of less than thirty days during the preceding thirty-six months,

(C) is not a Federal institution during any part of the period,

(D) derived less than 75 per centum of its inpatient care revenues from one or more health maintenance organizations (as defined in section 1301(a) of the Public Health Service Act) during the preceding twelve months, and

(E) if located in a nonmetropolitan area, had average annual admissions of over four thousand during the preceding thirty-six months,

(6) "accounting period" means—

(A) except as provided in subparagraph (B)—

(i) in the case of a hospital participating in the program established by title XVIII of the Social Security Act, the period of twelve

consecutive calendar months utilized as the reporting period for reimbursement purposes under that program,

(ii) in the case of a hospital not participating in the program established by title XVIII of the Social Security Act, a calendar year, or, if requested by the hospital, such other period of twelve consecutive calendar months as the Secretary may approve, and

(B) in the case of a hospital whose period under subparagraph (A) is changed from one twelve-month period to another, such shorter period as the Secretary may establish,

(7) "inpatient hospital services" has the meaning assigned by section 1861(b) of the Social Security Act, but includes in addition the services specified in section 1861(b)(5) of that Act,

(8) "inpatient charges" means charges (as defined by 42 CFR § 405.452(d)(4) as in effect on the date of enactment of this Act) for inpatient hospital services,

(9) "cost payer" means (A) a Federal or State program, or (B) a carrier (as defined by section 1842(f)(1) of the Social Security Act), that in either case reimburses a hospital for inpatient hospital services on a basis related to the hospital's costs in furnish-

ing those services or on any other basis other than inpatient charges,

(10) "reimbursement payable to a hospital by a cost payer" means the sum of—

(A) the amounts (other than the coinsurance or deductible amounts of another entity) payable by the cost payer to the hospital for inpatient hospital services, and

(B) the amounts payable by an individual or other entity to the hospital for inpatient hospital services if the individual's expenses for those services are payable in part by the cost payer, to the extent that those amounts are calculated as a portion of the costs or other basis on which the amounts payable by the cost payer are determined, except that amounts payable by a program established under title V, XVIII, or XIX of the Social Security Act shall be determined without regard to adjustments resulting from the application of section 405.415(d)(3), 405.415(f), 405.455(d), or 405.460(g), of title 42, Code of Federal Regulations,

(11) in the case of the admission of an individual whose inpatient hospital services are to be reimbursed in part by more than one cost payer, the admission

shall be attributed to the cost payer which is to reimburse for such services furnished before any such services are furnished for which other cost payers are to reimburse,

(12) "wages" has the same meaning as under the Fair Labor Standards Act of 1938,

(13) "supervisor" has the meaning assigned by section 2(12) of the National Labor Relations Act, and

(14) "base accounting period" means a hospital's last accounting period not subject to a mandatory limit under section 3(d).

O

Senator TALMADGE. This hearing will come to order. Today and tomorrow, the Subcommittee on Health will hear testimony on two legislative proposals.

We will consider the various provisions of S. 505, the Medicare-Medicaid Administrative and Reimbursement Reform Act and certain other cost containment measures.

We will also hear testimony on S. 570, the administration's proposal to establish a system of stand-by percentage limits on allowable rates of increase in hospital revenues.

The bills are related but differ significantly in their application and purpose. The two proposals are not competitive. They do not represent an either/or choice.

S. 505 is an effort to establish a reasonable means of payment to hospitals and others under the medicare and medicaid programs. The bill deals with the Government as a purchaser of hospital care.

S. 570, on the other hand, seeks to constrain the revenues of all hospitals from whatever source. That proposal relates to the Government's role as regulator, not as purchaser.

Throughout all of our work, we have been sensitive to the need to differentiate between efficient and inefficient hospitals for reimbursement purposes. One of the most serious problems confronting our Nation today is the rapidly increased cost of medicare and medicaid.

These costs have been escalating at the rate of about 15 percent per year, almost to bankrupting some States, unlike the Government who can print money. The cost to the taxpayers of our country for fiscal 1980 will approximate $55 billion. Total medicaid costs in the State of Georgia have risen in excess of 1,500 percent since the program started about a decade ago.

Under present law, the payer fills out a blank check and the payee fills in the amount. In other words, the more you spend, the greater your reimbursement from the Government.

The administration bill this year is vastly improved over that which was presented to the last Congress. In fact, a fair number of changes in the present bill bear a striking resemblance to a proposal developed by our staff and passed by the Senate last year.

With respect to major revenue-raising measures of this magnitude, the Senate ordinarily waits to receive a House-passed bill.

In any case, the Finance Committee has scheduled a markup on S. 505, S. 570 and related bills on the 22d and 23d of this month. In preparation for that markup, I have directed the staff to prepare a comparison of the proposal they developed in the last Congress with your present bill.

Mr. Secretary, you carry a heavy burden. You must establish that there is an overriding and urgent need to impose controls on only one segment of the economy. You must establish that what you propose is not only workable but also equitable.

I do want to emphasize that we share a common interest in finding workable ways to effectively avoid wasteful and inflationary practices in the health care field.

I remain openminded and trust that appropriate legislation can evolve reflecting and dealing with legitimate concerns.

With that out of the way, the subcommittee is pleased now to hear from the distinguished Secretary of the Department of Health, Education, and Welfare, Hon. Joseph A. Califano.

You may proceed in any manner you see fit, Mr. Secretary. You may insert your full statement into the record and summarize if you desire.

We do have a vote on the Senate floor at 10:15 a.m. I do think we will be interrupted at that time. We may have others. We will proceed as rapidly as we can considering the Senate business.

Chairman Long, do you have a statement?

Senator LONG. No; I do not.

STATEMENT OF HON. JOSEPH A. CALIFANO, JR., SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Secretary CALIFANO. Mr. Chairman, I would like, if I may, to submit my statement for the record.

Senator TALMADGE. Without objection, it will be inserted into the record in full.

Secretary CALIFANO. I would like to briefly go through the charts.

Senator TALMADGE. Fine.

Senator LONG. If I may interrupt, I would think you might be able to put those charts over here where everyone can see them.

[The charts referred to follow:]

March 8, 1979

Charts: Hospital Cost Containment

(For Testimony)

I. Background

1. Rising Health Costs of Highest Concern to Americans

2. State of the Union Address

3. Hospital Cost Containment Legislation: The Basic Approach

II. The Need for Hospital Cost Containment Legislation

A. Hospital Inflation

4. Hospital Inflation: Rising Hospital Costs Outstrip Other Price Increases During 1974 - 1978

5. Hospital Inflation: Costs of Hospital Care Consume Growing Share of Expenses for Family of Four at Median Income

6. Hospital Inflation: Sharp Rise in Federal Hospital Spending

B. Impact of Hospital Cost Containment

7. Impact of Hospital Cost Containment: Reduces Burden on American Families

8. Impact of Hospital Cost Containment: Reduces Burden on Average Family of Four

9. Impact of Hospital Cost Containment: Reduces Burden on Employers

10. Impact of Hospital Cost Containment: Reduces Burden on the Elderly (Medicare Deductible)

11. Impact of Hospital Cost Containment: Reduces Burden on the Uninsured

12. Impact of Hospital Cost Containment: Federal Spending for Hospital Services (Over the Next Five Years)

13. Impact of Hospital Cost Containment: The Federal Budget

14. Impact of Hospital Cost Containment: State and Local Spending

C. Causes of Hospital Cost Inflation

15. Causes of Hospital Inflation

16. Causes of Hospital Inflation: Examples of Wasteful Expenditures (Fiscal 1977)

III. Legislation

17. The Legislation: In Brief

18. The Legislation: The National Voluntary Limit on the Rate of Increase in Total Hospital Costs

19. The Legislation: The National Voluntary Limit Is a Reasonable Target

20. The Legislation: Mandatory Limits Established for Individual Hospitals if National Voluntary Limit Not Met

21. The Legislation: Hospitals Exempted From Mandatory Program

22. The Legislation: Hospitals Exempted From Mandatory Program

23. The Legislation: The Wage Pass-Through in the Mandatory Program

IV. Feasibility

24. Hospital Cost Containment: Existing State Mandatory Programs Are The Most Effective Anti-Inflation Tool to Date

25. Hospital Cost Containment: Mandatory State Programs Continue to Perform in 1978

26. Hospital Cost Containment: Savings Are Crucial in a Period of Budgetary Restraint

27. Hospital Cost Containment: Magnitude of Savings

RISING HEALTH COSTS OF HIGHEST CONCERN TO AMERICANS

- From a List of 21 National Problems, Highest Priority Was Given to:
  - Getting Inflation Under Control (69 Percent - First Priority)
  - Controlling Federal Government Spending (31 Percent - Second Priority)
  - Keeping Health Costs Under Control (28 Percent - Fourth Priority)*
- Hospital Cost Containment Dramatically Meets Each of these Concerns

---

Source: Harris Survey, September 21, 1978

*Creating New Jobs for the Unemployed Ranked Third (30 Percent)

45-558 O - 79 - 10

STATE OF THE UNION ADDRESS

- **"There Will Be No Clearer Test of the Commitment of this Congress to the Anti-Inflation Fight than . . . Legislation . . . to Hold Down Inflation in Hospital Care."**

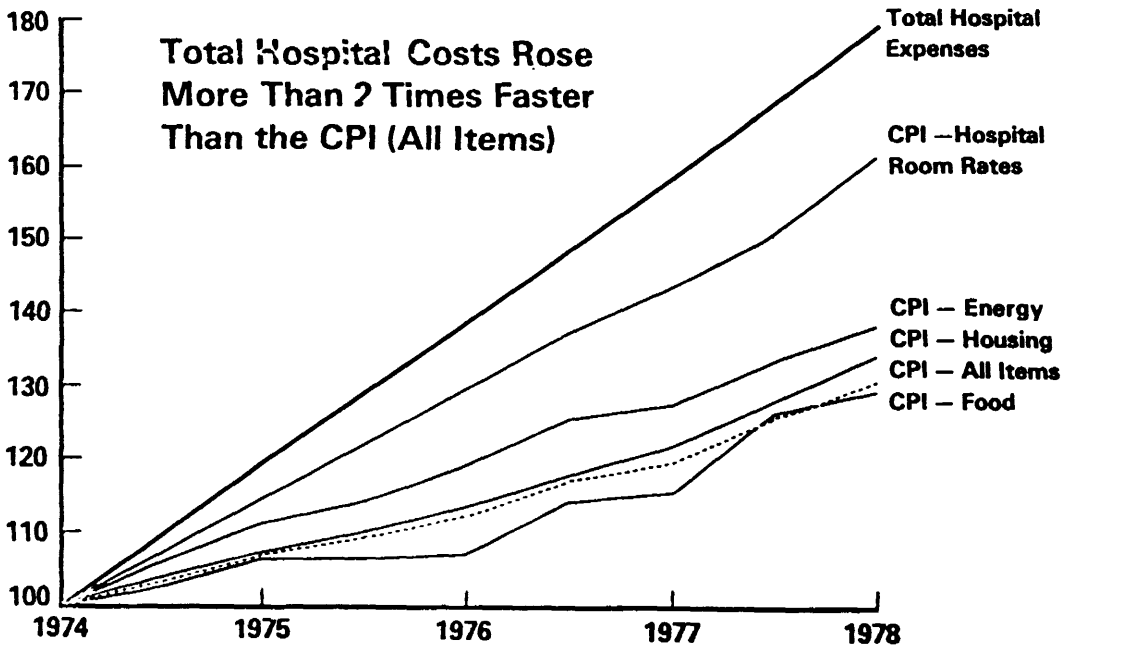
- **"We Must Act Now to Protect Americans from Health Care Costs that Are Rising One Million Dollars an Hour — Doubling Every Five Years . . . the American People Have Waited Long Enough. This Year We Must Act on Hospital Cost Containment."**

— President Jimmy Carter
January 24, 1979

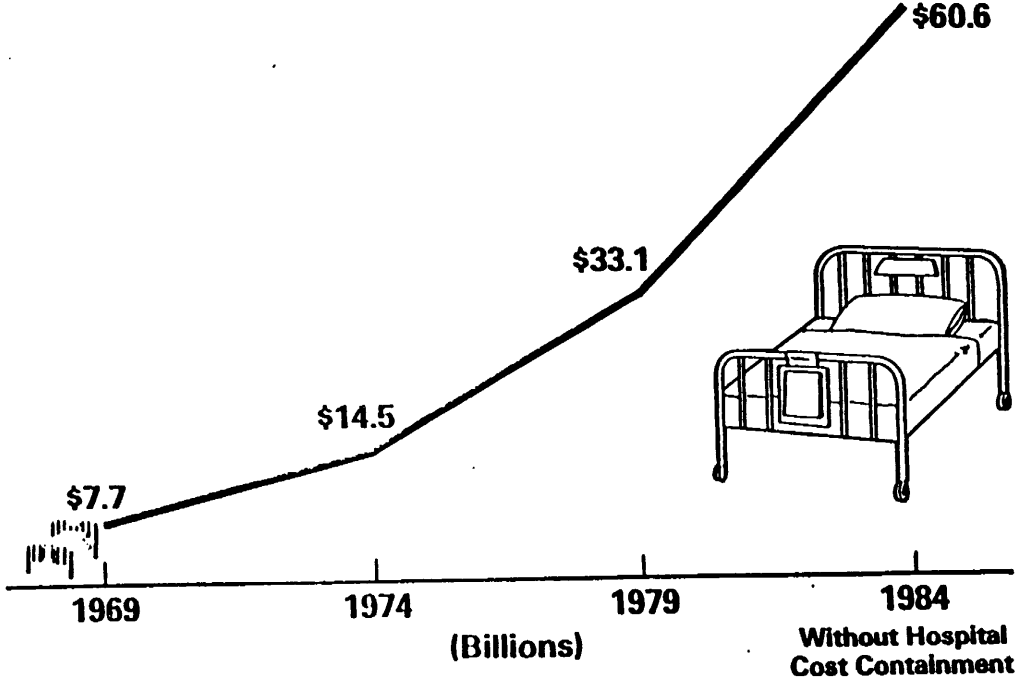
HOSPITAL COST CONTAINMENT LEGISLATION: THE BASIC APPROACH

- **National Voluntary Limit for 1979**
  - 9.7% Increase in Total Hospital Expenses
  - Nationwide Average
- **Mandatory Limits in 1980**
  - Only if Voluntary Limit Is Not Met
  - Apply to Individual Hospitals
- **Savings: Fiscal 1980 - 1984**
  - Federal: $21.8 Billion
  - Total Health System: $53.4 Billion

HOSPITAL INFLATION: RISING COSTS OUTSTRIP OTHER PRICE INCREASES DURING 1974-1978



HOSPITAL INFLATION: SHARP RISE IN FEDERAL HOSPITAL SPENDING



IMPACT OF HOSPITAL COST CONTAINMENT:

REDUCES BURDEN ON AMERICAN FAMILIES

American Families Pay for Hospital Costs Through:	Total 1980-1984 Without Hospital Cost Containment	Total 1980-1984 With Hospital Cost Containment	1980-1984 Savings
● Insurance Premiums	$ 52.1	$ 47.4	$4.7
● Personal Taxes	$136.5	$128.4	$8.1
● Payroll Taxes	$78.1	$ 68.6	$9.5
● Out-of-Pocket Expenses	$62.3	$ 56.7	$5.6
		(Billions)	

IMPACT OF HOSPITAL COST CONTAINMENT:
REDUCES BURDEN ON AVERAGE FAMILY OF FOUR

Family of Four With Median Income Pays for Hospital Costs Through:	Total 1980-1984 Without Hospital Cost Containment	Total 1980-1984 With Hospital Cost Containment	1980-1984 Savings
• Insurance Premiums	$1,054	$ 921	$133
• Personal Taxes	$1,636	$1,599	$ 37
• Payroll Taxes	$1,815	$1,595	$220

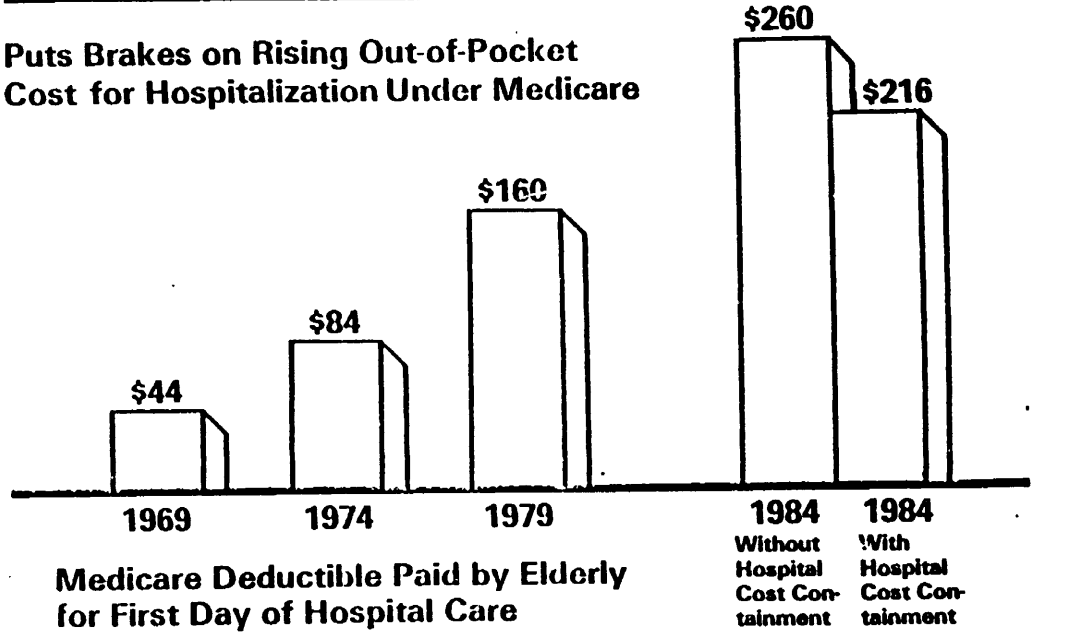
IMPACT OF HOSPITAL COST CONTAINMENT:

REDUCES BURDEN ON EMPLOYERS

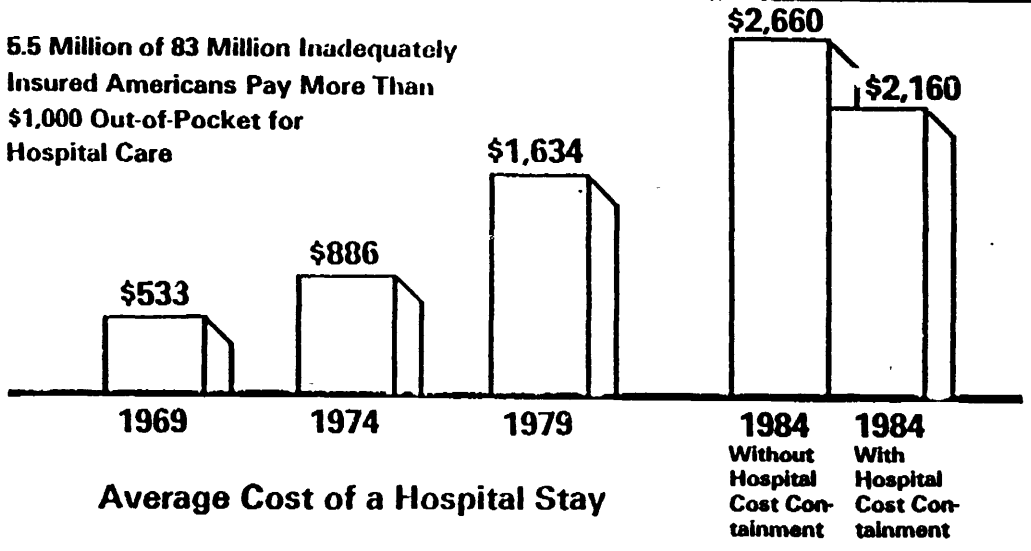
Employers Pay for Hospital Costs Through:	Total 1980-1984 Without Hospital Cost Containment	Total 1980-1984 With Hospital Cost Containment	1980-1984 Savings
o Employee Insurance Premiums	$159.6	$145.2	$14.4
o Payroll Taxes	$ 78.1	$ 68.6	$9.5
o Corporate Income Taxes	$ 17.8	$ 17.3	$ 0.5
		(Billions)	

These Costs to Employers Result in Lower Wages or Higher Prices for Individuals

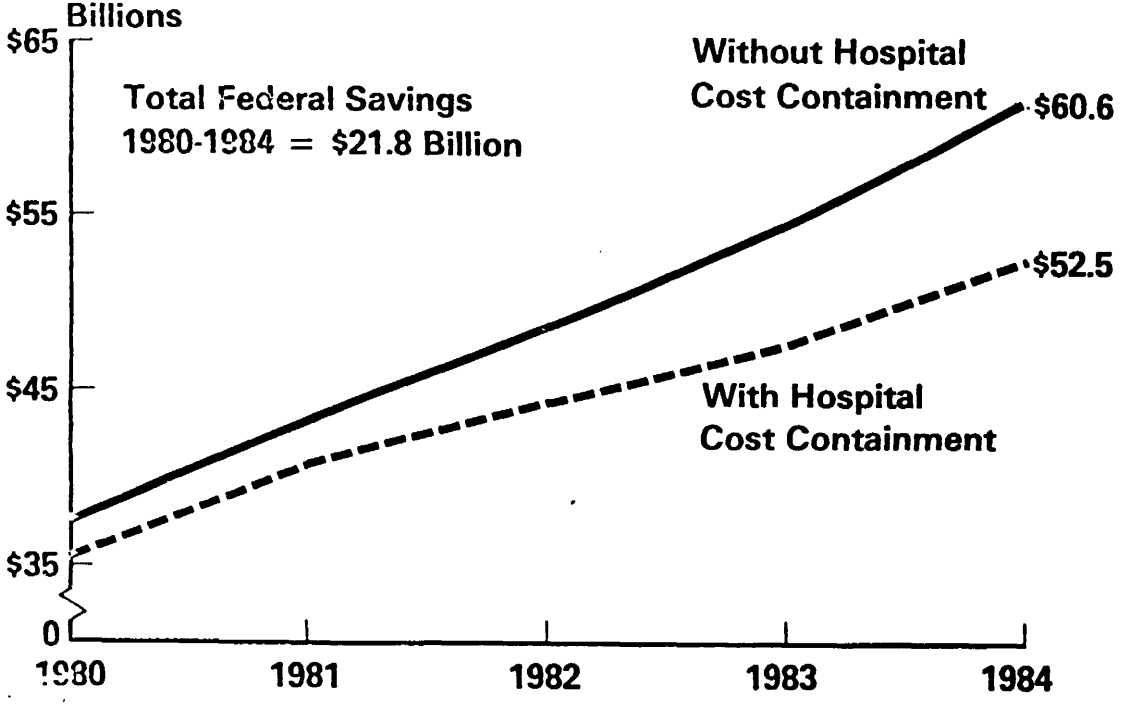
IMPACT OF HOSPITAL COST CONTAINMENT:
REDUCES BURDEN ON THE ELDERLY



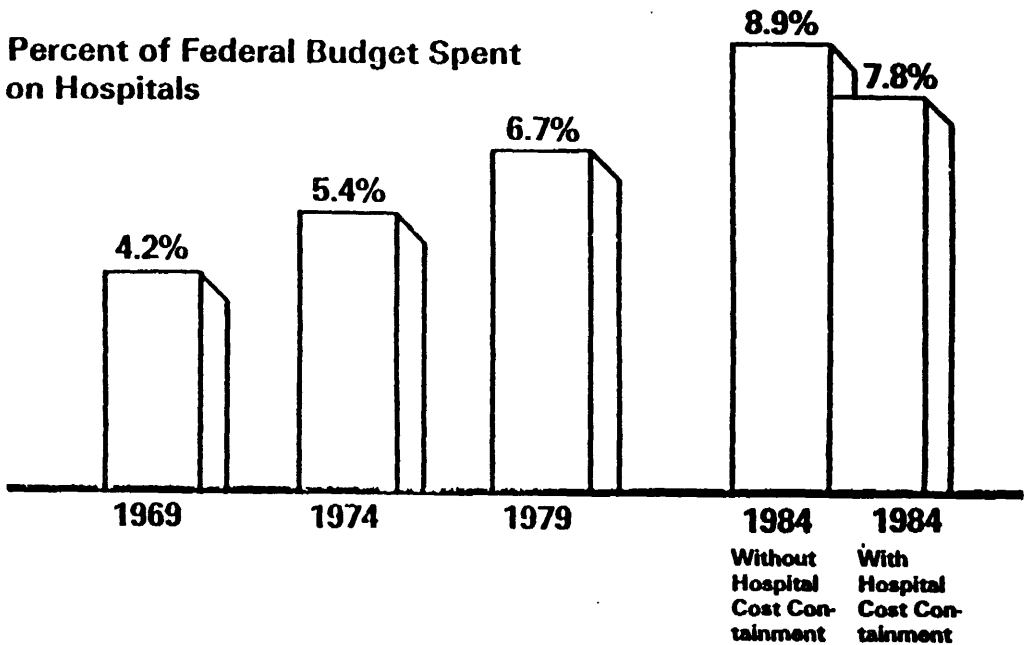
IMPACT OF HOSPITAL COST CONTAINMENT:
REDUCES BURDEN ON THE UNINSURED



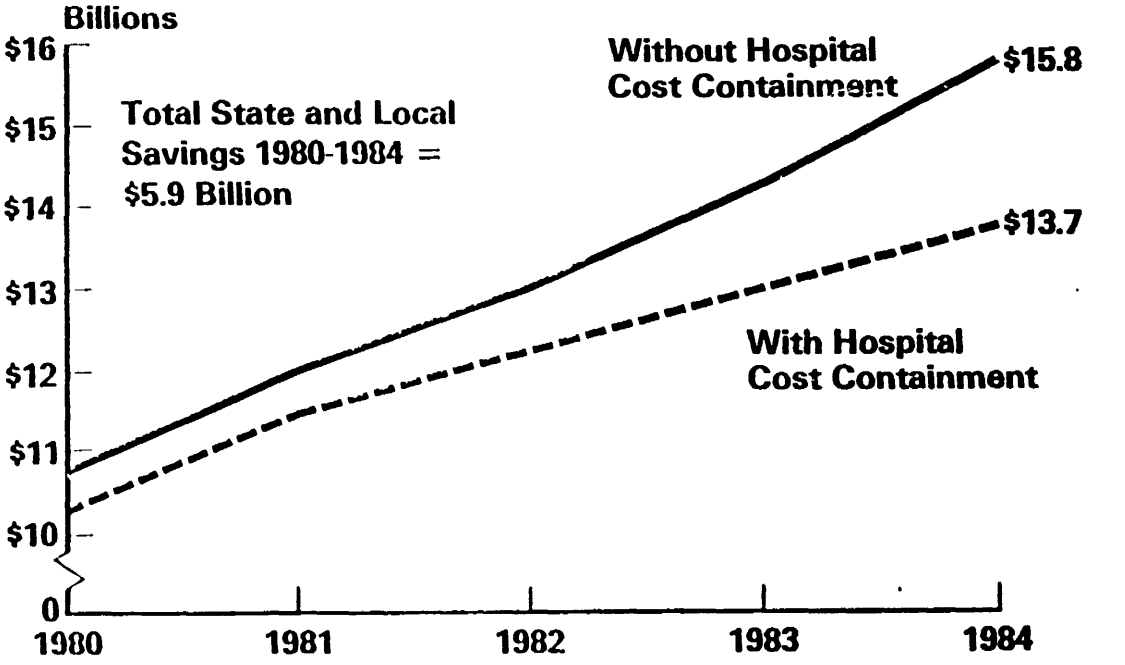
IMPACT OF HOSPITAL COST CONTAINMENT:
FEDERAL SPENDING FOR HOSPITAL SERVICES



IMPACT OF HOSPITAL COST CONTAINMENT:
THE FEDERAL BUDGET



IMPACT OF HOSPITAL COST CONTAINMENT:
STATE AND LOCAL SPENDING



CAUSES OF HOSPITAL INFLATION

- **Over 90 Percent of Hospital Bills Paid by Third Parties**
  - **Most Patients Do Not Pay Rising Costs Directly**
- **Hospitals Reimbursed by Inefficient "Cost-Plus" System**
  - **No Incentive to Save (the More Hospitals Spend, the More They Get)**
- **No Buyer/Seller Relationship**
  - **Physicians Make 70% of Health Care Decisions, but Have No Incentive to Hold Down Costs**

CAUSES OF HOSPITAL INFLATION:

EXAMPLES OF WASTEFUL EXPENDITURES (FISCAL 1977)

Under Hospital Control

o 130,000 Unnecessary Beds	$4.0 Billion
o Wasteful Buying Practices	$1.3 Billion
o Inefficient Energy Use	$1.3 Billion
o Excess CT Scanners	$0.2 Billion

Under Physician and Hospital Control

o Hospital Stays Longer than on West Coast	$2.6 Billion
o Weekend Admissions with No Medical Care	$1.6 Billion
o Unjustified Routine Diagnostic Tests	$0.3 Billion
o Eliminate Unnecessary X-Rays	$0.4 Billion

Result: **Hospital Savings Can Be Achieved by Reducing Waste without Affecting Quality of Care**

THE LEGISLATION: IN BRIEF

- **Goal: Reduce Rate of Increase in Total Hospital Costs**
- **Responsible Voluntary Target in 1979**
  - **Based Primarily on Hospitals' Actual Costs**
  - **Requires Better Management**
- **Standby Mandatory Limits To:**
  - **Provide Strong Incentives to Meet Voluntary Limit Through Productivity/Efficiency**
  - **Guarantee Savings if Voluntary Goal Is Not Met**

THE LEGISLATION: THE NATIONAL VOLUNTARY LIMIT ON THE RATE OF INCREASE IN TOTAL HOSPITAL COSTS

- Three Components
  - Allowance for Inflation in Costs of Goods and Services Used (The Hospital "Market Basket") 7.9%
  - Allowance for Population Growth .8%
  - Allowance for New Services 1.0%

  Total for 1979 = 9.7%

- Allowable Increase in "Market Basket" Adjusted at End of the Year if Actual Inflation Is Higher Than Estimated
  - Hospitals Have Limited Control Over These Costs

- Hospitals Pay for New Services with Increased Productivity and Efficiency
  - Hospitals Have Significant Control Over These Costs

THE LEGISLATION: THE NATIONAL VOLUNTARY LIMIT IS A REASONABLE TARGET

- 1977 — One-Third of All 6,000 Community Hospitals Were Below 9.7 Percent:
  - From All Regions of the Country: Rural/Urban
  - Of All Types: Teaching/Non-Teaching, Profit/Non-Profit
  - All Sizes: Large/Small
- 1978 — Six New England States Averaged 8.3 Percent*
  — More than One-Third of All Hospitals Are Expected to Be Below 9.7%

*Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont--AHA Panel Survey

THE LEGISLATION: MANDATORY LIMITS ESTABLISHED FOR INDIVIDUAL HOSPITALS IF NATIONAL VOLUNTARY LIMIT NOT MET

1 Basic Limit

- Inflation Allowance (Increases in the Costs of Goods and Services)

  and

- Allowance for Efficiency (a Bonus) or Inefficiency (a Penalty)

+

2 Exceptions/Adjustments

=

3 Mandatory Limit on Inpatient Revenues Per Admission

THE LEGISLATION: HOSPITALS EXEMPTED FROM MANDATORY PROGRAM

All Hospitals in State Exempted:

- In States With Mandatory Programs if:
  - Statewide Rate of Increase Is Within One Percent of National Voluntary Limit or
  - Other Standards Are Met
- In States Which Individually Meet National Voluntary Limit

Individual Hospitals Exempted:

- If They Meet the National Voluntary Limit But Are in Non-Exempt States
- If They:
  - Are Non-Metropolitan With Less Than 4,000 Admissions Per Year
  - Are Less Than Three Years Old
  - Have at Least 75% of Their Patients Enrolled in an HMO

THE LEGISLATION: HOSPITALS EXEMPTED FROM MANDATORY PROGRAM

Total Community Hospitals	**5,766**	**(100%)**
Type of Exemption	**Number* Exempted**	**Percent of Total**
1. Hospitals in Exempted States	841	15%
2. Individual Hospital Exemptions:		
o Individual Hospitals Which Meet 9.7% Limit	1,389	24%
o Small Hospitals in Non-Metropolitan Areas	1,060	18%
Total Exempted	3,290	57%

Result: **If Mandatory Program Starts on 1/1/80, More than Half of All Hospitals Will Be Exempted**

*Estimates based on 1977 AHA Annual Survey; number actually exempted likely to be higher.

THE LEGISLATION: THE WAGE PASS – THROUGH IN THE MANDATORY PROGRAM

Goal —

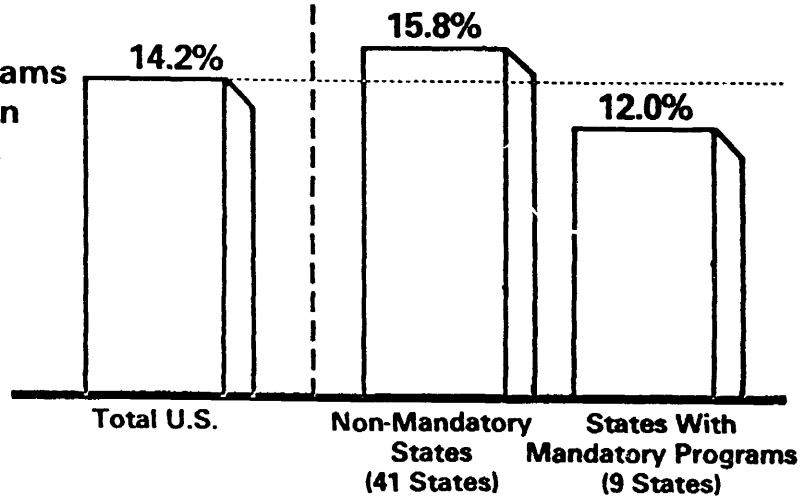
Ensure Low-Wage Nonsupervisory Workers Do Not Bear Burden of Hospital Cost Containment

Method —

The Wages of Nonsupervisory Workers Are Exempted

HOSPITAL COST CONTAINMENT: EXISTING STATE MANDATORY PROGRAMS ARE THE MOST EFFECTIVE ANTI-INFLATION TOOL TO DATE

States with Mandatory Programs Lead the Nation in Containing Costs



Rate of Increase in Total Hospital Expenses 1977 over 1976

Source: American Hospital Association Annual Survey

HOSPITAL COST CON..AINMENT:

MANDATORY STATE PROGRAMS CONTINUE TO PERFORM IN 1978

Year Program Began		Annual Rates of Increase in Total Hospital Costs	
		1977 Over 1976*	1978 Over 1977**
1977	Colorado	15.1%	13.3%
1974	Connecticut	11.4	9.9
1973	Maryland	11.8	10.5
1976	Massachusetts	13.7	8.2
1971	New Jersey	11.8	9.0
1969	New York	6.2	8.5
1971	Rhode Island	11.1	10.0
1973	Washington	15.2	8.9
1975	Wisconsin	12.4	11.0
	Nine State Average	12.0%	9.9%
	(National Average)	(14.2%)*	(13.3%)***

*Source: American Hospital Association Annual Survey
**Preliminary Estimates Based on State Data
***Estimate Based on American Hospital Association Panel Survey

HOSPITAL COST CONTAINMENT:

SAVINGS ARE CRUCIAL IN A PERIOD OF BUDGETARY RESTRAINT

Federal Savings from Hospital Cost Containment Might Be Used:

- To Reduce Social Security Tax Increases, or
- To Reduce the Federal Deficit, or
- To Provide Needed Benefits Under a National Health Plan

HOSPITAL COST CONTAINMENT:
MAGNITUDE OF SAVINGS

Hospital Cost Containment Will Save Nearly 53.4 Billion Dollars Between 1980-1984

- The $21.8 Billion in Federal Savings Would Pay for:*
  - — The Entire Federal Income Tax for 1.9 Million Average Families

  or
  - — The Total Health Care Expenditures of over 12 Million Children under 22 Years of Age

- The $5.9 Billion in State and Local Savings — Would Pay the City Expenditures for Education for the 12 Largest Cities in the United States*

- The $25.7 Billion in Private Savings — Would Pay the Food Bill for 930 Thousand Families*

*Per year over the five-year period

Senator TALMADGE. Mr. Heinz, did you wish to say something?

Senator HEINZ. No.

Senator TALMADGE. You are a man of brevity. We welcome you to our subcommittee.

Senator HEINZ. As someone who is not a member of your subcommittee, I feel brevity is probably important today.

Senator TALMADGE. It is always welcome in the Senate.

Senator LONG. The only thing that beats brevity, Senator Heinz, is silence.

Secretary CALIFANO. Mr. Chairman, if I may, let me preface what I say by noting that I think the legislation you are submitting this year, as you indicated in your opening statement, reflects very substantially the fact that in a true sense, the Senate spoke last year and we learned a great deal through the hearings which you conducted and the work of this committee as well as from the hearings that were conducted on the House side.

I think all of us learned a great deal, and speaking for myself, I did.

On the general question of the 21 national problems that our people were concerned about, 69 percent are interested in getting inflation under control as the first priority; and 31 percent are interested in controlling Federal Government spending and getting health care costs under control. This hospital cost containment bill meets all of those priorities.

The President in his State of the Union Address indicated this is the clearest test of the anti-inflation commitment of the 96th Congress.

The basic approach this year, Mr. Chairman, is to try and establish a voluntary limit for 1979. I will explain that in a moment. It is a 9.7 percent increase, but this is a flexible number, and for those who fail to meet that limit, we would impose mandatory controls in calendar 1980.

The savings, if the mandatory program is triggered, we estimate to be $21.8 billion, $22 billion over the 5 year period in Federal money alone, and $53.4 billion for the health care system as a whole.

Mr. Chairman, in terms of hospital costs vis-a-vis other costs, we often hear the point that other costs are rising, such as energy costs and food costs, and therefore, the hospitals have to have access to tremendous increases in order to handle that problem.

I think this chart makes that point very clearly.

Total hospital expenses are rising faster than anything else. What cost $100 in a hospital in 1974 costs $179.10 in 1978. To the contrary, what cost $100 in energy in 1974 costs only $138.20 in 1978 and what cost $100 in food in 1974 costs only $129.30.

What is happening in the Federal Government in terms of hospital spending? As you indicated, Senator, it is a good thing we can print money because we are printing it for hospitals.

In 1969, the Federal budget had paid $7.7 billion to the hospital industry. By 1979, it was paying $33.1 billion to the hospital industry. Without hospital cost containment, by 1984 it will pay $60.6 billion but with hospital cost containment, that will drop to $52.5 billion.

What is the impact of this cost containment legislation on American families? It reduces their financial burden. It will reduce their insurance premiums by $4.7 billion. It would require that $8.1 billion less of their personal income taxes be given to the hospital industry. It would require that $9.5 billion less of what the individual pays in the payroll tax be given to the hospital industry and that their out-of-pocket expenses would be reduced by $5.6 billion.

This chart reflects that burden in terms of the average American family and what would happen to them—indicating on chart. They would pay $133 less in insurance premiums; $37 less per year in personal taxes and $220 less in payroll taxes.

What about the burden on the American employer, the corporation? With hospital cost containment their premiums would drop by $14.4 billion over this 5-year period. Their share of the payroll tax, would drop by $9.5 billion.

Whatever ultimately is done to address problems with the social security program, one of the keys will be hospital cost containment, because we are talking about $19 billion of social security taxes paid to the hospital industry over this 5-year period that would be unnecessary with cost containment.

Corporate income tax would be reduced by $500 million. In terms of our elderly, they paid $44 in 1969 for the first day of hospital care under the medicare program. In 1979, they are paying $160 for that first day of care which comes out of their own pockets. By 1984, it will be $260 without hospital cost containment and it will be $216 with it.

As far as the uninsured are concerned, they paid $533 in 1969 to the hospitals, it is $1,600 for 1979, and will rise to $2,600 by 1984 without hospital cost containment.

What is indicated here in red [indicating on chart] is what we are giving to the hospital industry that would be saved by the cost containment legislation. As I mentioned, this is a total, in terms of Federal spending, of $22 billion over that 5-year period.

The percent of the Federal budget which went to the hospital industry was 4.2 percent in 1969. It will be 6.7 percent in 1979. By 1984, it will be almost 9 percent. That means that 9 cents of every tax dollar of the American people that the Federal Government spends will go to the hospital industry in 1984, without hospital cost containment. With it, 7.8 cents would go.

What about State and local spending, Mr. Chairman? The State and local governments would save almost $6 billion over the 5-year period which they could use for other pressing needs.

What causes hospital inflation? This goes very much to the point you indicated, Mr. Chairman, the burden of demonstrating why this industry is different. Mr. Kahn will deal with that in more detail but let me address it briefly.

More than 90 percent of hospital bills are paid by third parties, by medicare, by medicaid and by insurance companies. The individual patient, the customer, unlike the usual purchasing relationship, is not paying the bill directly, and so does not feel that he or she is paying the bill.

Hospitals are reimbursed on a cost-plus system. As you indicated in your opening statement, Mr. Chairman, the more they charge, the more we pay. There is no buyer/seller relationship. The patient

does not have a situation in which he or she picks the services they get. The physician picks those services and the physician is not paying the bill.

What is the potential for savings without in any way affecting the quality of care and indeed in some ways enhancing the quality of care? There are 130,000 unnecessary hospital beds which are costing us $4 billion a year to maintain. Wasteful buying practices total $1.3 billion, as indicated by a General Accounting Office study. Inefficient energy use costs us $1.3 billion and excess CT scanners, $200 million.

Another area of potential cost savings directly under the control of the physician and the hospital administrator is the length of hospital stay. On the West Coast, the average length of stay is 6.4 days. In New York State the average length of stay is 9.9 days. If the whole country averaged the same length of stay as the West Coast, we would spend $2.6 billion less.

Senator NELSON. Mr. Secretary, I did not hear those figures on the hospital length of stay.

Secretary CALIFANO. Senator Nelson, I said for the West Coast the average length of stay in the hospital is 6.4 days. In the State of Washington, the average length of stay is 5.5 days. If the whole country had the same length of stay on the average as the 6.4 days on the West Coast, we would save $2.6 billion. In New York State, the average length of a hospital stay is 9.9 days. It is higher on the East Coast than on the West Coast.

In terms of weekend admissions, a study done by Blue Cross and Blue Shield indicates that the practice of weekend admissions with no medical care costs an unnecessary $1.6 billion.

Unjustified routine diagnostic tests cost us $300 million. We should achieve a great deal in savings from the actions of Blue Cross and Blue Shield to require doctors to specifically select the tests instead of simply subjecting their patients to all those tests.

Eliminating unnecessary X-rays would save us $400 million a year. Here again, is a situation in which in addition to cost savings, we will provide better quality health care because we will subject our people to less radiation.

Senator HEINZ. Mr. Secretary, with respect to your first point on hospital control, the excess beds and the other two under physician/hospital control, the hospital stay being longer on the West Coast and the admissions, are not those two aspects of the same phenomenon? If you did not have the necessary beds, I do not think as a practical matter you would have the longer stays or the weekend admissions.

Are we not double counting?

Secretary CALIFANO. To a degree, yes, as we eliminate unnecessary beds, we would have fewer of those.

Senator HEINZ. You would have shorter hospital stays.

Secretary CALIFANO. Hopefully. There is certainly a significant level of overlap in those two items. For example, the State of Washington which has a 5.5 day average length of stay has about 3.5 beds per 1,000 people, one of the lowest in the country.

There is some overlap.

In terms of the legislation, basically it is designed to reduce the rate of increase in total hospital costs. We have a voluntary target

which we think is ambitious but responsible, stand-by mandatory limits if the target is not met.

Mr. Chairman, this is the voluntary program [indicating chart]. Under the voluntary program, the way we arrive at the 9.7 percent is through an allowance for the cost of goods that the hospitals have to buy. We give them a 7.9 percent allowance. That figure is our best estimate of what it will cost a hospital to buy the goods and services which it uses during the year.

This is in response to the claim of the hospitals last year. They told us: if you put an arbitrary cap on, we do not have control over the things we are buying, as inflation goes up in those areas, we——

Senator TALMADGE. Mr. Secretary, will you yield at this point?

Secretary CALIFANO. Yes, sir.

Senator TALMADGE. You are assuming inflation for this year will be 7.9 percent?

Secretary CALIFANO. We assume that it will be for the cost of goods and services which a hospital has to buy. This assumes that the President's wage and price guidelines will be met. If inflation goes up higher than the 7.9 percent, we will adjust the 9.7 percent upwards accordingly.

Senator TALMADGE. Will you yield further?

Secretary CALIFANO. Yes, sir.

Senator TALMADGE. It is about 11 percent now and CBO estimates it will probably run 14 percent this year. Is your bill flexible enough to allow that increase in inflation or not?

Secretary CALIFANO. Yes, the bill is flexible enough. This figure will be adjusted depending on what the rate of inflation actually is. The difference between the CBO estimate for this number and ours is essentially that we assume that the wage and price guidelines established by the President will be followed. They assume they will not be met.

Senator HEINZ. What about energy? Has the state of recent price increases that you have seen in the wake of Iran been factored in?

Secretary CALIFANO. They will be. The figure will be adjusted upward if inflation goes up. It is the same market basket that the hospitals themselves use in arriving at their 11.6 percent voluntary goal.

As I said, this is in response to their claim that we should not hold them responsible for the cost of those things they buy over which they have little or no control.

As I indicated on the earlier chart and as Mr. McMahon, the head of the hospital association, indicated before another Senate committee, there is room for better management and better buying practices.

The second item used to determine the 9.7 figure is an allowance for population growth, eight-tenths of a percent. This is the amount by which the U.S. population is expected to increase. It is the amount by which hospital utilization increased last year. We use that allowance. The hospitals in their voluntary program use a figure of 1.1 percent.

The final item used in reaching the 9.7 figure is an allowance for new services, service intensity. We allow for a 1 percent increase.

The hospitals in their voluntary program use 1.4 percent for service intensity.

As I said, the market basket will be adjusted upwards if inflation exceeds our estimate. Under no circumstances would it be adjusted down. Even if inflation, due to the miraculous work of Mr. Kahn, were to come in at about 7.5 percent, we would leave the market basket figure at 7.9 percent so that the hospitals can rely on that 7.9 percent base figure.

Senator HEINZ. Mr. Secretary, you have an allowance for population growth. Did you not have factored in there an allowance for change in the mix of the population?

Secretary CALIFANO. We looked at that question, but the hospital days or hospital admissions grew by an amount for 1978 over 1977 which was the same as the amount of population growth. It is simply population growth. We think that is about what it will be.

Senator HEINZ. I am referring to the phenomenon known as the "graying of America" which I know HEW is intimately aware of; I am just wondering to what extent that is reflected.

Secretary CALIFANO. We looked at that in terms of last year. That is how we started out. When we found that hospital admissions grew by only the same amount as the population grew, without regard to the demography of the population, in 1978 over 1977, 0.8 percent, we used that figure, just population growth.

Senator HEINZ. Can you look only at admissions? Is it not a question of the mix of services that are necessarily provided?

Secretary CALIFANO. The factor reflects what happened last year. The hospitals themselves used 1.1 percent, a higher factor than the 0.8 percent, 0.3 percent higher.

Senator NELSON. Mr. Chairman, may I ask a question?

Senator TALMADGE. Proceed, Senator Nelson.

Senator NELSON. It is true that you will have individual hospitals that will be below and above any one of those figures. Are we only talking about the aggregate?

Secretary CALIFANO. That is correct, Senator.

Senator NELSON. Therefore, a State that has met the standard would be exempt, yet you may very well have hospitals that may have a 14- to 16-percent growth, as well as some with 6 percent. However, there is flexibility in your proposal which allows those hospitals a mix of different costs within that State, as long as in the aggregate they achieve the percentage level that is in the bill, is that correct?

Secretary CALIFANO. That is correct, Senator.

Senator TALMADGE. I would like to ask a question to clarify further the question Senator Nelson asked; is that amount based on the average of the State, the average of the Nation or the average of the locale where the hospital is located?

Secretary CALIFANO. The 0.8 percent is based on the average in the Nation. That is just the growth of population in the Nation.

Senator TALMADGE. Suppose you had a hospital that is located in an area where they are growing 15 percent, another hospital in an area where the population is declining. Do you differentiate between the two?

Secretary CALIFANO. In terms of the voluntary program, we would not differentiate between the two.

Senator TALMADGE. Would you not have to break it down to the population in the area where the hospital is located? That is where the patients come from.

Secretary CALIFANO. Do you want to correct me, Karen?

Ms. DAVIS. On the State voluntary limit, that would be adjusted for population growth so it would vary between States with growing population and States without.

Senator TALMADGE. I could not hear the answer.

Secretary CALIFANO. On a State-by-State basis, that population adjustment would be made in terms of the voluntary limit.

Senator TALMADGE. Within the locality where the hospital is located?

Secretary CALIFANO. Not within the locality, within the State.

Senator TALMADGE. Would you not have to break it down to the locale where the hospital is located? For instance, you may have some State or some area where the population is quite young and does not have many health care problems. You might have another State where retirement is a big item in a locality and the citizens are quite aged. You would have a different situation between a youthful population and an aged population by locality, not by State.

Does your bill take that into consideration?

Secretary CALIFANO. We do not break it down by locality.

Senator TALMADGE. Look into that aspect of it because I think that is very important. Hospitals, by and large, receive patients from the locality where they reside.

Secretary CALIFANO. We will, sir.

In terms of the 9.7 percent voluntary limit, one-third of the 6,000 community hospitals in the country were at or below that limit, I should say below that limit in 1977, a year in which we had comparably high inflation. They were from all regions of the country, rural, urban, teaching hospitals, nonteaching hospitals, profit and nonprofit, large and small.

In 1978 over 1977, on the basis of preliminary figures, it looks as though the six New England States have averaged 8.3 percent, well below the 9.7 percent.

Senator HEINZ. Why is that, Mr. Secretary? Does that have anything to do with population loss?

Secretary CALIFANO. We do not think so. I say preliminary figures and I underline that. The detailed figures take months. It was not until September when we had figures on 1977 over 1976. It will be a while before we have final figures for 1978 over 1977.

One of the problems in this area, for reasons that I will never understand, is that HEW has not over the course of all of these years of dealing with medicare and medicaid, developed its own independent system on hospital numbers. We rely on the hospital associations for those numbers. By August we will have our own independent system in place and we will not have to rely on the industry for numbers about the industry.

Those are all hospital industry numbers.

In terms of the mandatory program, the basic limit is the inflation allowance which I discussed. There will also be an allowance for efficiency or inefficiency, and there will be the authority to make exceptions or adjustments for special circumstances.

A large number of hospitals would be exempt from the mandatory program. In States with mandatory programs, hospitals would be exempt if the program brings the statewide hospital rate of increase within 1 point of the voluntary limit. In States which have voluntary programs, they would be exempt if they meet the voluntary limit. For hospitals in States without such programs or with programs which fail, any individual hospital in the State that meets the voluntary limit will be exempt.

This is a provision basically developed in this committee by Senator Talmadge and Senator Nelson during consideration of legislation last year.

We also provide that small hospitals, hospitals in nonmetropolitan areas with 4,000 admissions or less a year would be exempt. Hospitals that are less than 3 years old will also be exempt.

I might note we have here in Washington the Children's Hospital, which is less than 3 years old and which is (a teaching hospital), is within the 9.7-percent limit.

Hospitals which have at least 75 percent of their patients enrolled in HMO's will be exempt because the report we sent to the Congress last week indicates that HMO patients have about half the hospitalization of others.

What do these exemptions mean in numbers? These estimates are based on the year 1977, the last year for which we have complete numbers, but We believe that we would have a total of 3,290 hospitals exempted, about 57 percent of all hospitals.

We do have a provision in this legislation which would pass through the wage increases of low-wage nonsupervisory workers, so they do not have to bear the burden of hospital cost containment. I should note over the last 5 years, the average increase of such wages has been about 8 percent. It is at about the 7.9-percent level.

Senator TALMADGE. Is any other item exempt besides wages?

Secretary CALIFANO. Nonsupervisory wages is the one that is completely passed through. Are there any others?

Ms. DAVIS. Energy and food.

Senator HEINZ. Mr. Secretary, are wages exempt when calculating the cap?

Secretary CALIFANO. The nonsupervisory wages are exempt. We pass through whatever those wage increases are.

We do not think that this will have an adverse impact. There may be isolated cases in which you have very low-waged, nonunionized workers at a hospital and they organize for the first time and finally get their wages up to a decent level.

Senator HEINZ. Has there been any thought as to the extent to which if there is a substantial wage increase in the nonsupervisory people that we are talking about here, that would have what is known as a ripple effect on other wage rates in the hospital?

Secretary CALIFANO. The reality of those nonsupervisory wage increases is that they have averaged about 8 percent over the last 5 or 6 years. The time when you might have a single large increase is when employees unionize for the first time or organize in some way for the first time.

I believe we can submit data for the record indicating that there has not been a ripple effect in those situations. They have normally

been people who were at the absolute bottom of the pay scale and are finally getting fair wages.

Senator HEINZ. Do you have any concern that by allowing a passthrough for nonsupervisory people who certainly have over various periods of time been really at the bottom of the economic ladder in many respects, that over time this might not result in nonsupervisory people being more highly paid than supervisory personnel?

Secretary CALIFANO. I do not think so. We do not have any such concern. Nonsupervisory personnel, by and large, are enormously well paid in hospitals.

In terms of the impact of a mandatory program versus that of a voluntary program, for the one year for which we do have complete numbers, 1977 over 1976, the total rate of increase for the United States was 14.2 percent. In the nonmandatory States, it rose at almost 16 percent, 15.8 percent. In those 9 States with mandatory programs, the increase was only 12 percent.

Senator NELSON. Mr. Chairman, may I ask a question?

Senator TALMADGE. Yes, sir.

Senator NELSON. In all the times I have seen those figures I have not seen a computation. Do you have a computation of what the dollar savings would be if the 41 States that are at 15.8 were at 12 in that year 1977?

Secretary CALIFANO. That is a terrific question, Senator. We will get you that computation before today is over if we can.[1]

Senator NELSON. I think it is worthwhile having the statistic to demonstrate what a 3.8-percent difference between the 9 mandatory States—12 percent in 1977—and the 41 nonmandatory states—15.8 percent in 1977—adds up to in dollars.

Secretary CALIFANO. We will provide that, Senator.

Again, noting that this is preliminary data and not final data in terms of 1978 over 1977, these are the nine mandatory States and you can see that by and large the rate of increase is continuing to go down [indicating on chart].

I would like to make one important point here. States can have significant reductions year to year. Massachusetts with all of its teaching hospitals had a 13.7-percent increase for 1977 over 1976 and only an 8.2-percent increase in 1978 over 1977.

Similarly, the State of Washington, had a 15.2-percent increase 1977 over 1976 and an 8.9-percent increase 1978 over 1977.

Senator TALMADGE. If you will yield at this point, Mr. Secretary. Is it true that none of those States have a mandatory wage passthrough for nonsupervisory personnel?

Secretary CALIFANO. I do not know which of those States do. I will have to submit that for the record.

Senator TALMADGE. My understanding is none of the nine have.

Secretary CALIFANO. I will have to check that, Mr. Chairman.

Senator TALMADGE. Will you check on it and provide it for the record?

Secretary CALIFANO. I will.[1]

We believe the magnitude of the savings we are talking about is so enormous that it is very important at a time when there is concern about the impact of cost increases on the payroll tax in

[1] See p 629

1981. One of the keys to providing relief, if that is what the Congress and the President choose to do, would be to have hospital cost containment, because it would provide a reduction of $19 billion on the drain of the trust funds. The funds can be used to reduce the Federal deficit. This may be the single most important action that can be taken this year in that connection.

For those who are interested in providing benefits for a national health plan or the beginnings of a national health plan, an area in which several members of this committee have presented legislation, cost containment could provide needed funds in that area.

The numbers on savings are so large it is hard to put them in some perspective. We tried to do that here. If you take the $21.8 billion in Federal savings, what would it pay for?

Senator TALMADGE. If you will yield at this point, Mr. Secretary. When you talk about Federal savings, that is an estimate of what we would save if the bill is passed over what would be spent if we do not?

In real terms, there would be no savings except the estimate of what it might be and what you hope it will be?

Secretary CALIFANO. Yes, Senator. If the bill is passed and the mandatory program is triggered, the savings would be higher. For example, certainly in the early years, if the hospitals met the voluntary limit.

Senator TALMADGE. Federal expenditures under any bill will increase over what they are now?

Secretary CALIFANO. That is correct, Mr. Chairman. No one has found a way to solve that problem yet.

Senator TALMADGE. I agree, it is difficult.

Secretary CALIFANO. The $21.8 billion in Federal savings would pay the entire Federal income tax for 1.9 million average American families. It would pay the total health care expenditures for over 12 million children under 22 years of age. It would provide in each of the 5 years or it could provide, a $49 reduction in the taxes of each tax paying unit in this country.

The $5.9 billion in State and local savings would pay the city expenditures for education for the 12 largest cities in the United States. The $25.7 billion in private savings, for example, would pay the food bill for 930,000 American families.

Thank you, Mr. Chairman.

Mr. Chairman, I do not know how you would like to proceed. Mr. Kahn is here.

Senator TALMADGE. I would suggest we go to the questions. I would also suggest we limit each Senator to 10 minutes. Is that agreeable? If we want additional time, we will have a second round.

Is there any objection?

[No response.]

Senator TALMADGE. Without objection, it is so ordered.

Mr. Secretary, based upon all data available on the hospital cost situation, is there any doubt in your mind that we will not have mandatory hospital revenue controls in effect as of January 1, 1980?

Secretary CALIFANO. I believe that is the date we have set in the budget. I believe if the Congress acts promptly, we can have those controls in place if we need them.

Is the question directed to whether they will meet the voluntary limit?

Senator TALMADGE. Yes.

Secretary CALIFANO. I believe hospitals can meet the voluntary limit, Mr. Chairman, because the one thing that is not within their control totally, although as I said, the better purchasing, prudent buyer kind of activities are within their control——

Senator TALMADGE. The prudent buys is in both bills, as I recall.

Secretary CALIFANO. I believe they can meet it because the largest single component of that 9.7 is a reflection of what inflation will actually be. We estimate it to be 7.9 percent. It will go up. It is not a situation to me, Mr. Chairman, in which someone should come in and say, we cannot achieve 9.7 because as you indicated, inflation for the first 2 months has been rising a little higher than any of us would like, instead the biggest component of the 9.7 will be adjusted upwards.

They should be able to meet it. As you can see from that red line on the chart, at this time they are way above the rate of increase of other components in the economy.

Senator TALMADGE. I notice the bill you are submitting this time omits much of the kinds of troublesome details that were so controversial in the last Congress. Instead, rather than leaving those issues for debate, they are left to the discretion of the Secretary.

For example, the bill allows the Secretary to reward or penalize the hospital in order to allow for such factors as the Secretary may find warrant special consideration.

I trust you, Mr. Secretary, but suppose we had a Secretary who smoked cigarettes and who supported paying for abortions under medicaid? What would happen then?

Secretary CALIFANO. Mr. Chairman, you came within 3 years of having a Secretary that smokes cigarettes. This is always a question of balance, how much to put in the bill and how much to leave to the discretion of the Secretary.

We are not locked in cement on this part of the legislation. We tried to strike a better balance reflecting what both the Senate and House did last year but we are certainly willing to work with you to the extent you and Senator Nelson and Senator Long feel there should be more specific language in the legislation.

Senator TALMADGE. We look forward to working with you. I think every member of the Finance Committee is dedicated to trying to do something this year. We did last year. Unfortunately, the House did not act. I hope we will get complete cooperation this year from all the subcommittees that have jurisdiction.

I am concerned over what appears to be a comparison of apples and oranges when you compare increases in total hospital expenditures with the CPI. Does not the CPI measure unit prices changes rather than aggregate changes?

For example, the price of an automobile, if it rolls 8 percent in 1978 and the total expenditure of the automobile industry went up by 15 percent, you would not say the price of a car had gone up 15 percent.

Quite simply, how much did the hospital expenditures for admissions increase in 1978 over 1977?

Secretary CALIFANO. If you will look at the chart, the second line, the blue line, "CPI-Hospital Room Rates", a component in the Consumer Price Index for hospitals, it is still rising much faster, about twice as fast as the CPI generally is rising. It is more than twice as fast.

Total hospital expenses are rising almost three times as fast.

Senator TALMADGE. Those are room charges and not room costs, as I understand it.

Secretary CALIFANO. That is correct, Mr. Chairman.

The reason we put hospital expenses on the chart is because that is what you are paying for, that is what I am paying for, that is what every American taxpayer is paying for, that is what every American employee is paying for, everyone that is buying an insurance policy is paying for it.

As you indicated in your opening statement, it is a wonderful business—charge whatever you want to charge, and there is somebody to pick up the bill.

That is why we think total hospital expenses are a relevant factor and something we should look at. We think they are a better measure of what is really happening to your pocketbook and my pocketbook than the CPI hospital room rate.

We put the CPI hospital room rate on the chart because we wanted to be eminently fair in our comparisons.

Senator TALMADGE. Nothing in your statement deals with the provisions of S. 505, Medicare and Medicaid Administrative and Reimbursement Reform Act. What are the current departmental positions with respect to the provisions of S. 505?

Secretary CALIFANO. Mr. Chairman, there are many things in that legislation, as I think you know, that we support. For example, you were probably the first person that mentioned the hospital cost containment problem to me when I was making courtesy calls before I became Secretary and what you do with the hospital based physicians, with anesthesiologists, radiologists, what have you, we support.

We will be submitting within the week detailed comments to your staff on the legislation.

The concerns we would express on the differences between the two pieces of legislation are as you indicated in your opening statement, that the President's legislation covers all the hospitals, and that your legislation covers only medicare and medicaid.

Senator TALMADGE. What the Government buys.

Secretary CALIFANO. Your legislation covers routine costs, which are about 40 percent of the costs. We would cover all costs, nonroutine costs as well—X-rays, drugs, inhalation, therapy, radiation, what have you.

We have in our legislation a voluntary period of compliance. Your legislation does not have a voluntary period of compliance.

I think those are the main differences. There are a tremendous number of similarities. As I indicated briefly in my opening statement, we learned a lot from your legislation and from what this committee did last year.

With respect to the whole host of provisions in your legislation, we will submit item-by-item views.

Senator TALMADGE. The staff, as you know, have prepared a number of possible alternatives to achieving Federal savings in medicare and medicaid. I assume you have had an opportunity to review that list. Could you comment on the staff alternatives or supply comments for the record thereon?

Secretary CALIFANO. I will submit them for the record. I would make one general comment that several of those items are very good and some of them we are moving on.

For example, one of the items the staff lists is the disproportionate share of certain payments that medicare and medicaid bear. We have issued and I have signed proposed regulations which would, for example, in the malpractice area, have us limited to our fair share. The American taxpayer now, through medicare and medicaid, pays 40 percent of the malpractice premiums in this country, although medicare and medicaid patients share in only 12 percent of the rewards.

We are changing the way we reimburse in that area to take care of that.

Senator TALMADGE. I believe that was a staff suggestion.

Secretary CALIFANO. That is correct, Mr. Chairman. There are other items on which we agree with the staff, the proposals relating to competitive bidding and negotiated rates under medicaid. We think they make a lot of sense. We would like to expand on that.

We have severe restrictions under the medicare program on our ability to go out for competitive bids from those who process our claims. The providers, essentially the hospitals, have the power to pick the intermediary to process the claim.

We have done this on a demonstration basis in two States, New York and Illinois. In western New York State today, we pay $3.08 to process a medicare claim. Under a competitive contract beginning next January, we will pay less than half that.

Senator TALMADGE. Mr. Secretary, my time has expired. I had only one other question, and if I may, I will ask Chairman Long to ask that question. He is recognized at this point under the early bird rule.

Senator LONG. This is Senator Talmadge's question. He is concerned about the equity of your exemptions from controls of the given State or hospital, assuming the failure of the national voluntary test established in 1979.

Take the following cases: Two adjoining States, one State's hospitals have an average cost for admission of $2,000 and the adjoining State has an average cost of $1,400. Would he be correct that under your bill, if the State with $2,000 cost kept its aggregate increase to about 9.7 in 1979, they would be exempt, while the State with only $1,400-per-case cost would be subject to mandatory controls if its costs increased only slightly more than that?

Secretary CALIFANO. The State would not get a State-wide exemption. We basically feel that percentages are the fairest way to do this. The individual hospitals within that State would get an exemption if they met the voluntary limit.

Senator LONG. As I understand it, let's say if in State A the cost is $2,000 for admission and in State B the cost is $1,000; if State B has an increase above the 9.7, would they still be under mandatory controls even though their cost is about one-half what it is in the adjoining State?

Secretary CALIFANO. That is correct, Mr. Chairman. Let me note that there are wide variations, in part contributable to location, wage rates, and costs. There are wide variations in doing something in New York City with respect to costs and the costs of doing something in Plains, Ga. We take into account the general economy; that is the only way we have to take the general economy into account.

Senator LONG. In 1977, according to Bureau of Labor Statistics, the wage levels of nonsupervisory hospital workers caught up with and passed the wage levels for comparable work outside of hospitals. Just for ordinary day-to-day work of cleaning in the kitchens and cleaning the place up, people are paid more inside hospitals than they are out working somewhere else.

The wages of a nonsupervisory hospital employee are a significant portion of hospital costs and, of course, they have a ripple effect on other workers as they increase.

What kind of sense does it make to pass a wage increase of those employees through? Would it not make better sense to pass those wage increases through only if they were below the prevailing wages for comparable work in a geographic area rather than simply writing a blank check on that?

Secretary CALIFANO. Mr. Chairman, in 1978, the average pay of a nonsupervisory employee in a hospital was $5.23. The average pay of a nonsupervisory employee in the nonagricultural private sector was $5.90 an hour.

Our numbers in 1978 indicate that nonsupervisory hospital workers had a wage increase of 9.1 percent; all workers, nonsupervisory, an increase of 9.3 percent.

In the period of 1972 through 1978, hospital workers had an average increase of 8.1 percent; all workers had an average increase of 7.6 percent. In recent years, wages of hospital workers have been at the same level as or below those of other workers.

I think by and large, in terms of administrability and simplicity and in the interest of making this easier and fairer, the general, broad, complete passthrough is a better way to do it.

Senator LONG. Yes, but in New York City, as an example, pot scrubbers working for hospitals are paid about 50 percent more than clerk-typists working in the medicare regional office.

The point is, if the people you have working as pot scrubbers are already making more than the secretaries are making and your clerks in the office, and they are making 50 percent more than people doing similar work in the private industry, why should they just get a wage passthrough?

Par for the course on this kind of thing is that you have workers making a certain wage and then someone comes in from a Teamsters Union or some other union, proceeds to organize these people and jump up wages, so that you move from an average wage of $8,000 a year up to an average wage of $15,000 a year for doing nonskilled work.

The question is, why should they get a blank check?

Secretary CALIFANO. Mr. Chairman, by and large, I believe the hospital workers, nonsupervisory hospital workers, are at a very low level. The blank check, as you call it, is simply to give them a fair opportunity and to make sure the hospital administrators and others do not place the burden of hospital cost containment on people that are, by and large, at the bottom of the economic ladder. That is the objective of this passthrough.

Senator LONG. Mr. Secretary, in my hometown, I have to compliment the Teamsters' business agent because he went to work and organized the garbage workers. They had a tremendous increase. The Mayor of the city said they did not have the money to pay it. They said you either pay it or you do without garbage collection.

Finally, as I understand it, they paid it, and the way they did it was not to buy equipment—no automobiles, or police cars, or garbage trucks. Whatever money there was in the budget to buy the equipment was gone.

That is how the unions can very effectively do a job and, even if the money is not there, make them pay it, take it out of some essential item that they cannot do without.

You have got in your program a complete wage passthrough. Suppose a guy wants $20,000 as a pot scrubber? It is all passed on and either the government or the public is going to have to pay for it.

Why would you want to say that in a certain area you are going to have rigid controls and at the same time have a complete wage passthrough. A very able and highly competent union could come in and organize those people and ask for a 300-percent increase?

Secretary CALIFANO. Mr. Chairman, I do not think there are many or anv cases of people getting a 300-percent increase.

Senator LONG. You do not have a limit. It could be 500 percent according to your bill, the way I understand the bill. You just can't pretend that there is no and cannot be a problem.

Secretary CALIFANO. Mr. Chairman, the Senate of the United States last year made the same judgment in the legislation that it passed. We agree with that judgment.

Senator LONG. Do not pass the buck. The question is, is it right or not? That is what I am asking you.

Somebody calls the roll out there and I have seen us do some awful silly things on some of these votes.

Secretary CALIFANO. I figure 60 Senators cannot be wrong, Mr. Chairman.

Senator LONG. I would be the last person to allege that. Mr. Kahn, do you agree there should be a blank check for the hospital workers, the nonsupervisory workers?

Mr. KAHN. Senator, I wish you would not drag me into that fight. I cannot defend on grounds of economic principle exempting any costs from control, but I cannot either make the judgment; it is a political judgment and it is an equity judgment about what is fair and what is unfair.

Senator LONG. You have a point of difference right now with the Governor of Louisiana. He said he would like to give those State employees a bigger pay raise than you would permit, and you are urging him not to do so.

Mr. KAHN. In our general program, Senator, we have set somewhat more specific limits and said wages are subnormal or very low. I cannot in principle defend any other standard elsewhere, but that is a judgment that I am going to have to leave to the Secretary on the one hand and the Senate on the other.

Senator LONG. Thank you.

Senator TALMADGE. Senator Nelson?

Senator NELSON. On that point, I think there have not been any controls on hospital employee wages, so you have a long history to look at. In that long history, you will find out that hospital employees are on the low end of the pay scale.

You have not had 300-percent. or 100-percent, or 50-percent increases under a circumstance which has been a free market for many years.

The President has asked for a voluntary effort to restrain wage increases to no more than 7 percent by the employees out in the rest of the sector of the economy; and if they hold to that limit he is then prepared to support a wage insurance supplement if it goes up further than 7 percent.

You are treating the hospital employees roughly the same as all other workers in the economy, in a situation in which hospital employees are among the least powerful group in the labor market sector in America. I think they are being treated roughly the same as the other employees and the worry of some dramatic increase just is not there. They do not have that power in the bargaining picture compared with other unions, as a general proposition.

Senator TALMADGE. Senator Heinz?

Senator HEINZ. I have one question, Mr. Chairman.

Mr. Secretary, all of the proposals considered in the last Congress carried an expiration date. Your current bill has no termination date, no sunset provision.

You could say it is a light sentence without any hope of parole. If we do what you want, would we be giving hospitals and their patients a perpetual endownment of Federal bureaucracy and boondoggle?

Secretary CALIFANO. Mr. Heinz, I think if you do what we want, you will be giving the American taxpayers relief from the hidden tax that is now imposed on them. It is a $50 billion tax that has been imposed on them without representation.

Normally when a tax is placed on the American people, the Congressmen and Senators have to stand up and vote for it. The hospitals have managed to place this tax on the American people without anybody having to be called to account.

The main thing you would be giving them is relief from this tax.

As far as putting an expiration date on, we do not regard this program as the be all and end all of the way to deal with this problem.

As Senator Talmadge and others have indicated on many occasions, ultimately the whole reimbursement system in the health industry has to be changed. We cannot continue forever in this world of cost plus.

As the chairman said in his opening statement, whatever you charge, we will pick up the bill.

I think we do not have any objection to some kind of a reasonable provision, 5 years or what have you, in terms of reauthorization of this legislation.

It is not intended to be the be all and end all, but it is something that it seems to us imperative to do. It is the test of whether or not the Congress is serious about inflation. This is an act that the Congress can take that will immediately have an impact on the inflationary spiral in this country, something Mr. Kahn will talk to in a more general way when he gives his statement.

Senator HEINZ. Mr. Secretary, HEW has often argued that there is a little real competition in the physician area and indeed, when you cited the increase in hospital costs between 1975 and 1977 as warranting mandatory price controls for hospitals, the fact is the cost of physician services and the expenditures on them increased by 31 percent during the same period, exactly the same as the hospitals for the same period.

Given all those similarities, do you also have mandatory controls in mind for physicians as well or doctors next on your hit list here, along with lawyers and others?

Secretary CALIFANO. No, there is no proposal in this legislation in that area. I believe there is in Senator Talmadge's legislation, a limitation on the reimbursement of hospital based physicians. That is either in the legislation itself or it is one of the proposals the staff has made, the Finance Committee staff.

Senator TALMADGE. Ours is reimbursement reform and not mandatory revenue controls.

Secretary CALIFANO. Change in the reimbursement method.

One element of that, one provision in the Talmadge legislation that we strongly support, addresses the problem that presently in many situations, radiologists, pathologists, and anesthesiologists, are paid by a percentage of the gross, the way a big entertainer is paid at the gate.

We think that practice should be stopped. We think there are serious ethical questions about that practice as well as the questions of reimbursement.

For years, Senator Talmadge has proposed this and we strongly support it. In that particular area, we should do something.

Senator HEINZ. Mr. Secretary, in the presentation you made, you used the example of New York State which had relatively long hospital stays, 9.9 days. It is very interesting that New York State has mandatory hospital cost controls. Therefore the fact that you singled them out as having long stays I find very difficult to understand, if they are an example.

Are they doing something wrong? Is their program lousy? It seems to be working if hospital stays are increasing, the implication is you do not really know what is causing hospital cost increases.

You point in your initial presentation to admissions problems, number of beds, length of stay and yet here is a hospital system that seems to be doing well overall with very long bed stays.

What is your analysis of what the increases in hospital costs are based on? What are the critical variables? Who is getting all this money that you are concerned about?

Secretary CALIFANO. There are a number of critical variables, some of which I have listed. With respect to New York State, let me say that it is in the last couple of years that New York State has started to move with its program. Governor Cary has demonstrated extraordinary courage in moving to close hospital beds.

We have in the past year worked with the Governor to reorganize the whole PSRO effort in New York State. We think PSROs are going to have a significant impact on the length of stay problem there which would even further reduce costs in New York State.

The kinds of variables we are talking about are the tremendous excess capacity which we pay for, the length of stay, the unnecessary tests, and the fundamental problem that the competitive system, the fabulous system in this country of competition that makes a car available to almost everyone or a television set available to almost everyone, does not function in this area.

Hospital administrators do not wear black hats and the Government white hats. The fact is they act in their environment which is a cost plus environment and in which the customer does not pay the bill, and the customer does not pick the service. They act in their environment just the way any of us would act and that is why this is such a special and peculiar environment.

In many cases, people do not have the choice as to whether or not to get the service. If I could steal one of Senator Nelson's great stories, it is about a bear that goes into a bar in Wisconsin and says, I would like a beer. He sits on the stool. The bartender serves him a beer and the bear puts $5 down on the bar and the bartender says, I am going to take this bear and just give him a nickel change.

Later on he goes around to talk to the bear. He says, we do not see many bears in this place, how come you came in? The bear said I do not wonder you do not see many bears in here at $4.95 a beer.

Senator Nelson should have told that joke, he does it better.

Senator HEINZ. I agree.

Secretary CALIFANO. The fact is the bear can choose——

Senator HEINZ. Are you advocating controls on the price of liquor? You will really get in trouble!

Secretary CALIFANO. The fact is that the bear can choose whether or not to go someplace or to get a particular service and in most cases our patients are subject to decisions made by their doctors and their hospitals.

Senator HEINZ. Mr. Secretary, I am sure you would like to come up to the Allegheny National Forest sometime and see the bears standing in line for Tastee-Freeze as well.

The only thing that amazes me is the people standing in line with them.

The thing which concerns me and maybe it is just a kind of effort to sort out how you get reductions in hospital costs, I suspect the only way you really get reductions in hospital costs, notwithstanding all this information that we have seen today, is you close hospitals. That is the way they have cut hospital costs in New York State, they have closed hospitals.

Is that not really the bottom line on what your legislation will do, it will force the closing of hospitals?

Secretary CALIFANO. That and the Health Planning Act, I hope, will encourage eliminating 130,000 excess hospital beds.

Senator HEINZ. How can that legislation Public Law 93-641 do that? Unless you advocate recertification of need, it is never going to close any existing beds. I have not heard you advocate that.

Secretary CALIFANO. The number of hospital beds is a function of the number of beds that already exist. The certificate of need process deals with the number of new beds that are put in place. Our health planning legislation deals with the problem of the number of beds that are there that can over a period of time be closed down or converted.

In many parts of this country, we have a need for nursing home care. Hospital beds could be converted to that use. Senator Talmadge in his legislation has a provision which would provide incentives for the conversion of hospital beds and the closure of hospital beds.

Senator HEINZ. We have had Public Law 93-641 on the books for quite a while. There has not been a great deal of evidence that it is working to shut down hospital beds.

I kind of suspect that you and I will be very small footnotes, you larger than I, in history, by the time that particular legislation has any significant impact on the number of hospital beds. I wish it were not the case.

When I was on the Health Committee in the House, that was one of our goals. Frankly, experience has shown we are not going to meet that goal, as far as I can tell.

Secretary CALIFANO. Senator, that legislation is important in terms of getting every State to have a certificate of need and to have a strong process vis-a-vis new beds. I would note that while the legislation, as you know, was passed in 1974 HEW did not put out any regulations, did not do anything to move with that legislation for 2 years. It was not until late 1976 that they began to move and no guidelines were issued until 1978. Having put the first guidelines out in 1978, I can understand (in some respects) why they waited—there was so much controversy over them.

I think this legislation is an essential element in dealing with the excess bed problem. There is so much out there already. I think this will deal with it.

Senator TALMADGE. Senator Nelson?

Senator NELSON. Mr. Secretary, the reason the audience did not laugh at your bear joke is that they missed the point. You see, out here in Washington, a beer does cost $4.95.

I just want to make a 1-minute statement on the question of the rates of increase. The point that I think escapes a lot of people is that this bill does not require any hospital to reduce the number of dollars spent. It just looks that way. All the bill does is say that the hospitals' national aggregate rate of increase in expenditures this year must be contained within the 9.7 voluntary goal.

If you look at hospitals around the country, you will see that some had a 20 percent annual increase suddenly dropped to 14 or 13 percent. That does not mean they spent less dollars. They spent a whole lot more dollars than they did the year before, they just had an increase of 13 percent instead of 20 percent.

Let me ask one question. As you know, Senator Talmadge and his staff have done an enormous amount of work in the area of hospital cost containment. We dealt with that issue last year here in the Finance Committee as well as the Human Resources Committee and on the floor of the Senate.

A whole lot of provisions and principles were put in Senator Talmadge's bill, S. 505, some of which have been adopted by you in your bill, S. 570.

As far as the big picture is concerned, the basic difference between last year's administration bill and Senator Talmadge's bill, was the extension of the coverage. Senator Talmadge was covering only those costs incurred in medicare and medicaid. The administration bill was covering all third-party payers, all payers.

In looking at the provisions drafted by Senator Talmadge and his staff, and those contained in the administration is proposals, and in view of the fact the Senate did vote last year to cover all payers rather than limit it to medicare and medicaid, my question, Mr. Secretary, is: Do you think it is practical to design a bill that incorporates the best aspects of both the administration's proposal, the fundamental one being to cover everybody, and the best aspects of Senator Talmadge's proposal, so that we might go to the floor with an agreed upon bill?

I do not know if that is possible. It seems to me it may very well be, since there are a number of provisions in Senator Talmadge's bill which I think we would all endorse, as well as the fact that, at least from the vote of the Senate last year, the Senate is prepared to extend coverage to all third-party payers.

Secretary CALIFANO. Senator, we do think that it is imperative to cover all third-party payers, that if we cover only medicare and medicaid, it is like pushing down on one part of the balloon—the other part will come up.

Senator NELSON. Assuming that could be done, assuming that principle were accepted, can you meld the best parts of both proposals?

Secretary CALIFANO. I think there are many provisions in Senator Talmadge's legislation that can be melded with the legislation that you have introduced in the administration bill.

I would be delighted if the Senate Finance Committee marched as one to the floor of the Senate on this legislation.

Senator NELSON. As you know, if you have Senator Talmadge and Senator Long on your side, you can pass anything, even if it is not very good, you can pass it.

Senator Talmadge. The Senator's amendment was agreed to by four votes on the floor of the Senate and both Long and Talmadge were against it.

Senator NELSON. On final passage, you supported it.

Senator TALMADGE. All of us have the same objective.

Senator Durenberger?

Senator DURENBERGER. Let me start with one last kick at the issue of the wage pass through. Have you a figure for the percentage that wages are of total hospital cost?

Secretary CALIFANO. It is about 50 percent.

Senator DURENBERGER. How does that break out between supervisory and nonsupervisory?

Secretary CALIFANO. We can give you that, Senator, for the record.[1]

Senator DURENBERGER. Fine. The second question deals with voluntary efforts on the part of States, such as the one I represent, even though it does not have some official State sanction. My question is whether or not programs like that are going to be permitted to continue and how they are going to relate to the mandatory aspects of this program?

Secretary CALIFANO. A State with a voluntary program that meets the voluntary limit will be exempt from the mandatory program. We estimate that some States will.

Even if the State does not meet the voluntary limit, any individual hospital in the State which does meet the voluntary limit, that hospital will be exempt. I think we have Senator Nelson to thank for this provision.

Senator NELSON. I do not want to take credit for that. It was an amendment on the floor. It was not mine. I accepted the amendment on the floor. I think it was a good amendment.

Senator DURENBERGER. My concern there is because you used the nine mandatory States as some kind of a sell piece for the value of mandatory. I think you know from your own figures that Minnesota's rate of increase back in 1977 was something like 16 percent. The figures I just got from the director of the State Planning Agency which covers a lot of the health planning activities, state for 1978, under a voluntary nonmandatory plan, it was 9.6 percent.

Obviously, I think there is tremendous value in the right kind of a voluntary program. I hate to see the concept of mandatory being sold as the only way to solve the problem.

Secretary CALIFANO. Senator, that is indeed why we have a voluntary program. This legislation is essentially a voluntary program. Any hospital that meets it will never see the mandatory aspects of it.

Senator DURENBERGER. The next question deals with the 1 percent figure in your formula. I will read from the description of the major features in the administration's bill.

> The third component is an allowance for new services of 1 percent. The hospital industry can increase productivity or efficiency to offset the cost of services then it will be able to expand services by more than 1 percent upon the average.

I am curious to know how you are going to measure that.

Secretary CALIFANO. We will measure it the way hospitals now measure it. I can submit in detail how we will do that. In their 11.6 percent voluntary goal for 1979, they have a service intensity factor of 1.4 percent. We used a figure of 1 percent. I can submit for the record how we got that figure.[2]

Senator DURENBERGER. Fine.

Related to that, going back to the early bird question of the $2,000 State next to the $1,400 State, as I recall your response, you said it could be the wage difference between New York and Plains.

I am curious to know from your own experience, if it could not also be the result of either individual, collective, or community wide efforts at costing?

---

[1] See p. 629.
[2] See p. 629.

I raise the issue only because there is a penalty feature in this bill rather than much of an incentive. I think we need to better address that issue of the $2,000 State versus the $1,400 State, if in fact a lot of those $1,400 States got there should voluntary cooperative kinds of cost saving measures.

Secretary CALIFANO. Very few States by and large. I did not mean to imply it was just wages. There are a lot of other things that go into that, the kind of equipment the people buy, how much excessive equipment they have, how many excessive tests they run.

We are prepared to address that and provide a lot more information on that subject.

I think by and large, in terms of at least the 1976-77 data, few voluntary programs worked as compared with the mandatory programs.

Second, there was no voluntary program until Senator Talmadge introduced his legislation and the President introduced his legislation in 1977. That is when the voluntary programs began. The voluntary programs are in a sense a function of the fact that there is a mandatory program in the wings.

What we would like to do is keep the mandatory program in the wings formally with legislation and hopefully the hospitals with that incentive, that encouragement, will continue with their voluntary efforts to drive these costs down so they will never have to see the mandatory program take place.

Without this, we will not have the effort by the hospitals because all the incentives are the other way. The fact is when the hospital industry came to testify in favor of relief from the Nixon price controls, they testified there was no need to worry, that they would still hold things very level or with just a moderate increase.

The first year after the hospital industry was relieved from those wage and price controls, hospital rates went up by more than 20 percent.

We need something, some conscience, if you will, and the mandatory program provides a conscience for the hospitals of this country.

Senator DURENBERGER. Somewhere in part of your presentation you talked about having your own source of cost data by August and you are not going to have to rely on the hospital industry's data.

Where is that coming from?

Secretary CALIFANO. Senator, HEW has never developed an independent capability in this area. I think we have a responsibility to do that. We will always in some measure or another have to depend on the hospitals.

The Congress itself indicated in legislation passed last year a concern about hospital accounting systems and a desire to have them set up to follow uniform reporting systems.

I think we will develop an independent capability by this summer; why we have not developed it before, I do not know.

Senator DURENBERGER. Thank you, sir.

Senator TALMADGE. Senator Roth?

Senator ROTH. Mr. Secretary, as I understand it, the formula for computing the 1-percent increase includes new services. What hap-

pens to the case of new construction of a hospital facility? Obviously, its construction will be a significant factor.

How will they be treated in determining whether the hospitals have met the goal?

Secretary CALIFANO. I am not sure I understand the question, Senator. In terms of a new hospital, hospitals are exempt from the program for the first 3 years after they are constructed. Personally, I am not sure that exemption is really necessary—for example, Children's Hospital here in Washington is within the first 3 years and it is within the 9.7 percent limit, but we have provided such an exemption.

Senator ROTH. In my State, they have been constructing a hospital for 5 years. It has been tied down between the courts and HEW. Construction has not started. It would replace an existing hospital or existing facilities.

If I understand you, under this new legislation, that new hospital would not be covered for the first 3 years.

Secretary CALIFANO. That is correct, Senator.

Senator ROTH. Mr. Chairman, that is all I have. Thank you.

Senator TALMADGE. Senator Wallop?

Senator WALLOP. Thank you, Mr. Chairman.

Mr. Califano, I find some difficulty engaging in the kind of discussion about "hidden taxes" and other things as you have because this is a serious matter.

There is an inherent unfairness in this legislation with respect to its treatment of rural and growing States. This unfairness stems from the fact that the legislation applies the same cap on allowable percentage increase in expenses for both efficient and inefficient hospitals which effectively will reward inefficiency while it penalizes efficiency.

Let's use my own State as an example of the problem with the approach taken in this legislation. Wyoming has one of the lowest cost of hospital stays in America. We also have one of the shortest periods of stay by record in America. Yet, under this bill, you apply the 9.7 percentage increase limitation to a hospital that costs 3 times as much to stay in as a hospital in Wyoming and the same 9.7 percent to our hospital. Next year, you are going to allow them 9.7 percent—on a larger amount, and so forth.

You begin to expand the difference, dramatically, allowing the inefficient to go on getting more and more inefficient, and constricting our hospitals that have been working. We are penalized despite the fact that we have growing populations and despite the fact that, because of that fool gas regulation bill last year, the intrastate market in Wyoming has resulted in a dramatic increase in the price of energy (despite the fact that we provide the gas for the rest of the country!)

How can that be fair given this set of circumstances?

Secretary CALIFANO. Senator, we believe the percentage way is the fairest way to do it. This legislation has both incentives for efficiency and disincentives for inefficiency built into it, in the mandatory program.

The reality is that there are differences in the costs of all kinds of things, with Wyoming, for example, on the one hand, and Los Angeles or New York City on the other hand.

We know of no fairer way to do it.

Senator WALLOP. Do you disagree that the figures are compounding? That is, 9.7 percent of $1,000 this year and 9.7 percent of $1,097.60 and gradually, that goes this way whereas the more efficient one gets 9.7 percent of a smaller figure and their increase remains smaller. You are actually expanding the opportunity of the inefficient one to be inefficient. Yet, those who were efficient have absolutely no elbow room at all.

Secretary CALIFANO. We know of no fairer way to do it than what we have done here. A house costs less in Wyoming than a house costs in Washington, D.C.

Senator WALLOP. A house costs less in Wyoming than the raise in the house while you are dealing with one in Washington, D.C. I was trying to buy one the other day and while we were talking, they raised the price of that house $65,000. I could have bought the whole house for the raise in Wyoming.

Incidently, they are not going with your guidelines.

Secretary CALIFANO. If Mr. Kahn can solve the problem of the Washington real estate market, we have nothing to fear in this country about inflation.

Senator WALLOP. I am seriously concerned about the compounding effects of a mandatory guideline with no terminous on it.

Secretary CALIFANO. Wages are compounded, prices are compounded, that is the fundamental economic system in this country. We do not know of a fairer way to do it. We tried to get down to individual hospital by hospital. There are items in here for certain types of hospitals which Senator Talmadge set us to look at 2 years ago and which we now think we are ready to handle.

Percentage was the fairest way we thought we could do it.

Senator WALLOP. It is inherently unfair. It builds in an inequity that is worse next year than this year. You can live with it this year. In 3 years' time, it is appalling and in 5 years' time, you have really gotten to the situation where our ability in an expanding State, a growing State, to deliver health services is going to be basically gone. It is going to close rural hospitals.

Secretary CALIFANO. I think that will not occur. First of all, hospitals with less than 4,000 admissions are exempt from this program. It is going to take care of the overwhelming number of rural hospitals. They will be exempt from the program. It is something we have now added to this legislation this year which was not in our original submission last year.

Second, if you say operating on this kind of percentage basis is unfair, you are basically saying the whole economic system of the country is unfair because housing prices, wage increases, food increases, fuel increases, telephone rate increases, utility rate increases, they all go up by percentages. They go up by different percentages and it is a larger amount——

Senator WALLOP. The cost of a scanner, a CT scanner is going to be the same in Casper, Wyo. or New York City. It may not be to operate it, but you have exempted the operators. The cost of that scanner is going to be the same.

You are going to deny it to people in Wyoming because they will not be able to stay within the limits when you have an approxi-

mate increase of between 25 and 50 percent in 1 year in the price of natural gas.

Secretary CALIFANO. As far as fuel is concerned, we have exempted fuel as I indicated in my earlier statement. You will not have a problem as far as fuel is concerned.

The cost of scanners vary widely. I do not think any hospital administrator that wants to negotiate a little bit——

Senator WALLOP. We get the ones made outside the country everybody else can afford domestic-built equipment, is that right?

Secretary CALIFANO. I think that the components of most scanners, like the components of most electronic material in this country, are probably not made in this country under any circumstances.

Senator WALLOP. Our people get the availability of the cheap model because that is the only way. They vary widely. The ones who have expensive stays and a lot of compounding in the inflationary allowance are going to get the expensive ones, the best ones.

Secretary CALIFANO. Obviously I am not saying that.

Senator WALLOP. It will work that way, will it not?

Secretary CALIFANO. I do not know how many CT scanners there are in the State of Wyoming. I doubt if your people have any trouble getting them and getting good ones. I doubt if your hospital administrators would buy cheap ones that would not do the job.

The problem in this country is we have too many CT scanners. We have enough CT scanners in southern California for the whole United States west of the Mississippi.

Senator WALLOP. What happens in the following circumstance; I could not determine it from reading the legislation.

The community which I come from, Sheridan, Wyo., is growing very rapidly. We have a hospital that was built in the late 1950's. Last year, we had to put a substantial addition onto that hospital merely to accommodate the increasing population and demand for services. Is it a new hospital or an old hospital?

Secretary CALIFANO. An addition to a hospital would not be a new hospital. I do not know how substantial the wing was.

Senator WALLOP. What happens to a community that has grown 100 percent in 3 years? How can they provide services under this legislative scheme?

Secretary CALIFANO. First of all, there is and has been at HEW for many years an exceptions process. There is an exceptions process built into our medicare and medicaid programs. That exceptions process is operated. I guess we have granted 300 exceptions over the past several years.

They could apply for an exception if they needed one. That particular hospital, I am told, is up 21.4 percent. It would be way over the guidelines at this point in time.

Senator TALMADGE. Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

Secretary Califano, I wonder if you could tell me to what degree there is an exemption referring to the 4,000 admissions a year or less, are they partially exempt?

Secretary CALIFANO. They are totally exempt.

Senator BAUCUS. I have no more questions. Thank you, Mr. Chairman.

Senator TALMADGE. Senator Bradley?

Senator BRADLEY. I have no questions, Mr. Chairman.

Senator TALMADGE. Senator Dole?

Senator DOLE. Thank you, Mr. Chairman. I apologize for being late. We were having a session with Secretary Bergland on trade with the Peoples Republic of China.

I would like permission to include my statement in the record at the appropriate place.

Senator TALMADGE. Without objection, it will be inserted into the record in its entirety at this point.

[The prepared statement of Senator Dole follows:]

STATEMENT OF SENATOR BOB DOLE

Thank you, Mr. Chairman. I am pleased today to join you and the other members of the subcommittee to hear testimony on the legislative proposals before us.

I would like to echo much of what Senator Talmadge has said regarding the rapid rise in health care expenditures. During the past ten years, the number of poor, disabled, and aged enrolled in governmental health programs have greatly increased. The costs of providing benefits for these people also continue to increase Federal, State, and local governments are now facing serious budgetary problems because of the growing amount of health care services purchased by governmental programs and the rapidly increasing costs of those services; 12.5 percent of our federal taxes are now spent for health care. Increasing hospital costs present one of the most serious problems facing our economy.

I feel it is important to note that there has been an improvement in this situation during the past year due to the voluntary efforts of the health care industry to hold down their costs; but the government must also do its part by managing its programs in a cost-efficient manner.

During our debate on this subject last year, I supported the voluntary efforts of the health care industry to control costs. I continue to believe that we should avoid heavy-handed federal regulation whenever possible. I have watched with interest as the industry has devised its own guidelines, meeting its targets, the most recent one falling under 13 percent. However, I am still of the opinion that basic, reform in medicare and medicaid are needed to create the incentives for cost control that will assist the industry and set us on a path of solving this long-term problem.

The bill, S. 505, that Senator Talmadge and I have introduced builds on our experience of the last two congressional sessions. It has been improved by suggestions we have received and starts us on a road to long-term, sensible cost moderation policy. I am pleased to see that the administration's bill, S. 570, has incorporated some of the better aspects of the medicare/medicaid reimbursement reform act of 1979 by comparing hospitals with like hospitals and making an effort to incorporate some type of incentives and disincentives based on efficiency. There remains, however, a basic philosophical difference between the two proposals. S. 505 recognizes the destructive effect of mandatory and somewhat arbitrary controls on health care expenses while the administration proposal continues to try to develop a larger, more comprehensive approach by creating a regulatory nightmare for which we would ultimately have to pay a greater price.

The reason we have not attempted to go as far or as fast as the administration would like in reimbursement reform is a simple one. There are too many legitimate subjective factors and too many areas of imprecision in comparison and measurement for us to blithely ignore in the interests of speed. No one here would knowingly countenance excessive hospital costs or unjustifiable increases in those costs.

At the same time, there is a national interest in maintaining and nourishing a strong, viable hospital system that is capable of responding in a timely, professional and efficient fashion to the needs of more than 200 million Americans. We have the responsibility of determining whether what is proposed carries a greater risk of harm than good to the nation. That is not an easy matter.

There are those, frankly, who have a great deal more confidence and certainty about the workability and equity of mandatory hospital controls than I do.

My fear is that if they are wrong—and the bureaucracy has been known to be wrong—will we be able to repair the damage?

For example, the administration's bill, S. 570, has no termination date—no sunset provision. It's a life sentence without parole. Given the enormous latitude and nonspecific discretion allowed HEW under S. 570, can we even attempt to guess what the future holds?

I would hope that in addition to comments on the hospital reimbursement provision contained in the Talmadge/Dole bill, we would also hear suggestions and comments of some of the other 36 sections of our bill. We have an excellent opportunity with this bill to correct some of the present defects in our medicare/medicaid system.

With this in mind, Mr. Chairman, I join you in welcoming the witnesses who are with us today and those we will hear from tomorrow. I feel that no provision of S. 505 is written in concrete, and I would hope for a similar flexibility in the administration's proposal. I am particularly interested in hearing Mr. Califano's remarks regarding all aspects of S. 505 in addition to the administration's proposal, and look forward to hearing Mr. Kahn's remarks regarding increasing governmental regulation.

Senator DOLE. I simply indicated my concern as expressed by the Secretary for rising costs and also the concern expressed by our distinguished Chairman Talmadge, where I also commend the Administration for adopting some of the provisions and express hope that we might be able to resolve some of the other problems because I think it is a problem.

I do not know of anybody who has the perfect solution. I know of a number of strong opinions.

I guess we looked at the projected savings. They are based on the 9.7 guidelines, is that correct?

Secretary CALIFANO. Senator, the savings in 1980 in the budget, the $1.7 billion, is based on the assumption that the hospitals meet the voluntary limit. If the mandatory legislation was there and they did not meet the voluntary limit, we project savings of about $1.4 billion in fiscal 1980.

The savings which are projected on the charts and in my testimony are based on the assumption that the mandatory program is triggered. I think in the fact sheet accompanying it, we have the percentages laid out.

Senator DOLE. Does that take into account what might be a different figure of CBO of 10.9 percent?

Secretary CALIFANO. The difference between the CBO number vis-a-vis the 9.7 percent figure in our legislation is related to several factors. There are three components in the 9.7 percent. First, is the factor of inflation which will go up, we have that factored as 7.9 percent for 1979. That assumes the President's wage price guidelines will be met. The CBO factors that increase at 8.9 percent. It does not assume the President's guidelines will be met.

The second factor we have is .8 for population increase, the CBO uses 1.0 for population increase.

The third factor we have is 1.0 for service intensity increase and the Congressional Budget Office has the same number.

Senator DOLE. It is probably not fair to the witness to go back over areas already covered but I think Senator Heinz may have touched in your adjustment for population in setting the voluntary limit, did you consider merely the total number increase?

Secretary CALIFANO. We did, Senator, consider the total number increase. We started out by looking at the possibility of a number with some adjustment for the changes in the age of the population. Since 1978 over 1977, the change increase was related directly to the population .8 and we used that same number.

Senator DOLE. In my State, for example, we have right now 12.5 percent of the population being 65 or older. By 1980, this number will be up over 13 percent. It has been demonstrated time and again that it is more expensive to care for the elderly.

I wondered if that was a factor.

Secretary CALIFANO. We started from that premise, Senator. When we found that the increase was the same as the increase in the population overall last year, we used that number in the 9.7 percent.

Senator TALMADGE. I think we are going to have a vote shortly. I will be as brief as I can. We will try to rotate the responsibility of the chair in the hearings while we have the vote.

Mr. Secretary, several Senators have expressed their concern about penalizing efficient hospitals and rewarding inefficient hospitals with a rigid formula, it rewards the rich and penalizes the poor.

Suppose you have a hospital that charges $70 a day for a private room and another one that charges $500 a day for a private room. When you take an arbitrary 9.7 percent of $70, that is less than $10. The 9.7 percent of $500 is almost $50.

How are you going to differentiate in trying to pass through 9.7 of $500 and limiting it to 9.7 percent of $70? Would that not penalize the efficient and reward the inefficient?

Secretary CALIFANO. Mr. Chairman, we know of no fairer way than to go by this percentage.

Senator TALMADGE. Can you not get it down to the hospital and reward the efficient and penalize the inefficient by requiring common accounting practices and classify hospitals by the nature of the service they render, whether they are teaching hospitals, urban hospitals, rural hospitals or whatever, and put the squeeze on these people who are inefficient and try to help those that are efficient?

Would that not be a better yardstick?

Secretary CALIFANO. As far as establishment of common accounting practices are concerned, as you know, the Congress passed legislation last year, and we now have proposed regulations on a SHUR system for common accounting. There is no question that we need that.

We have looked at this classification system. We have talked about it. We think there are some benefits to it but we think at this point in time, the fairest way we know how to do it is by this percentage mechanism.

We have put in this legislation a penalty for inefficiency and a reward for efficiency of 1 percent and of 2 percent, respectfully. They will be based on the type of hospital. Those penalties will be

based on the type of hospital as modeled by-and-large on the concepts you set forth 2 or 3 years ago.

The 9.7 percent is not a flatcap, an arbitrary cap of the kind we had talked about last year. It is adjustable upwards if inflation goes higher than we had originally anticipated.

Senator TALMADGE. I would appreciate it if you would work with the staff and see if we can work out a formula. This percentage that arbitrarily passes through, whether a hospital is efficient or inefficient, it seems to me to be the grossest kind of discrimination.

We want to bring all hospitals, if we can, to efficiency. You would agree with that, would you not?

When you have an arbitrary figure which goes across the board, I think that is the grossest kind of discrimination. It is like putting everybody on a diet when some people weigh 250 pounds and others weigh 130. You do not want to put the people who weigh 130 pounds on a diet if they are underweight but you do want to bring down gross obesity.

You want to do that with hospitals, do you not?

Secretary CALIFANO. Yes. We are very much for trimming back the obesity of those hospitals which are obese. That is why the program is selective and would exempt 57 percent of the hospitals. We think 57 percent of the hospitals in this country are by-and-large trim and fit. It is the 43 percent that are so overweight that we think they need to be put on a diet program.

Senator TALMADGE. I think our staff who has worked in this area for years can show you how to do that if you work with them. Maybe we can work it out.

Secretary CALIFANO. We have learned a lot from your staff over the past few years, Senator. We look forward to learning more in the future.

Senator TALMADGE. We hope to learn from you also.

In S. 570, why would not hospitals have an incentive to lease out their radiology and pathology departments and their emergency rooms if the cost and the revenues of those departments were increasing faster than other hospitals?

Those increases would not count against them in meeting the voluntary test or mandatory controls?

Secretary CALIFANO. We are in agreement on that, Senator. If the bill does not contain adequate provisions to prevent that from happening, we would like to make the necessary changes.

Senator TALMADGE. You will work with our staff in trying to correct that?

Secretary CALIFANO. Yes, sir.

Senator TALMADGE. Mr. Secretary, you testified here on hospital cost containment in October, 1977. You stated something like one-fifth of all hospitals, including John Hopkins Hospital, had expenditure increases of 9 percent or less. You used this to indicate that if those hospitals could do it, all hospitals could do it.

The subcommittee asked for a list of those hospitals where it limited their expenditures to increases of 9 percent or less 2 years in a role. The material you submitted showed that only some 2 percent of the hospitals not including John Hopkins, I might add, were able to maintain that level of performance.

In view of your claim once again that one-third of the hospitals kept their rates of increase and expenditures to 9.7, does that claim seem to be an echo of the earlier claim and subject to the same deficiency?

Secretary CALIFANO. I do not think so, Senator. I think it is maybe 20 percent and not 2 percent. A good example is Grady Memorial Hospital in Atlanta, Ga., which has been under 9 percent for at least 2 years in a row. We do not know how they are doing in the third year.

Senator TALMADGE. Senator Heinz, any further questions?

Senator HEINZ. I have no questions.

Senator TALMADGE. Any further questions?

Senator WALLOP. Mr. Secretary, I did not get an answer. I got a complaint about the rise in the rate of inflation at Sheridan Memorial Hospital. The question was not about that. Even if it did come in under or slightly more than your guidelines, my question was, what happens in the community, we have many of them in Wyoming who are undergoing perhaps the most rapid rate of population change in America today and they are adding on to older hospitals to take care of increased population and yet they will be old hospitals and not new hospitals.

My question was, how can they provide services under the guidelines in this bill?

Secretary CALIFANO. They should be able to provide services. They should not have any trouble under the guidelines in this bill.

Senator WALLOP. Would they build new hospitals instead of adding onto an old one in order to get rid of the——

Secretary CALIFANO. Senator, I think you raise an interesting question. We will have to look at how we should define a new hospital.

There is an exceptions process. There is an exceptions process now for people who exceed the routine costs and there has been for many years in HEW. There is an exceptions process in this bill, they can apply for an exception.

There are 1,357 hospitals that over the 5 years have exceeded our 223 limits, 347 of them have applied for exceptions and we have granted partial or full exception to about two-thirds of them, about 200.

There is a process in place to make sure that people receive and have access to first-class quality care. I think it would take care of any problems you have. I would have to look at the specifics.

Senator WALLOP. I note in the language that Federal institutions are not covered. Is that an expression that your house is cleaner than ours?

Secretary CALIFANO. I would be the last one to say that, especially after 2½ years in the Government. The reason Federal hospitals are not covered in the legislation is because we have budgetary control over them and the Office of Management and Budget has held the Federal hospitals to less than 9.7 percent in increases this year over last year.

Senator WALLOP. Part of that has been accomplished by setting down a certain number of beds and other things.

Secretary CALIFANO. I hope that by-and-large the Governors have better luck at closing hospital beds than the Federal Government

has had over the past several years. There have been attempts to close the VA Hospitals or Public Health Hospitals and it has met with enormous resistance.

I do not think that this reduction in increase has been accomplished by shutting down beds.

Senator WALLOP. It has been accomplished by the decrease in the amount of services available to people?

Secretary CALIFANO. No. In large measure, it has been accomplished by much more efficient operations. The Public Health Service Hospitals have become really quite efficient hospitals. I was out looking at one in Seattle a couple of weeks ago. They have much better management practices.

It is my own sense at looking at hospitals, that they are barely scratching the surface of sound management. There are simple things that hospital administrators can do and there are some hospitals where it has tremendous impacts.

Senator WALLOP. This whole thing goes on a State-by-State basis, does it not?

Secretary CALIFANO. It does. In terms of the State-by-State basis with the population in Wyoming growing at 3 percent as compared with the 0.8 percent on that board, you take the 7.9 percent or whatever the inflation factor turns out to be for the hospital market basket, the population percentage for Wyoming would be 3.0 percent and then you have the 1 percent service intensity factor. In the State of Wyoming, you would be talking about 11.9 percent.

Senator WALLOP. As the guideline?

Secretary CALIFANO. As the voluntary guideline with that 7.9 percent adjustable for inflation.

Senator WALLOP. Thank you, Mr. Chairman.

Senator TALMADGE. Thank you, Mr. Secretary, for your usual expert job. We have the same common objective. We have been working in this vineyard now for some years in the Senate Finance Committee.

As you know, we passed a bill last year and the House did not act. We have some problems with the bill you recommended. You admitted this morning you have some problems with what you have recommended.

Your staff and our staff could work together and I hope we can march in unison before the Senate with a good bill this year.

Secretary CALIFANO. So do I, Mr. Chairman. It has been a pleasure working with you. I hope we can put something together.

[The prepared statement of Secretary Califano follows:]

STATEMENT OF SECRETARY JOSEPH A. CALIFANO, JR., DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. Chairman, I appreciate the opportunity to appear before this distinguished Health Subcommittee on the most important piece of anti-inflation legislation that the 96th Congress will consider—the Hospital Cost Containment Act of 1979.

Your expeditious scheduling of this hearing signals to the Nation that controlling the sharp increases in hospital costs is a matter of grave urgency and importance both to President Carter and to the Congress.

As the President stressed in his State of the Union message, "There will be no clearer test of the commitment of this Congress to the anti-inflation fight, than . . . legislation . . . to hold down inflation in hospital care . . . we must act now to protect all Americans from health care costs that are rising $1 million per hour, 24

hours a day—doubling every five years. We must take control of the largest contributor to that inflation—sky-rocketing hospital costs . . . the American people have waited long enough. This year we must act on hospital cost containment."

By constraining the intolerable increases in hospital costs, we can achieve substantial savings in Federal, State, local, employer and individual spending. Indeed, no other legislative proposal before the 96th Congress can contribute so significantly:

To curbing inflation in the economy: If health care prices had increased at the same rate as other goods and services in 1975-77, the average annual rate of increase in the Consumer Price Index for that period would have been 5.8 percent rather than 6.1 percent;

To lightening the burden on Federal, State and local taxpayers: Federal savings for fiscal 1980-84 would be $22 billion, including $19 billion of social security trust fund savings; State and local savings for fiscal 1980-84 would be $6 billion;

To reducing the increasing cost to employers and workers of health insurance premiums: Employers would save $14 billion for fiscal 1980-84, and individuals $5 billion in lower health insurance premiums; and

To lowering the direct cost of hospital care for the aged, poor, unemployed, and uninsured: Individual out-of-pocket payments for hospital care would be $6 billion lower in fiscal 1980-84.

Thus, fighting inflation, eliminating unnecessary spending, and cutting down the rise in health care costs go hand in hand.

And as the members of this subcommittee know well, eliminating unnecessary Federal spending for hospitals in this time of budgetary restraint is of extraordinary significance. For example:

Such reductions, which would decrease expenditures from the medicare trust fund, might provide a means of reducing the social security tax increases slated to take effect in 1981; or

Such reductions might help reduce the Federal deficit; or

Such reductions, especially the savings we could realize in future years, might be critical if we as a nation are to afford the needed expansion in health benefits that would occur under a national health plan.

We cannot afford any delay in implementing effective hospital cost containment. The only effective constraint is legislation that provides mandatory, standby controls if the hospital industry fails to meet meaningful voluntary goals during 1979.

INFLATION IN THE HOSPITAL INDUSTRY

In the last four years, inflation in the United States has been due primarily to rising prices for housing, food, fuel, and health care. If prices of these four major consumer expenditures had risen at the same rate as other goods and services, the average annual increase in the Consumer Price Index from 1975 to 1978 would have been 5.8 percent annually, rather than 7.2 percent.

Of the four major sectors pushing inflation, rising hospital costs have been, and continue to be, the most serious inflation problem in the economy. Designing specific policies to deal with inflation in this sector of the economy is a critically important step that can be taken to restrain inflation.

Between 1975 and 1977, hospital costs increased between 14 and 20 percent annually—more than twice the increase in the Consumer Price Index. And this intolerable rise exceeds other highly inflationary elements in the economy. During the same period food prices increased between 3 and 8 percent and fuel prices increased between 7 and 13 percent.

In 1978, according to estimates based on hospital industry data, hospital expenses rose at an annual rate of 13.1 percent and hospital room rates increased 12.4 percent—still much faster than food (11.8 percent) or fuel (8 percent), or the CPI as a whole (9 percent).

The average cost of hospital stay rose from $533 in 1969 to $1,634 in 1979 and is expected to reach $2,660 in 1984 given present trends.

These precipitious increases in hospital costs have meant that expenditures for health care services:

Grew from $60.3 billion in 1969 to $206 billion in 1979; and

Rose from 6.7 percent of GNP in 1969 to 9.1 percent in 1979.

Without hospital cost containment, health expenditures are expected to equal 10.2 percent of GNP in 1984. But with hospital cost containment, we can slow this sharp rate of growth, and hold the share of GNP devoted to health expenditures to 9.7 percent in 1984.

IMPACT OF RISING HOSPITAL COSTS

Let me turn now to the corrosive impact rising hospital costs has on our society, and the extent to which the President's hospital cost containment legislation can reduce this impact.

First, total hospital expenditures are expected to increase from $83.0 billion in 1979 to $145.8 billion in 1984—a 76-percent increase over the five year period at current rates of increase. With the proposed hospital cost containment legislation, hospital expenditures in 1984 would be $126.5 billion, or $19.3 billion lower than these costs would be without legislation.

Total savings in the health system from reduced hospital expenditures in 1980-84 would be $53.4 billion.

Second, rising hospital costs affect the average individual in four ways:

They increase out-of-pocket expenditures;

They increase health insurance premiums paid directly by the individual employee;

They increase health insurance premiums and taxes paid by employers—costs that are ultimately borne by workers in the form of foregone wages or higher prices; and

They lead to increased Federal, State, and local government tax burdens.

With the extensive growth of private insurance coverage and public programs for the aged and poor, these costs are largely hidden from view. Over 80 percent of all hospital expenditures are paid by the Government or by employers. Yet these hidden costs are ultimately borne by workers and taxpayers, and are no less burdensome for their indirect impact.

The average expenditure on hospital care for each man, woman, and child is expected to increase from $370 in 1979 to $623 in 1984 if hospital costs continue to rise unchecked. This represents an increased cost of $253 per person. Of this incrased cost, $25 is for higher out-of-pocket payments, $22 is for higher individual insurance premiums, $116 is for higher employer payments which consumers and workers can expect to bear in the form of higher prices or lower wages, and $90 is for higher individual income and payroll taxes.

Under the proposed hospital cost containment legislation, the per capita cost of hospital care in 1984 is expected to be $541, or $82 lower for each man, woman, and child. Total savings for 1980-84 are $232 per person, including a reduction in out-of-pocket payments averaging $24 per person, a reduction in individual health insurance premiums averaging $20 per person, a reduction in employer payments averaging $111 per person, and a reduction in individual taxes of $77 per person.

Third, rising hospital costs exact a particularly heavy toll on the uninsured. Over 18 million Americans have no health insurance coverage, and an additional 65 million have inadequate or minimal coverage. Few of the uninsured are equipped to pay their hospital bills. Twenty-nine percent have incomes below the poverty level—all but 11 percent of individuals not covered by public programs or private insurance plans have family incomes below $20,000.

For those attempting to pay higher hospital bills, the result can be severe financial hardship. In 1975, 5.5 million individuals had out-of-pocket health care expenses of more than $1,000.

For uninsured patients hospitalized in a community hospital, the average cost of care is expected to increase from $1,634 per hospital stay in 1979 to $2,660 in 1984 at curent rates of increase.

Under the proposed hospital cost containment legislation, the average cost of a hospital stay will be $2,160 in 1984, or $500 less on average for each patient hospitalized. These savings will be of particular importance for the uninsured.

Fourth, the elderly are also hard hit by rising hospital costs. Even with the medicare program, hospital costs can be a heavy burden because the elderly need more health services and their incomes are limited.

Under medicare, the elderly are required to pay a deductible covering the average cost of the first day of hospital care. This deductible paid by the elderly has risen from $44 in 1969 to $160 in 1979. If current rates of hospital costs are not constrained, the deductible will reach $260 in 1984.

With hospital cost containment, the medicare deductible will be held to $216 in 1984. Each elderly person who was hospitalized would save $44 per spell of illness in 1984 alone. And if effective hospital cost containment begins now, there would be savings in 1980, 1981, 1982, and 1983 as well.

Fifth, rising hospital costs affect employers, who pay through private health insurance premiums for their employees and through corporate income taxes to support Federal health programs. These expenditures for hospital care are expected to be $37 billion in 1979, or 3.1 percent of the Nation's wage bill. At current rates of

increase, employer payments for hospital care are expected to increase to $65.9 billion by 1984, or 3.3 percent of the wage bill.

Total savings to employers for 1980-84 would be $25.3 billion, including $14.5 billion in lower employer premiums.

Sixth, the Federal Government feels the impact of rising hospital costs since, out of every Federal tax dollar in 1979, 6.7 cents goes for hospital care. By 1984, 8.9 cents of each Federal tax dollar will go for hospital care.

Federal expenditures for hospital care have increased from $7.7 billion in 1969 to $33.1 billion in 1979, an increase of 330 percent, and are likely to reach $60.6 billion in 1984 without hospital cost containment.

The proposed hospital cost containment bill would reduce Federal expenditures by $8.1 billion in fiscal year 1984, or 7.8 cents of every Federal dollar (down from the projected 8.9 cents). Total Federal savings for 1980-84 would, as noted above, be $21.8 billion.

Seventh, State and local governments are also hard hit by rising hospital costs—through increasing medicaid costs, costs of State and local hospitals, and through higher health insurance premiums paid for State and local government workers. Direct State and local government spending for hospital care was $4.2 billion in 1969, is estimated at $10 billion in 1979 (an increase of 240 percent) and is expected to reach $15.8 billion in 1984 (an increase of 376 percent in 15 years) if there is no cost containment.

With hospital cost containment, State and local government spending would be $13.7 billion in 1984 or $2.1 billion less than without legislation. Total savings to State and local governments during 1980-84 would be $5.9 billion.

REASONS FOR HOSPITAL INFLATION

There are many reasons for the rampant inflation in hospital costs. Demand for health and hospital services has, of course, risen since the passage of medicare and medicaid in the mid-sixties. And hospitals—like other institutions—are affected by general inflation in the economy.

But the extraordinary inflation in the hospital sector is primarily due to inflationary pressures that are built right into the system—pressures that cost containment legislation will forecefully counter.

Ninety percent of all hospital bills are paid by third parties—insurance companies, medicaid or medicare. Thus neither the consumer (the patient) nor the provider (the doctor and the hospital) feel the pinch of rising costs.

Payments to hospitals are primarily cost-plus payments: that is, most payments are based on cost and insurance covers whatever service has been provided. There are few incentives in such a system to hold down costs, and the more hospitals spend the more they get.

Most decisions in the health care marketplace are made by the provider, not the consumer: physicians control 70 percent of health care decisions. So the usual mechanisms of the marketplace, like competition, do not work to bring down costs. We know that physicians often have little knowledge of the cost of the services they order and almost no incentive to ask.

Thus, the traditional competitive forces of the marketplace do not operate in the hospital industry.

WASTE IN THE HOSPITAL INDUSTRY

Examples of waste and inefficiency in the hospital industry are plentiful. Literally billions of dollars could be saved each year in the industry by tough, effective management—and without affecting the quality of care.

Increased productivity and efficiency are thus the critical area in which savings from hospital cost containment can be realized. Historically hospitals have expanded services and introduced new technology with little effort to offset these additional costs. Major improvements are needed in this area. For example:

Potential sources of annual savings in the hospital industry

[In millions]

Hospital controlled savings:	
Eliminating 130,000 excess beds (DHEW, Bureau of Health Planning, "Excess Hospital Beds", 1978)	$4,000
Replacing inefficient supply purchasing practices (based on data from Seattle, first part of General Accounting Office study)	1,340
Eliminating excess CT scanners (Office of Technology Assessment)	200

Eliminating energy waste (DHEW, Health Resources Administration, 1979)	1,260
Joint hospital and medical staff controlled savings:	
Eliminating unnecessary weekend admissions (national estimates based on Michigan Blue Cross-Blue Shield, "Factors Affecting Length of Stay," Feb. 8, 1977)	1,600
Eliminating routine admission diagnostic tests for nonsurgical patients (Blue Cross-Blue Shield press conference, February 1979)	300
Decreasing average lengths of stay nationwide to the average in west coast hospitals (calculated from American Hospital Association, Hospitals, 1978)	2,600
Eliminating unnecessary X-rays (DHEW, Food and Drug Administration)	435

These are just a few of the many opportunities for hospitals to achieve savings by cutting unnecessary services, increasing productivity, and introducing innovative management techniques—without cutting the quality of patient care. And these examples of waste yield more savings than called for by the proposed legislation.

PURELY VOLUNTARY EFFORTS CANNOT CONTAIN HOSPITAL INFLATION

Given the lack of competition and the lack of incentives for efficiency in the hospital industry, a purely voluntary effort to constrain hospital costs will not be adequate because it does not affect the industry's cost-plus method of acquiring revenue. Only standby mandatory controls will be effective in halting skyrocketing hospital costs.

In December 1977, the American Hospital Association, the Federation of American Hospitals and the American Medical Association announced the formation of a voluntary effort by the industry to curtail spiraling hospital costs. The group established voluntary goals:

Two percentage points deceleration in the rate of increase in total hospital expenditures in 1978 over 1977, and

A total of four percentage points deceleration by the end of 1979 over 1977.

The voluntary effort's goals are based on the rate of increase in costs in 1977. That rate varies, depending on which AHA data are used to calculate it: the AHA annual survey's rate of increase in 1977 was 14.2 percent while the AHA's panel survey rate of increase in 1977 was 15.6 percent. Thus, there is confusion about what is the hospital industry's own 1979 goal—is it 10.2 percent (14.2 minus 4) or is it 11.6 percent (15.6 minus 4)?

But the hospital industry's approach to cost containment is flawed for several additional reasons.

First, the industry goals for 1978 and 1979 bear no relationship to the underlying factors affecting hospital costs.

The goals are not based on a sound determination of what the increase in hospital costs should be given the costs hospitals actually face and given the waste in the hospital industry. The goals merely accepts past, highly inflationary trends and proposes improvements relative to those intolerably high rates of increase.

The goals do not recognize the national anti-inflation program launched last fall by President Carter and do not, therefore, take into account the impact of the President's wage and price guidelines. The effect of these guidelines should reduce the increase in hospital costs by about one percentage point more than the hospital industry projects.

Second, despite the hospital industry's voluntary efforts in 1978, hospital inflation continued to rise at a higher rate than any other sector of the economy.

As noted, total hospital costs continued to rise in 1978 at or above 13 percent annually, according to estimates based on the industry's own data. And the rate of increase in hospital room rate (12.4 percent) is still higher than the rates for the other goods and services, including such inflationary items as energy and food (and significantly higher than the CPI as a whole which rose at 9 percent in 1978).

Although the increase in total hospital costs slowed in late 1977 and in part of 1978, that trend ceased in the last half of 1978 and, in fact, the rate of increase in hospital costs appears to be turning upward.

Third, the moderation in hospital inflation during late 1977 and early 1978 can be largely credited to two factors beyond any purely voluntary efforts by the hospital industry.

The very prospect of the mandatory Federal controls debated by the last Congress has caused the industry to avert those controls if possible.

Much of the moderate nationwide reduction in hospital costs is attributable to the relative success of mandatory cost containment programs in nine States. The contrast between rates of hospital inflation in states with mandatory programs and states with no controls is striking:

In the nine States with mandatory programs[1], the rate of hospital cost increases in 1977 averaged 12 percent in a year when the nationwide average, based on the AHA annual survey, was 14.2 percent;

In States with no controls, the inflation rate averaged 15.8 percent in 1977;

Much of the reduction in the increase in 1977 over 1976 can thus be attributed to the superior performance of states with mandatory cost containment programs; and

The superior performance of States with mandatory programs continues in 1978. Preliminary data indicate that the average rate of increase of total costs in 1978 in those nine States was 9.9 percent, significantly lower than the estimated national average rate of increase of about 13 percent.

Effective hospital cost containment must therefore be based upon two key principles—principles that differentiate the administration's approach from the hospital industry's effort to date.

While there should be a period of voluntary restraint, that period must be directed towards achievement of a responsible goal based on the costs hospitals actually face, not on past, unacceptably high inflationary trends.

The voluntary period must be backed up by mandatory controls. Mandatory controls function as an incentive to hold down costs. They provide a guarantee that, if the hospital industry cannot perform voluntarily, then the savings to our citizens will nonetheless be realized.

Let me now briefly describe the proposed hospital cost containment legislation. It is an effective cost containment mechanism that builds on congressional experience over the past two years, responds to the legitimate concerns of the hospital industry and will accomplish its goals with virtually no additional regulations.

BASIC APPROACH

The proposed legislation has two basic parts:

National voluntary limit:— The legislation would establish a national limit for the rate of increase in hospital costs in calendar 1979 which hospitals would be asked to meet voluntarily.

Standby mandatory controls:— Should the hospital industry fail to achieve this nationwide voluntary limit in 1979, standby mandatory controls would be applied to individual hospitals beginning January 1, 1980.

National voluntary limit

The national voluntary limit for calendar 1979 would be an estimated 9.7 percent rate of increase in total hospital expenses. This limit is set by adding three components:

An inflation allowance based on the increase in the cost of goods and services purchased by hospitals during 1979. This so-called "market basket" is estimated to be 7.9 percent in 1979. But if the market basket rate of inflation during the year actually changes, corresponding changes would be made in this component of the national voluntary limit. For example, if actual inflation caused the hospital market basket to rise from 7.9 percent to 8.2 percent during the course of the year, then the national voluntary limit would rise correspondingly from 9.7 to 10 percent.

An allowance for population growth would be 0.8 percent.

An allowance for net new services is the cost of additional services (e.g., new technology or more lab tests) minus savings from increased productivity and efficiency. This net new services allowance would be 1 percent.

The key assumption in this approach is that the hospital industry should be able to hold down the rate of increase attributable to additional services to approximately one percent annually. This rate of increase is about one-quarter of the increase this factor has averaged during the last five years. Hospitals could incur higher costs for additional services by offsetting such increases through improved productivity, economies, or effectiveness.

The justification for requiring a reduction in the rate of increase in expenditures for additional services is that this area has traditionally been the source of the greatest waste. This waste has occurred because, as noted, there is so little competition in the health care industry and because the standard payment system—the cost-plus system which reimburses hospitals for their costs—have provided hospitals

[1] Colorado, Connecticut, Maryland, Massachusetts, New Jersey, New York, Rhode Island, Washington, and Wisconsin.

little incentive to reduce unnecessary spending or to increase efficiency. The hospital industry's failure to adopt effective management controls must end.

This 9.7-percent national voluntary limit on the 1979 rate of increase in total hospital expenses can be met by hospitals while they continue to provide high quality care to their patients:

In calendar 1977, the last year for which there are complete records, one-third of the Nation's 6,000 community hospitals were able to operate at or below a 9.7-percent rate of increase in total expenditures. An even higher percentage of hospitals is expected to operate below that level in 1978.

These hospitals are of all types—profit and nonprofit, teaching and nonteaching, urban and rural, small and large—and are located in all regions of the country.

In fiscal 1978, the entire New England region (Connecticut, Rhode Island, Massachusetts, Vermont, New Hampshire, Maine) averaged an 8.3-percent rate of increase in hospital costs (based on AHA panel survey data) the Middle Atlantic region (New York, New Jersey, and Pennsylvania) averaged a 10.4-percent rate of increase. It is clear that the large majority of hospitals in these two areas have been able to hold increases below 9.7 percent in the year ending October 1, 1978.

Exemptions from mandatory controls for individual hospitals

If the national voluntary limit is not met in 1979, certain types of hospitals that would otherwise be subject to mandatory controls would be exempted from those controls under the following conditions:

If the rate of increase in total hospital costs in any State during 1979 is within the national voluntary limit (adjusted for State population trends and its nonsupervisory wage experience), all hospitals in that State would be exempt from mandatory controls in 1980.

Hospitals in States with mandatory cost containment programs of their own could be exempt if the State program either met performance standards (i.e., the statewide rate of increase in 1979 was within 1 percent of the national voluntary limit) or met other requirements established by regulation.

Even if total hospital costs in a State do no meet the limit, individual hospitals would be exempt in 1980 if their individual rates of increase in total costs (adjusted for their own nonsupervisory wage experience) were at or below the voluntary limit in 1979.

Small, nonmetropolitan hospitals (under 4,000 admissions), new hospitals (less than 3 years old), and HMO hospitals (with 75 percent of patients enrolled in qualified HMO's) would be exempt from the mandatory program regardless of their rate of increase in 1979.

Present estimates indicate that more than half of the Nation's 6,000 community hospitals would be exempted from the mandatory program under the provisions outlined above.

Mandatory program for individual hospitals

Individual hospitals which are not exempted and which, thus, come under the mandatory program would be given an allowable rate of increase in total inpatient revenues per admission for 1980. This mandatory limit includes a basic limit—comprised of an allowance for inflation and an allowance for efficiency or inefficiency—and adjustments for exceptional circumstances.

Basic limit

Each hospital would be granted an inflation allowance to cover its own market basket price increases (increases in the cost of goods and services purchased). This includes an allowance for the actual rate of increase in non-supervisory wage rates experienced by that hospital. This assures that low-wage workers will not bear the burden of hospital cost constraints.

Efficiency/inefficiency allowance:

Each hospital under the mandatory program would also receive a bonus for efficiency or penalty for inefficiency. This efficiency/inefficiency allowance is then added to or subtracted from the hospital's inflation allowance in determining the hospital's basic limit on inpatient revenue per admission.

A hospital would be considered efficient if its routine costs per day are the same or lower than those of similar hospitals.

Routine costs are "hotel-type" room and board services and nursing services.

Hospitals would be grouped according to bed size, urban-rural location, and possibly other factors to determine similarity.

Hospitals above 115 percent of the group median would receive a penalty. Those below the median would receive a bonus. Those between the median and a 115 percent of the median would receive neither a penalty nor a bonus. For

example. A hospital with a basic limit of 7.9 might receive an inefficiency penalty of 1.0 percent. Thus its allowable rate of increase in inpatient revenues per admission in 1980 would be 6.9 percent.

The Congress has demonstrated its desire to reward efficient hospitals and penalize inefficient ones rather than giving a uniform limit to all hospitals. Routine costs per day relative to peer hospitals are the best available measure of efficiency. As better measures are developed they will be used.

Adjustments and exceptions to the basic limit include an:

Admissions adjustment: Under regulations, increases in total revenues would be limited to the additional costs resulting from any increase in admissions;

Base year adjustment: The hospitals' mandatory limit in 1980 would be adjusted downward if hospitals seek to increase costs in 1979 in anticipation of controls in 1980; and

General exceptions: Hospitals with unusual circumstances would be permitted, on an exception basis, to have their mandatory limit adjusted upward.

The mandatory limit on the rate of increase in revenues per admission would be enforced in the following manner.

Cost payers

Medicare, medicaid, and most Blue Cross plans reimburse hospitals for services provided their beneficiaries not on the basis of the hospital bill but rather on the basis of cost.

Approximately 60 percent of hospital revenues come from these types of payers.

Each major cost payer would limit its interim payments during the year to the mandatory limit.

For example, if the average cost of a medicare patient in Hospital A was $2,000 in 1979, and Hospital A's mandatory limit was 8.0 percent, then medicare would pay $2,160 per medicare patient hospitalized in Hospital A in 1980.

If the hospital's market basket inflation was higher than estimated forecast, medicare would make an end of the year adjustment.

Charge payers

Uninsured patients and patients insured by commercial insurance plans pay hospitals on the basis of charges for individual services.

Approximately 40 percent of hospital revenues come from these types of payers.

Hospitals would be required to collect no more than the mandatory limit from charge-paying patients during 1980.

For example, if the average bill of a private patient in Hospital A was $2,000 in 1979 and Hospital A's mandatory limit was 8 percent, than the hospital could not collect more than $2,160 per private patient hospitalized.

At the end of the year, the mandatory limit would be adjusted for actual market basket inflation. If revenues from private charge-paying patients exceeded the mandatory limit, the hospital would be required to place excess revenues in an escrow account. The hospital could draw on the escrow account in future years if its revenue from charge payers were below the mandatory limit.

If the hospital received less than the mandatory limit from charge-paying patients, it would be permitted more rapid increases in future years.

A hospital's refusal to comply with the escrow requirement would result in a Federal tax of 150 percent on the excess revenues.

Mr. Chairman, the Hospital Cost Containment Act of 1979 is a fair and responsible approach to a vexing national problem. The administration has listened to the Congress and made important changes in the bill submitted this year as compared with our original bill proposed in the last Congress.

We have included a voluntary trigger period.

We have taken into account actual market basket inflation in determining the national voluntary limit.

We have built in an allowance for efficiency and inefficiency.

We have proposed a system of mandatory limits which, if triggered in, will be applied, in part, on the basis of the experience of individual hospitals.

We have adopted various exemptions that were proposed by Members last year.

With two years of legislative history behind us, I am hopeful that this legislation can move swiftly. In a period when there is deep concern about inflation and when unnecessary spending must be curtailed sharply, passage of the Hospital Cost Containment Act of 1979 is not just important. It is imperative.

Thank you.

Senator TALMADGE. Our next witness is Mr. Alfred E. Kahn Chairman of the Council on Wage and Price Stability. Mr. Kahn has been patiently waiting for almost 2 hours.

Has inflation increased while you have been waiting?

STATEMENT OF ALFRED E. KAHN, CHAIRMAN, COUNCIL ON WAGE AND PRICE STABILITY

Mr. KAHN. Good morning.

Senator TALMADGE. Let the record show there was no response. You may proceed in any way you see fit. You may insert your full statement or summarize it in any way you see fit, sir.

Mr. KAHN. If I may put it in the record, I will summarize it.

Senator TALMADGE. Without objection, it will be inserted in full in the record at this time.

Mr. KAHN. I feel a little like a fish out of water, Mr. Chairman. My purpose is only the rather general one of putting the hospital cost containment bill in the context of the President's anti-inflation program. I do not pretend to be an expert on the details of the bill itself. Secretary Califano is the expert, as well as the expert on beer drinking bears.

As we used to say when we were children, it takes one to know one.

As I say, I would like to explain how this bill fits in the context of the President's program and also to explain why we consider it a key element of our fight against inflation.

As I am sure you know, the President's program is a very broad ranging one. It embraces fiscal restraint, monetary restraint, the wage and price standards for the economy at large, the use of procurement to reinforce the standards and our own effort to reform the regulatory process and see that it contributes less to inflation than it has in the past.

But no matter what we do with budget policy, the guidelines, and regulations, we must also make a special effort to attack the causes of inflation in the areas of the basic necessities, food, energy, housing and health.

The causes of the skyrocketing inflation in each of those four areas, are, in large measure unique to that area. Each requires its own set of solutions.

To take a simple case, you simply cannot attribute the inflation of food, energy, housing and health costs in any way to the high pressure of wage costs. There have been other kinds of factors that explain it. Of course, it just happens that in these areas in which inflation has been way above the national average, it has also borne with special severity on working people, on people of limited means.

I just cannot emphasize this too much. There is an understandable tendency in this country to identify the President's program as consisting only of the budget or only monetary policy or only the wage and price standards. Yet while each of these will undoubtedly help, none of them separately and indeed all of them together are not a sufficient substitute for a concerted attack directly in the field of food, health, housing and energy.

We are in my office working very hard to develop specific recommendations for action in those four fields. One cannot perform

miracles. There are very serious problems. In each case, we think we can develop programs that we will have ready to send to the President in the next few months.

Fortunately, in the area of health, the trail has already been well marked by the legislation that you are considering today. There is absolutely no room for doubt, no matter what numbers you look at, that hospital costs have increased far more than the general price level, in the last 10 years, in the last 7 years or in the last 4 or 5 years.

Since you are going to have a lot of statistics thrown at you, I do think it is important to recognize that there are usually two kinds of figures that you get. One is a set of figures for total hospital expenses. Between 1975 and 1977, those went up 14 to 20 percent a year which is about two and a half times the increase in the consumer price index.

Those are not prices. Those are total outlays of hospitals. If we look at prices alone, you do not find quite such an extreme difference but it is still extreme.

In the period from 1970 to 1977, the price of hospital care increased 10.5 percent a year, while the Consumer Price Index went up only 6.5 percent a year. Even in pure price terms, there is a difference; but in addition, you have to look at the total expenses as well, because one of the problems in this industry is the inflation in the use of hospital services.

Somewhere between the figure on expenses, which went up two and a half times the CPI, and hospital prices, is the true picture of the way in which inflation in this sector is bearing on people generally in the economy.

Had health care costs increased at the same rate as other goods and services in the period 1975 to 1977, the increase in the Consumer Price Index would have been 5.8 percent rather than 6.1 percent. Please do not minimize that fact. Three-tenths of a point in the CPI is dramatic. Only a few changes of that order of magnitude would represent the difference between success and failure in our whole war on inflation.

If you will forgive me for repeating what I said yesterday, I would shed blood for three-tenths of a point on the CPI.

This legislation would accomplish these results by establishing voluntary standards for containing hospital costs, backed up with mandatory controls that would be triggered if the voluntary system does not work.

The last question to which I want to address myself is the obvious one—how do mandatory controls or just the threat of them comport with the rest of the President's program which is essentially a voluntary one?

Why does hospital care demand this special requirement? Or, if I may be slightly personal, and as people ask me every day, what is an ardent deregulator like Fred Kahn doing spending his time pushing for a bill that would impose mandatory standards in the health field?

I think the reasons are very clear. First is the obvious one that hospital cost increases have been so extraordinary in the last several years. Second, unlike other sectors of the economy, there are few incentives for hospitals to hold down their costs. In fact, inflation-

ary pressures are built right into the system, for the reasons Secretary Califano has generally summarized.

Let me repeat them. As I repeat them, think of other industries and ask yourself, is there another private industry in this country that has these peculiar characteristics?

One, more than 90 percent of all hospital bills are paid by third parties, insurance companies, medicare and medicaid. I do not know another private industry of which that is true.

This means that neither the consumer, that is, the patient, nor the provider, that is the doctor or the hospital, nor the agency that decides what cost will be incurred in every individual case, that is the doctor, feels the pinch of rising costs in deciding what kind of facilities and care is to be provided.

Reimbursement is on a cost plus basis. Hospitals receive about 60 percent of their revenues on the principle of the more they spend, the more they get. It is pure cost plus.

The rest of the payments are made on the basis of the prices that the hospitals set. They are paid what they ask. Neither of these kind of charges is subjected to the test of the competitive marketplace.

Consumers do not make comparisions. Consumers do not shop around. Most of the decisions are made not by them but by physicians whose earnings may be directly affected by those decisions.

In other words, this is not like any other industry. The reasonableness of those charges and services cannot safely be left to the competitive marketplace. The effective checks that are present elsewhere in our free enterprise system are simply not present here.

Observe, for example, to take an industry at random, an airline. There the overwhelming majority of objective disinterested observers who have done research on that industry, concluded that it would function better if the Government would get out of the way, that it was a potentially competitive industry and the main obstacle of the competition was the Government.

That is why I became an enthusiastic deregulator and one of my proudest accomplishments eventually will be the abolition of the Civil Aeronautics Board.

Those circumstances do not prevail in this industry. It is not potentially effectively competitive as long as it is organized the way it is now.

In contrast, the regulatory system proposed by this legislation demonstrably works. Secretary Califano has presented you with figures that show the difference between the behavior of total expenses and figures that show the same thing in States that have mandatory programs and States that do not have mandatory programs.

Observe that those figures he gave you, of 15.8 and the 12 percent, are for total expenditures. I had hoped I would have the figures now to adjust that for differences in the rate of population growth in the one sector and the other. However, my people assure me this would not significantly change the picture.

In any case, the proposed legislation would permit those State programs to continue; and indeed it would encourage them by exempting all hospitals in States that meet the standards.

Finally, we are not contemplating establishing an enormous new enforcement bureaucracy. Most of the tools that we need for the mandatory program are already in place. We already collect most of the data through medicaid and medicare.

If sanctions need to be applied, they will be administered by already existing mechanisms, principally the cost base reimbursement system under medicare, medicaid and Blue Cross.

This legislation is an important part of the Federal effort to control the cost of medical care, but it is not the only thing we can do and must do. On the contrary, we must strive over the years to develop the more fundamental cures for the problem that I have myself identified. But it is going to take a long time.

We are strongly urging State and local governments as part of their participation in the anti-inflation effort—and 48 Governors have now subscribed to the program and promised to do everything they can to support it—to make a special effort in the health field.

They have a clear role to play in reforming our antiquated system of delivering and paying for medical care. The inflation of hospital costs undoubtedly owes a great deal to the lack of systematic regional planning. The result is a costly proliferation of hospital facilities and duplication of increasingly expensive equipment.

State insurance regulatory commissions can demand greater efforts by insurance companies to contain costs. State governments can repeal laws that probit the substitution of generic for brand name drugs. Like Florida, they can actively promote the establishment of health maintenance organizations.

The Federal Government is moving against inflation in a number of ways. In the areas of health care costs, the centerpiece of our program is the legislation that is before you today.

We urgently solicit your support. Thank you.

Senator TALMADGE. Thank you very much, Mr. Kahn, for an excellent statement.

I believe you are administrator of the wage and price guidelines for the Government, is that not correct?

Mr. KAHN. That is correct, Mr. Chairman.

Senator TALMADGE. Those wage and price guidelines, do they provide for unlimited pass through of wages of nonsupervisory personnel?

Mr. KAHN. No, we do not.

Senator TALMADGE. You do not recommend such a policy, to try to take care of hospitals and cost controls under medicare and medicaid or otherwise?

Mr. KAHN. As I answered in what I hope was a statesman-like fashion to Senator Long, I genuinely am not an expert on the equity or inequity of the present levels of wages in the hospital field.

Senator TALMADGE. Would you recommend having unlimited passthroughs for any wages whether they are 10 percent, 15 percent, 40 percent or 100 percent?

Mr. KAHN. I have a problem. I speak for the administration. The administration has decided all things considered, including the question of equity, the passthrough is desirable.

Senator TALMADGE. In other words, you are recommending violating your own wage guidelines?

Mr. KAHN. Mr. Chairman, what can I say?

Senator TALMADGE. I understand the position in which you find yourself and I sympathize with it.

Senator Baucus?

Mr. KAHN. It was easier when I was Chairman of an independent regulatory agency.

Senator BAUCUS. Thank you, Mr. Chairman.

Mr. Kahn, I wonder if you could tell us what you project the rate of inflation to be in the fiscal year in which the administration's bill, if it were enacted, would come into effect and what degree enactment of the bill would lessen that rate of inflation.

Mr. KAHN. The administration's official estimate of rate of inflation, and the only one I have, for the period from December, 1978, to December, 1979, is 7.5 percent. It is obvious that the reliability of that estimate is questionable in view of some of the recent developments, particularly what has happened to the price of beef, oil, and more recently fresh fruits and vegetables which went up over 10 percent in 1 month.

We do not reestimate every month partly because it is really impossible to know what is going to happen to the price of oil in the next couple of months. We have high hopes that within a short time, the beef situation will turn around and similarly with fresh fruits and vegetables.

While I must say the chances of our being in error are increased, and, if we are in error, it is likely to be on the high side, we do not now have any official estimate that is different from the 7.5 percent.

If this bill is effective, then we must recognize that in terms of direct costs, hospital care payments in the CPI directory are a very small percentage because most of the costs are paid for by third-party payers. I would be surprised if we had an effect of more than one-tenth of a point immediately on the CPI. It might conceivably be one-tenth and a half. The rest of the effect would be indirect, through what happens to insurance rates in the longer term, and through what happens to the major portion of health costs that are paid by employers rather than by consumers directly. Sooner or later, that gets into the CPI, too.

Senator BAUCUS. If I understand your answer, you think the immediate effect and I take it you mean in a year, to have approximately one-tenth of 1-percent effect?

Mr. KAHN. I would think that would be reasonable.

Senator BAUCUS. Do you have any estimate as to what the effect would be 5 years hence?

Mr. KAHN. No, I do not, Senator. The main reason is that we certainly do not contemplate that the rate of general inflation is going to be 7.5 percent, let alone the 9 or 9.5 percent that it is running at right now, for the next 5 years. We have every reason to believe that the rate of inflation will begin to taper down in the next few months. But how much, only God knows, and it would be foolish for me to make an estimate.

Senator TALMADGE. We have a vote on the Senate floor. Senator Baucus has agreed to preside until I go vote. I will come back and relieve him. We can keep the hearings going with continuity.

I want to apologize to Senator Heinz. We are following the early-bird rule and I should have recognized you in lieu of Senator Baucus. Will you take the gavel, please.

Senator BAUCUS. Senator Heinz?

Senator HEINZ. Thank you, Mr. Chairman.

Mr. Kahn, you make the point that there are several reasons why the hospital industry is different from the rest of the industries in the United States. From that you deduce that there is a per se case of overspending, wasting money. This is the only conclusion you can logically come to if you believe controls have some fact to squeeze out.

Do you believe that?

Mr. KAHN. Yes, I do, although it is not based solely on deductive reasoning.

Senator HEINZ. What areas do you think hospitals have wasted all our money on?

Mr. KAHN. Please understand that I am not an expert in the hospital field. Examples: inadequate planning of the construction of new hospital facilities in terms of their affect on the aggregate supply. I rely heavily for my information on the experience of the State of Maryland, because the executive director of the Maryland Hospital Price Control Agency was particularly well trained academically, that is, by me.

He observes, for example, that in recent years, several new hospitals have been constructed in Montgomery and Prince Georges County, right around the outskirts of Washington for a number of reasons.

The people in those localities pay only a small fraction of the total costs and obviously they are anxious to have the best hospital facilities immediately available to them.

The consequence of that has been, he points out, that we have had a large drain of people into those hospitals from the District of Columbia. As a result, he says the total hospital costs per patient in the District of Columbia went up something like 30 percent last year.

You obviously have no consideration in the planning of that situation of what construction of the new hospital in a particular place does to the regional balance. You have a similar kind of quality competition to put in the most modern equipment in every hospital. I am told the result is that you have underutilized equipment and very great pressure to use it.

Senator HEINZ. As I understand what Secretary Califano is proposing, it does not address that question. New hospitals are exempt.

Mr. KAHN. That is correct. In addition, all the hospitals in a State will comply and be exempt if the State as a whole controls the increase in total hospital expenses.

Senator HEINZ. Let's assume for a second a State is asleep at the switch or muscle bound or too weak and the mandatory program goes into effect. Under the mandatory program, not the voluntary, what you have just described, a building of a new hospital is exempt.

Mr. KAHN. That is correct. What we hope and expect this bill will do is to create an incentive on the part of every State to see to

it that excessive hospitals are not built. Remember that every hospital in a State that would wish to be exempt will be a lobbyist against excessive construction of additional hospitals and against overequipment.

Senator HEINZ. As an economic practitioner, not just a theorist, you have had some notable successes. You mentioned the airline deregulation.

One of the things that somewhat bothers me about the entire discussion we have had this morning during the 2½ hours is that nobody, neither you nor Secretary Califano, have addressed the elements of the health care industry, the hospital sector in particular, that is industry as a whole, to take into account the very point you have made respecting the cost-plus nature, the inability of consumers to make a choice based on some cost awareness.

Let me ask you, here we are slapping on some kind of a cost control band-aid because certain elements of competition and consumer choice do not exist, do you not have any ideas or proposals as to how this industry could be sensitized to the normal laws of economics? If so, what are they?

Mr. KAHN. Of course I do. Again, I remind you that in my profession, I used to refuse to talk about anything until I thought I had read everything on the subject. I have not in this case.

I can think of some obvious ideas. I have already mentioned one, a regional planning of hospital facilities so as to get away from the problem where the people in the locality do not pay most of the costs and therefore you have this built-in tendency toward installation of excessively costly equipment which then stands unused.

A second way would be the development of some sort of a system of reimbursement that provides incentives.

Senator HEINZ. What?

Mr. KAHN. For example, we could pay hospitals on the basis of a prospective assessment of what is necessary rather than a retrospective one. The second way is cost-plus.

Senator HEINZ. The first is an HMO.

Mr. KAHN. Not necessarily. You could, for example, reimburse through normal hospitals, through Blue Cross, through medicare and medicaid, on the basis of an examination of the patient in advance, with a classification of the type of case and a statement of a flat average fee for that kind of case approximating what we think should be the average cost of taking care of that patient.

The burden is shifted to the hospital because it now has an incentive to economize, instead of us saying, you take the patient, we do not care whether he belongs in a hospital or a nursing home.

My brother is a surgeon and he practices in New York City. He points out to me that in the hospitals in New York City, half of the inhabitants are alcoholics and drug addicts.

As long as you have a system of blind cost-plus retrospective reimbursement, there is no incentive to put them in other kinds of confinement facilities.

Senator HEINZ. Those are five bells and I think it means the chairman and I are going to have to go and do our thing on the floor.

Let me leave you with the thought that this measure proposed by the administration would appear to be a program that continues forever.

Mr. KAHN. The President is strongly in favor of sunsets and so am I.

Senator HEINZ. He did not see fit to put it in his bill.

Mr. KAHN. Put it in.

Senator HEINZ. The second thing is it seems to me you and HEW should be encouraged to get to the question of the kind of structuring of health care. I am somewhat embarrassed as an American citizen that the people who are supposed to be thinking about this and who have large staffs as HEW and your growing staff—

Mr. KAHN. All 120 of them.

Senator HEINZ. You are not giving us a structural solution to this problem and yet it is not a new problem. I think we deserve the best.

Mr. KAHN. We will get the best but it is going to take a lot of time. Meanwhile, I believe that setting a cap will provide precisely the kind of incentive we need in the shortrun. I agree with you totally about the desirability of pursuing the other ideas.

Senator HEINZ. If you will excuse me, I have to run.

Mr. KAHN. It seems reasonable.

Senator BAUCUS. At this point we will temporarily recess until the Chairman returns. I have to go vote also.

[Whereupon, at 11:25 a.m., the subcommittee took a short recess.

AFTER RECESS

[The subcommittee reconvened at 11:28 a.m., Hon. Herman E. Talmadge, chairman of the subcommittee, presiding.]

Senator TALMADGE. Thank you, Mr. Kahn. You always do an outstanding job. I congratulate you and we appreciate your cooperation.

Mr. KAHN. Thank you, Mr. Chairman.

[The prepared statement of Mr. Kahn follows:]

PREPARED STATEMENT OF ALFRED E. KAHN, CHAIRMAN, COUNCIL ON WAGE AND PRICE STABILITY

I'm pleased to be here this morning to discuss a key element of the President's anti-inflation program—Hospital Cost Containment legislation.

As I'm sure you know, the President's anti-inflation program is designed to attack this most important national problem along a broad front. He has recommended an austere budget. He has promulgated definite standards for wages and prices against which we can measure the performance of business and labor in helping stop the inflationary spiral; and he has directed that prudent procurement be used to reinforce the standards. And he has dedicated his Administration to making the regulatory process work efficiently and fairly, and impose on the economy the lowest costs necessary to accomplish valid regulatory goals.

But, no matter what we do with budget policy, the guidelines and regulations, we must also seek to take specific actions now to curb inflation in the necessities—food, energy, housing and health. The causes of sky-rocketing inflation in each of these sectors is in large measure unique, and each requires its own set of solutions.

We are now working hard to develop specific recommendations for action in energy, housing and food; and we will have programs in each of these areas ready to send to the President in the next two months.

Fortunately, in the area of health the trail has already been well marked. The legislation you are considering today has been refined and improved as a result of two years deliberation in the Congress and can make an important immediate contribution to lowering the costs of hospital care.

Between 1975 and 1977 the rate of hospital cost inflation was between 14 and 20 percent a year. This is more than 2½ times the increase in the CPI.

In 1978, these costs continued to rise at about 13 percent annually. In so far as there has been a decrease from previous years' rates, much of it represents a reaction of the hospital industry to the threat of cost containment legislation. If legislation is not enacted, we have no assurance that hospital costs will not continue along their depressingly well-marked historic inflationary path.

The record of the last six months gives cause for intensified alarm: charges have been rising at an annual rate of 15 percent, substantially more than during the same period last year.

The effects of this rapid increase are felt throughout the economy—in taxes, in health insurance costs, and in wages generally.

Government pays more than half of all hospital costs (55 percent), with the Federal share 39 percent. In fiscal year 1979, Federal hospital expenditures will be approximately $35 billion.

The higher health insurance costs to employers are passed along to all consumers in higher prices for goods and services.

Hospital costs have a direct impact on the CPI, which in turn translates into higher wages through cost of living adjustments.

Here's how HEW estimates this bill would alter these trends.

First, it will lighten the burden on taxpayers. Federal savings for fiscal 1980-84 would exceed $20 billion. State and local government savings for the same period could be as much as $5.9 billion.

Second, it will reduce the cost of health insurance premiums to employers and employees—by more than $14 billion for employers during fiscal year 1980-84, as much as $4.7 for employees.

Third, it will lower the direct out-of-pocket payments for hospital care by the uninsured, by $5.6 billion in Fiscal 1980-84.

In other words, the bill you have before you will work to curb inflation throughout the entire economy. And the effects are likely to be dramatic. Had health care costs increased at the same rate as other goods and services during the period 1975-77, the CPI increase would have been only 5.8 percent rather than 6.1 percent. Three tenths of a point on the CPI is a dramatic difference: only a few changes of this order of magnitude would represent the difference between success and failure in the whole war on inflation.

This legislation would accomplish these results by establishing voluntary standards for containing hospital costs, backed up with mandatory controls that would be triggered if the voluntary system does not work. How do mandatory controls, or just the threat of them, comport with the rest of the President's program, which is after all a voluntary one? Why does hospital care require this special treatment?

The reasons are clear, and in my view indisputable.

First, as I have already said, hospital cost increases over the past few years have been extraordinary.

Second, unlike other sectors of the economy, there are few incentives for hospitals to hold down costs on their own. In fact, inflationary pressures are built right into the system. More than 90 percent of all hospital bills are paid by third parties—insurance companies, Medicaid or Medicare. This means that neither the consumer—that is, the patient—nor the provider—the doctor and the hospital—nor the agency that decides what costs will be incurred—the doctor—feels the pinch of rising costs in deciding what kind of facilities and care are to be provided.

Moreover, reimbursement is on a cost-plus basis: hospitals receive about 60 percent of their revenues on the principle of the more they spend, the more they get. The rest of the payments are made on the basis of hospital-established prices; the hospitals are paid what they ask.

And neither of these kinds of charges is subjected to the test of a competitive marketplace: consumers do not make comparisons and shop around. Most of the decisions are made not by them but by physicians, whose earnings may be directly affected by those decisions.

In other words this is not like any other industry, the reasonableness of whose charges and services can safely be left to the competitive marketplace; the effective checks present elsewhere in the free enterprise system are simply not present here.

In contrast, the regulatory system that this legislation would establish demonstrably works. In the nine states with mandatory programs, the rate of hospital cost increases in 1977 averaged 12 percent; in states with no controls, it averaged 15.8 percent. Moreover, preliminary data show that for 1978, those nine states with mandatory programs have experienced a rate of increase averaging under 10 percent.

The proposed legislation would permit those state programs to continue; indeed, it would encourage them, by exempting all hospitals in states that meet the standards. It would also encourage voluntary efforts by hospitals, by exempting those that meet the standards. But if the targets are not met, if voluntary action is not enough, then—and only then—the mandatory program would take over.

We are not contemplating the establishment of an enormous new enforcement bureaucracy. Most of the tools that we need to make the mandatory program work are already in place. We already collect most of the data through Medicaid and Medicare. And if sanctions need to be applied, they will be administered by already existing mechanisms—principally the cost based reimbursement system under Medicare, Medicaid and Blue Cross.

In any event, the cost of running the program—which HEW estimates at less than $10 million annually—is likely to be only a minute fraction of the savings.

This legislation is an important part of the Federal effort to control the costs of medical care, but it is not the only thing we can and must do. The Council on Wage and Price Stability has developed voluntary standards for physicians' fees and for health insurance. HEW is moving in numerous other ways to hold down its outlays in this area.

Meanwhile, we are strongly urging state and local governments, as part of their participation inthe anti-inflation effort, to make a special effort in the health field. They have a clear role to play in reforming our antiquated system of delivering health care. The inflation of hospital costs undoubtedly owes a great deal to the lack of systematic regional planning; the result is a costly proliferation of hospital facilities, and duplication of increasingly expensive equipment. State insurance regulatory commissions can demand greater efforts by insurance companies to contain costs. State governments can repeal laws that forbid the substitution of generic for brand named drugs; and they can, like Florida, actively promote the establishment of health maintenance organizations.

The Federal government is moving against inflation in a number of ways. In the areas of health care costs, the centerpiece of our program is the legislation before you today. We urgently solicit your support.

Senator TALMADGE. The next witness is the Honorable Lawrence DeNardis, State Senator from Connecticut on behalf of the National Conference of State Legislatures.

I believe the Michigan people who were scheduled for tomorrow are here. They are the Honorable Raymond C. Kehres, State Representative from Michigan, accompanied by Mr. John T. Dempsey, Director of Michigan Department of Social Services and Mr. Paul M. Allen, Director of Medical Services Administration, Michigan.

We are honored to have you.

Senator DeNardis, you may proceed. You may insert your full statement or summarize it in any manner you see fit.

STATEMENT OF HON. LAWRENCE DeNARDIS, A STATE SENATOR FROM THE STATE OF CONNECTICUT ON BEHALF OF THE NATIONAL CONFERENCE OF STATE LEGISLATURES

Senator DENARDIS. Thank you, Mr. Chairman.

My name is Larry DeNardis and I am a State senator from Connecticut serving in my fifth term.

Senator TALMADGE. How long will you take, Senator?

Senator DENARDIS. Ten minutes, I believe.

Senator TALMADGE. How long will you need, Mr. Kehres?

Mr. KEHRES. Probably about 10 minutes.

Senator TALMADGE. You may proceed, Mr. DeNardis.

Senator DENARDIS. With me today is Dick Merritt and Russ Hereford from the NCSL staff. We are very appreciative of the opportunity to testify.

Senator TALMADGE. We are delighted to have you.

Senator DENARDIS. As you know, the National Conference of State Legislatures is the only national organization which represents the interests and concerns of the Nation's 7,500 lawmakers.

I would like to insert our comments into the record and make brief summary remarks.

Senator TALMADGE. The entire statement will be inserted, Senator, into the record at this point.

Senator DENARDIS. Thank you.

I would like to quickly address five points, medicaid reform in the States, some comments as to S. 505, the Talmadge bill, some comments on the President's hospital cost containment bill with particular reference to the nine States including my own that are now currently engaged in hospital cost regulation, and some concluding remarks about the health system's reform problem.

Let me first say that we have been witnessing in the States an unacceptable growth in medicaid expenditures over the past few years. It has gone from $1.6 billion in its original year to currently something in excess of $20 billion, a thirteenfold increase that has all levels of Government searching for ways to bring expenditures back within acceptable bounds.

Medicaid expenditures are already assuming a disproportionate share of limited State funds available to finance social programs for low income individuals.

As Senator Talmadge indicated last year, with the introduction of his bill, the choice is a simple one, either we make medicare and medicaid more efficient and economical or we reduce benefits. Indeed, in the mid-1970's, the most common approach to the problem was to focus on reducing the scope of services offered or the number of individuals who might be served under the medicaid program.

In recent years, there seems to be a trend away from cuts in benefits and eligibility as cost saving devices and to look more closely at the question of structural reforms and management improvements.

In my own State of Connecticut, under our program review and investigations committee, which is our principal legislative oversight committee, we did a detailed study of our State's medicaid program, looking at controls that we might be able to insert with respect to eligibility, prices, expenditures, utilization and other shortcomings in the program. The publication of our report brought some rather significant changes in our State medicaid program in terms of these management and structural problems both in terms of administrative changes that the Grasso administration was able to implement and some legislative changes that we implemented in the general assembly.

We continue to monitor in the legislature. We continue to monitor the medicaid program very closely and we think meaningful cost control is possible.

That brings me to comments on your bill, Mr. Chairman. I would say State legislators are generally supportive of many of the provisions that are in your legislative proposal as well as many of the new alternatives that were suggested by your staff in their press release of March 1, 1979.

We are particularly concerned at the State level about hospital costs in general and medicare and medicaid in particular. Inflation in hospital costs affects State governments in a variety of ways. We are a major employer so we are affected in that way. We are a major purchaser of health care so we are involved in that way.

We have a responsibility for our State's economic environment so we are concerned about the health cost on businesses and that has a component of whether they will expand in our State or move on or curtail their operation.

As representatives of the taxpayers, we State legislators have to be worried about the growing frustration of our constituents as larger and larger demands are being made on them for financing medicaid and other programs.

We believe many of the principles underlying the proposed reforms in the reimbursement methodology, the very sophisticated reimbursement methodology under S. 505 are wise. We concur that retrospective reimbursement must give way to a prospective payment system and that target rates should be established for comparable hospitals and that a new methodology should exist to reward efficiency and penalize waste and inefficiency.

We feel however that there are some problems. One key problem is that we must look at how we can deal with the full scope of health payers rather than just medicaid and medicare. We have Blue Cross/Blue Shield and private insurers and other third party payers to contend with.

We must deal with the full picture which is why we also are very much interested and supportive of the administration's bill.

We feel the experience in the nine States, including my own home State of Connecticut, in operating mandatory or quasi-mandatory systems, can be looked at as models. We are experiencing significantly lower rates of increase in hospital costs in the nine States that have controls as compared to the 41 without such programs.

I am proud to say that my own State of Connecticut has been operating a commission on hospitals and health care since 1973-1974. In the last 2 years, we have registered increases of 11.4 percent in 1977 and 9.9 percent in 1978.

In addition to that, if you look at this from a cost-benefit ratio analysis, the actual expenses of the commission during the 4-year period it has been in existence, compared to the estimated savings that have been produced in Connecticut—and those estimated savings have been determined through a formula that the American Hospital Association has propounded—the savings range from a minimum of $62 million to upwards of $95 or $100 million.

The cost-benefit ratio based on the actual expenses of the commission during this period vis-a-vis the savings range from at least 1 to 135 to possibly 1 to 53, which is rather significant.

At our annual meeting last year, the National Conference of State Legislatures endorsed a policy which calls for establishing reasonable guidelines or performance standards for the hospital sector to meet the terms of restraints or increases in hospital expenditures to be backed up with a mandatory compliance system if the hospital industry fails to meet the guidelines voluntarily.

If a mandatory system becomes necessary, we feel the following exclusions should be established; that states regardless of their method that have managed to retain the total rate of increase in hospital expenditures equal to or less than the national standard be excluded; States presently operating mandatory hospital cost containment programs meeting minimum Federal requirements and States which develop new cost containment systems after the effective date of the Federal legislation and which are consistent with minimal Federal standards should be excluded.

We realize hospital cost containment is still largely an art, not a science. It has proven to be a very complex area. It took many years for us to get a handle on utility rate control and we are dealing with an infinitely more complex subject when we talk about the delivery of health services.

I think flexibility and experimentation ought to be the key and we should try to encourage the States to develop as many different approaches to the subject as possible.

There are a considerable number of other points that I wanted to make but I do want to observe the time limit and your graciousness in allowing us to testify.

Senator TALMADGE. We appreciate your cooperation, Senator. We are running behind in our hearings. I have a very important appointment at 12 p.m. I will ask one of my colleagues to take the gavel at that time.

Over a period of years, the association of State legislatures has worked diligently with this committee in this vineyard and I want to thank you and the State legislators who have contributed so much to our efforts. We are deeply grateful for that. We urge you to continue to work with our staff.

Much of what you have suggested is incorporated in our bill and I hope in the administration's bill. I also hope this year will be the year we will finally succeed in something in this area.

Are there any questions? [No response.]

Senator TALMADGE. Thank you, Senator DeNardis.

[The prepared statement of Senator DeNardis follows:]

STATEMENT OF SENATOR LAWRENCE DENARDIS, CONNECTICUT, ON BEHALF OF THE NATIONAL CONFERENCE OF STATE LEGISLATURES

Mr. Chairman, my name is Larry DeNardis and I am a State Senator from Connecticut. I am presently serving my fifth term in the Connecticut Senate and I am the ranking Republican member of our Senate Finance Committee. During my non-legislative days I am an associate professor and chairman of the political science department at Albertus Magnus College in Connecticut.

I very much appreciate the opportunity to testify before this Subcommittee on behalf of the National Conference of State Legislatures on an issue which has rapidly become a national concern—the explosion in health care costs.

As you know, the National Conference of State Legislatures is the only national organization which represents the interests and concerns of the nation's 7,500 state lawmakers. For the past year, I have served as a member of the Executive Committee of the NCSL.

Most of the observations and recommendations I will make in this testimony grew out of discussions and resolutions emanating from the Human Resources Committee of the NCSL. That Committee is made up of chairmen and ranking members of the health committees from most of the state legislatures. Legislators and staff to the Human Resources Committee have had a continuing interest in both federal and state initiatives designed to curb the rate of inflation in health care costs.

Mr. Chairman, we at the state level realize the enormous time and energy that have gone in to the creation of this legislation. Moreover, we sincerely appreciate

the willingness,—and even the initiative, taken by you staff to meet with representatives of state government on the merits of this bill. Over the past two years, your very able staff director, Mr. Constantine, has conferred with members of our organization on several occasions and, at each point made it clear that the contributions of state officials are most highly valued by the committee. We have taken this invitation most seriously, Mr. Chairman. In preparation for this testimony we have gone through a series of steps to ensure a broad range of inputs from elected officials and program administrators at the state level.

STATE LEGISLATIVE INTERESTS

I need not tell you that the unacceptable growth in Medicaid expenditures over the past few years is one of the most troublesome problems facing all levels of government today. You will recall that in its first year of operation over a decade ago, state and local governments, along with the federal government, spent $1.6 billion on the Medicaid program. Projections for fiscal year 1979 estimate the cost of the program at nearly $20.5 billion—a thirteenfold increase that has all levels of government searching for ways to bring expenditures back within acceptable bounds. Needless to say, such cost escalations have had a tremendous impact on state budgets. Medicaid expenditures are already assuming a disproportionate share of the limited state funds available to finance social programs for low income individuals. As you so correctly noted last year in your introduction of S. 1470 Mr. Chairman: "The choice is a simple one—either we make Medicare and Medicaid more efficient and economical or we reduce benefits."

While the factors contributing to the rapid expansion in the costs of providing Medicaid services are easily discernible—inflation in Medicaid prices and fees, expansion in the number of eligibles served, growth in the utilization per eligible person—effective and equitable methods for controlling the acceleration of costs are more elusive.

With growing budgetary restraints on the one hand and rising medical costs on the other, the States' most common approach to the problem was to focus on reducing the scope of services offered or the number of individuals served under the Medicaid program. However, in recent years the trend appears to be away from cuts in benefits and eligibility as cost saving devices. While in 1975, over half the States took some action at limiting benefits through such measures as reducing optional services, limiting inpatient hospitalization or restricting the number of visits to a physician, during 1977 only fourteen States adopted one form of action or another to limit program coverage. Interestingly, in the same year, nineteen States took some action to expand coverage. For example, Delaware, Indiana, and New Jersey added intermediate care facility services for the mentally retarded, Michigan expanded its program to include outpatient psychiatric services, Kansas increased the number of home health aide visits from 100 to 200 per year, and Louisiana added a medically needy program.

Legislators seem to be increasingly aware that benefit and coverage limitations, while yielding short term savings, too often only force a substitution of more costly services, and thereby often lead to overall increases in expenditures and sometimes even undesirable effects on recipients' health and welfare. Consequently, while benefit limitations represented the most widely used option for controlling costs in the early to mid-1970's, it has recently been replaced with more serious attention to structural reforms and management improvements.

Increasing recognition has been given over the past few years to the contribution poor Medicaid management and administration make to overall cost increases. The Government Accounting Office and the Inspector General of HEW have suggested that between $750 million and $1.5 billion in Medicaid expenditures are wasted or inappropriately spent each year due to fraud and abuse. Examples of Medicaid fraud and abuse include such practices as: billing for services not provided, bill padding by physicians, double billing on claims already paid, kickbacks by clinical laboratories, prescribing excessive services and overutilization or misappropriate utilization of services.

As early as 1970, New Jersey developed a computerized information system to detect patterns of fraud and abuse among Medicaid providers and recipients. The elements of that system were adopted a few years later by the Department of HEW in developing the federal Medicaid Management Information System (MMIS). The MMIS program is designed to improve claims processing and to check such costly problems as excessive and inappropriate utilization of Medicaid services. Under amendments to the Social Security Act of 1972, Congress authorized 90 percent matching payments to the States for the development of MMIS and 75 percent matching for the costs of operating the systems. Such MMIS system as capable of

providing a broad range of information including: indentification and verification of all eligible recipients and all providers qualified to render services; ensurance that correct payments are made to providers; a statistical profile of health care delivery and utilization patterns; and indentification of possible instances of fraudulent and abusive practices. As of July, 1978, seventeen States had fully certified MMIS systems, with the expectation that by mid-1979 over half the States would be certified.

Some States have clearly been more aggressive than others in attacking Medicaid fraud. New Jersey and New York were early pioneers in the field of investigating and prosecuting nursing home operators. Three years ago, Wisconsin established a 30 member strike force against Medicaid fraud and investigations. Audits carried out by the Illinois Bureau of Special Investigation and the Governor's Task Force on Medicaid Fraud resulted in the suspension of 60 providers in 1976.

Recently, the 95th Congress authorized 90 percent federal matching to States for the establishment and operation of State Medicaid fraud control units. The same law provided for strengthened criminal penalties to be imposed on providers convicted of fraud, as well as the authority to suspend such providers from further participation in the program. Prior to the enactment of the federal legislation, seventeen States had statutes which authorized criminal sanctions on Medicaid providers and vendors for a wide range of fraudulent and abusive practices. Eleven States adopted statutes which permit suspending Medicaid provider from participation in the program for administrative, civil or criminal malfeasance.

In addition to fraud control, many States have developed programs to check unnecessary hospital and nursing home admissions and unwarranted length of stay in institutions. About fifteen States have systems in effect which require prior authorization for hospital services and extensions of stay for non-emergency hospitalization.

One promising innovation that is demonstrating significant cost savings and at the same time protecting the dignity and rights of the elderly and disabled is the Virginia Nursing Home Preadmission screening program. The program is designed to control the alarming increase in patient admissions from the community directly into long term care facilities. A 1976 pilot project revealed that slightly more than one quarter of the applicants screened could be provided for in the community through various alternative methods of care. Due to the success of the pilot project the State of Virginia incorporated the preadmission screening program into its Medicaid plan. Now preadmission screening is mandated statewide and Medicaid payments cannot be made without the local screening committees' approval.

While the Medicaid statute and regulations require States to ensure that medical services are being utilized at an appropriate level, several States have gone beyond the minimal federal requirements. The Indiana legislature, for example, recently established a joint legislative committee on Medicaid costs utilization. The purpose of the committee, as defined by the statute, is to "compare the scope utilization, rates, utilization control methods, and unit prices of Indiana's major Medicaid services with other States' Medicaid services, to identify any frivolous utilization and any unjustified provider profits." Moreover, the committee is to "assess the cost effectiveness and health implications of alternate approaches to reduce unwarranted profits and unnecessary utilization."

The States of Minnesota and Missouri are presently experimenting with a recipient "lock-in" system to cut down on recipient generated misutilization and overutilization. Misutilization is generally discovered through recipient profiles on computerized information systems. Following certain corrective action procedures, such as, caseworker contact to explain that services have been overutilized and how such behavior may be dangerous to their health, the caseworker will explain proper utilization and ask the recipient to select one physician and one pharmacy from which to receive their services and medication needs. The individual's Medicaid card indicates that services rendered (except emergency services) by other than the authorized vendor will not be authorized for reimbursement.

States are beginning to focus on cost containment options which encourage more appropriate utilization of services through restructuring the incentives in health financing and delivery and which promote more rational priorities for health care.

One of the most promising ways to reduce the incentives and overall demand for the provision of high cost health services is through one of the various forms of prepaid medical practices. The HMO is perhaps the most recognized example; however, many other prepaid systems exist such as Individual Practice Associations and Health Care Alliances. While only 17 States to date have certified HMO's as a provider of Medicaid services, many more are expected to follow in the near future.

One of the most perverse incentives within the health care financing structure is the provision in the Medicaid statute and regulations which requires States to follow the reasonable cost related principles of Medicare in reimbursing hospitals, unless the Secretary of HEW approves an alternative reimbursement method. The reasonable cost reimbursement method has been widely criticized as inflationary, since it contains few, if any, incentives for efficient performance on the part of the hospitals. Instead the reimbursement system tends to stimulate unnecessary and inefficient operations. Consequently, eight States at present have received HEW approval to implement reimbursement methods different from that which Medicare follows: New York, Maryland, Wisconsin, Washington, Massachusetts, Colorado, Rhode Island and Michigan. Several other States are seriously considering altering their reimbursement methodologies as well. Moreover, some States, e.g. New York, Maryland, Massachusetts, Connecticut, Colorado, Wisconsin and Washington through mandatory rate setting programs have sought to regulate Medicaid and/or non-governmental payors. The most recent action was taken in the 1978 New Jersey legislative session wherein the legislature created a Hospital Rate Setting Commission with the power to approve rates for all payors of hospital services. Several other States have adopted or endorsed voluntary rate review programs.

Other examples of actions taken by state legislatures to reduce health care cost inflation would include recent efforts in Alabama and North Carolina. In 1976 the Alabama legislature appointed a joint Senate-House Committee to examine the problem of Medicaid and the increasing financial crisis it presented to the State. At that time Alabama's financial contribution to Medicaid had grown to such a point that the State's allocation exceeded 25 percent of the entire general fund of the State. It soon became apparent that the State's investment for Medicaid constricted the amount of funds available for other important general fund services such as mental health and prisons. It therefore became necessary for the State to stop and evaluate its Medicaid investment, to examine the program relative to other State priorities, and to give attention to some alternative action.

Similarly, the 1978 North Carolina legislature created a Legislative Commission on Medical Cost Containment. The Commission's chief duty is to review the North Carolina Medicaid program and to lay out a series of options for containing Medicaid costs, as well as recommend medical cost containment proposal that will benefit all citizens of the State.

The legislatures have also taken actions to influence the flow of health care dollars through limitations on the supply of expensive acute care services. Currently, forty one States have certificate of need statutes providing for a public review and check on the unwarrented initiation or expansion in capital expenditures for health care facilities or services. And many of those statutes pre-dated the federal mandate for certificate of need programs under the Health Planning Act of 1975.

Waste and mismanagement are likely to continue under Medicaid unless the conduct of the program administration is appropriately checked. This is the duty and the function of the state legislature. In addition to its policy and program development role, the responsibility of the legislature extends to the control of policy and program after the stage of formulation. The legislature must review the performance of its administrators—conducting oversight, curbing dishonesty and waste, ensuring compliance with legislative intent, and challenging bureaucrats. It must also assess the effectiveness of state policies and programs.

The past few years have witnessed a growing interest on the part of the legislatures in enhanced oversight of the Medicaid program. I am proud to say that my own legislature in Connecticut was one of the pioneers in this area. In 1975 the Connecticut General Assembly instructed its Legislative Program Review and Investigations Committee to analyze the State's Medicaid program, to identify problems and to recommend solutions designed to improve performance and reduce the rate of growth in program costs. Medicaid expenditures in Connecticut had been increasing at an average annual rate of more than 15 percent since fiscal year 1971.

In its study the Committee looked at controls over eligibility, prices, expenditures and utilization, and found major shortcomings in all areas. In the areas of eligibility, for example, the Committee found that annual eligibility redeterminations of the medically needy caseload were not being done as required by federal regulation. Also, unacceptable error rates in the cash assistance caseload (AFDC) was costing Connecticut millions of dollars in medical assistance to ineligibles. The Committee recommended upgrading of staffing, improved training, and implementation of a caseload system to help.

In reviewing rate setting procedures, the Committee endorsed a new case-related system of reimbursement for nursing homes. The new system was designed to end profiteering through complex manipulation of investments and fraudulent reporting

practices documented in other States. The Committee also recommended that nursing homes only be reimbursed for the level of care required by the patient. We estimated that of the total number of parients receiving skilled nursing care in Connecticut, between 20 to 50 percent actually needed only less costly intermediate care.

The Committee found that understaffing was a major problem in the medical payments section. Overexpenditures were occurring because of lack of controls in the bill processing system and inadequate staff auditing of bills on a post payment basis.

Utilization review was also deficient. Connecticut's Medicaid Management Information System (MMIS)—essential to controlling and monitoring cost and utilization—had not yet been developed and implemented. The Committee found that the MMIS project lacked sufficient leadership and recommended hiring a full time director to oversee the project.

In summary, our Legislative Oversight Committee found that an increased investment in the management and administration of the Medicaid program was needed to save wasted and unnecessary program costs. A cost-benefit analysis estimated that almost $17 million of Connecticut's $200 million Medicaid program in 1977 could be saved if $4 million was spent to improve administrative controls by implementing the Committee's 55 recommendations.

Some compliance with the Committee's recommendations has already been achieved. The Department of Social Services obtained a full time MMIS director; more staff has been hired to fill vacancies in the Medical Payments Section, and the Department has begun implementing plans to improve the training of eligibility workers. Many other recommendations are scheduled for implementation once staff is available.

Whether these administrative changes will result in meaningful cost control remains to be seen. The legislature, however, is now fully equipped to monitor the performance of the Department to ensure that the State's Medicaid program is being managed properly.

SPECIFIC COMMENTS ON S. 505

Mr. Chairman, I would say that state legislators are generally supportive of many of the provisions in your legislative proposal, as well as many of the new alternatives suggested by Senate Finance Committee staff in the Press Release of March 1, 1979.

The concern over the inflation in health care costs, which is reflected in the Talmadge bill as well as in the Administration's hospital cost containment proposal, is clearly justified. Twelve and one-half percent of every federal tax dollar now goes for health care. Since hospital costs are the most rapidly rising component of health care costs and since they account for about 45 percent of personal health expenditures, proposals designed to slow the rate of increase in hospital costs deserve a high priority consideration. Federal expenditures on hospital care have risen from $6.5 billion in 1968 to $29.3 billion in 1978 and unless some containment action is taken are projected to reach $58 billion in 1983. State and local government spending for hospital care was $3.8 billion in 1968, $9.3 billion in 1978 and will exceed $15 billion 1983 absent some cost control.

A focus on hospital costs is particularly desirable because hospital care is the most expensive form of care; hence, policies which encourage economizing on hospital services and substitution of other forms of care will almost certainly reduce costs of treatment.

Inflation in hospital costs affect state governments in a variety of ways:

As a major employer, state governments are concerned about the rapid increase in premiums for hospital care they contribute to on behalf of their employees.

As a purchaser of health care for the needy through the Medicaid program, States continue to face thirteen to fifteen percent annual increases in their Medicaid budgets. And an increasing proportion of those increases are being devoted to institutional care, thus drying up scarce resources for other, perhaps more worthwhile health and social service programs.

Having responsibility for our States' economic environment, legislators are concerned about the ability of some businesses to remain competitive and still generate sufficient profits for future capital investment in the face of growing demands by workers for health benefit increases.

As representatives of taxpayers, legislators have to be worried about the growing frustrations of their constituents as larger and larger demands are made upon them for financing Medicaid, Medicare and country indigents.

Finally, the inability to provide the necessary fiscal resources due to unacceptable inflation in hospital and health care costs, means a continuous postponement of national catastrophic health insurance coverage or more comprehensive health insurance protection.

We believe that many of the principles underlying the proposed reforms in reimbursement methodology under the Talmadge bill are wise. We concur that retrospective reimbursement must give way to a prospective payment system; that target rates should be established for comparable hospitals; and that a new methodology should exist to reward efficiency and penalize waste and inefficiency.

The reimbursement approach proposed in S. 505, while constituting a major improvement over the current hospital reimbursement structure for Medicare and Medicaid, should, however, extend eventually to all third party payors.

Rising hospital costs have been a major concern to many States for a number of years, and several of the third-party payors—particularly Medicaid and Blue Cross/Blue Shield—have initiated programs which aim at restraining hospital costs. However, what that experience confirms is that policies promoted by different payors acting alone can have only a limited impact on controlling hospital costs for the whole system.

The present piecemeal reimbursement structure is an inequitable and ineffective approach to hospital cost containment, as well as being a disruptive influence on hospital planning and financing. Reforms which apply to the reimbursement policies of only a single payor (e.g., Medicaid) provide strong incentives for hospitals which are being squeezed by that payor's policies to either opt out of the program or to pass on the costs to other purchasers. In such circumstances costs are shifted from payors who have imposed reimbursement constraints (e.g. Medicaid) to other payors who do not or cannot control their level of reimbursement (e.g. private insurers and patients without insurance.) The result is that total hospital costs are not effectively controlled, private payors realize an inequitable fiscal burden, and those hospitals which have a high proportion of Medicaid patients bear the brunt of cost containment efforts. Furthermore, hospitals may increasingly view Medicaid admission as undesirable, with the long-run result that Medicaid admissions are shifted to a few hospitals.

Hence, if the reimbursement system is to provide the lever for controlling costs, a uniform policy which applies to all payors is essential.

While the record demonstrates that many States have made great strides in controlling Medicaid expenditures, it is abundantly clear that State efforts focused on Medicaid alone cannot resolve the more general problem of widespread cost inflation throughout the health care sector. We believe that although S. 505 contains numerous worthwhile cost savings proposals that deserve the support of all levels of government, the bill cannot be represented as the exclusive answer to controlling health care costs, particularly in the hospital sector. Medicaid and Medicare account for only about one-third of the total health care dollars spent nationally; hence, it is obvious that new reimbursement reforms and controls on Medicare and Medicaid cannot bring other costs in the health care sector in line. Fragmented controls, no matter how well devised, are likely to be ineffective in restraining future cost increases and may well result in the patients excluded from the process paying higher rates as the excluded costs under the control program are passed on.

We are unable to accept at face value the hospital industry's contention that the voluntary hospital cost containment effort is working and therefore federal legislation would be unnecessary and even counterproductive. While it is true that the rate of increase in total hospital expenses in 1977 over 1976 was 14.2 percent—a definite reduction over the previous year—the data overlooks the contributions that the mandatory state cost containment programs made to keeping the overall average down. Specifically, in the nine States considered to be operating mandatory or quasi-mandatory systems, the rate of increase was 12 percent, compared to 15.8 percent in the 41 States without programs. Preliminary estimates indicated that the national average rate of increase in hospital costs in 1978 over 1977 is 13.3 percent, while the estimate for the mandatory state program is 9.9 percent. Hence, it seems reasonable to suggest that if it were not for the success of the mandatory state programs, the overall rate of increase under the voluntary effort would have been higher than the heralded 14.2 percent in 1977 or the 13.3 percent in 1978.

I am proud to say that my own State of Connecticut, which has been operating a Hospital and Health Care Commission since 1973, registered increases of 11.4 percent and 9.9 percent in 1977 and 1978 respectively—averages which fell well below the national average.

I might add that while our Commission has authority only over charge-based payors, the legislature last year enacted legislation to require the State Medicaid program, subject to a federal waiver, to reimburse using the Commission rate.

Last year at our Annual Meeting, the National Conference of State Legislatures endorsed a policy which calls for establishing reasonable guidelines or performance standards for the hospital sector to meet in terms of restraints on increases in hospital expenditures, to be backed up with a mandatory compliance system if the hospital industry fails to meet the guidelines voluntarily.

If a mandatory system becomes necessary, it should provide for the following exclusions:

States, regardless of their method, that have managed to contain the total rate of increase in hospital expenditures equal to or less than the national standard;

States presently operating mandatory hospital cost containment programs meeting minimum federal requirements; and

States which develop cost containment systems after the effective date of the federal legislation and which are consistent with minimum federal standards.

There is little dispute that a sensible hospital cost containment policy ought to precede the implementation of expansions in health benefits or coverage, be it catastrophic or comprehensive national health insurance. Disagreement does exist, however, over the kind of cost containment system or systems that will prove effective and what level of government should be responsible for administering the system or systems.

Given the fact that hospital cost containment is still largely an art, not a science, flexibility and experimentation ought to be key to the eventual discovery of the kinds of approaches that will function properly. Hence, we believe, as the Administration's bill allows, that States which are operating effective cost containment programs consistent with minimum guidelines should be free to continue to administer their own programs. The use of state expertise and staff would greatly augment the limited number of federal employees who would be available to administer a nationwide program.

We emphasize, however, that the criteria by which States would be permitted to operate their own hospital reimbursement systems should be minimum standards. Since the development of a sound incentive system for reimbursing hospitals is still in its infancy, States should not be put in the position of having to demonstrate "beyond a reasonable doubt" they can do a better job than the federal government.

Some suggested criteria by which the State programs ought to be evaluated might include:

A methodology that will ensure that the rate of increase will not exceed the permitted federal ceiling;

A methodology for the recovery of excess hospital revenue;

An identifiable unit of state government supervises the administration of the program;

A uniform definition of costs is developed; and

Provision is made for sanctions and enforcement.

We also believe that an appropriate federal role would be to provide front end financial assistance on a matching basis to help cover start-up costs for those States that wish to create alternative hospital cost containment systems. Strong evaluation measures should be built in to those new programs to insure that innovations in procedure, methodology and technology are measured and made available nationwide.

Consideration of State requests for Medicare and Medicaid participation in the hospital reimbursement systems should be given the most expeditious consideration by the Department of HEW. Additionally, the legislation should contain incentives to States to adopt even tougher standards than federal requirements. For example, if a State operated system can manage to control hospital costs below a reasonable level, the State should be able to retain part of those savings and devote them to such purposes as preventive services and debt retirement on unnecessary facilities.

Presently, alternative hospital cost containment strategies are under serious consideration in about eight state legislatures. Several other legislatures have established study commissions on cost containment with an eye to some possible action early next year.

The case for State participation rests not only on the argument that States are good experimental "testing grounds"; other arguments are equally compelling:

The protection of the citizenry's health has traditionally been within the recognized police powers of the state;

States shall continue to make large contributions to the health care system through Medicaid and as purchasers of health care for state employees, therefore, they have a financial stake in the success of the program;

States are in the best position to view individual hospitals' needs, priorities, budgets, and operations in the context of statewide needs, priorities and resources for health care; and

States can most easily assure the coordination of rate review and other forms of regulations, such as, certificate of need review.

In summary, Mr. Chairman, we are hopeful that your efforts and the efforts of other appropriate committees within the Congress will result in a compromise measure on hospital cost containment similar to the kind of compromise the Senate, due in a large part to your leadership, managed to forge last year in the final days of the 95th Congress. Such a compromise would hopefully combine the best elements of the well thought out, long range structural reimbursement reforms as represented by S. 505 with the more short range, temporary restraints on hospital costs suggested by the Administration's proposal.

Having spent a considerable portion of my testimony on our reservations and recommendations regarding the legislation's approach to reforming hospital reimbursement, I would like to focus the remainder of my statement on those elements within S. 505 which our organization fully endorses.

1. Requirement that information regarding deficiencies in the administration of a state's Medicaid program be made available not only to the Governor of the State, but also be shared with the legislative leader of each house in the state legislature, as well as the Chairman of the legislative committees with jurisdiction over the Medicaid program.

Mr. Chairman, it is an unfortunate reality that legislators are often among the last to know when things are going wrong with the Medicaid program. The deference S. 505 pays to the importance of the state legislative branch of government—in recognizing its accountability for the expenditure of state funds and assuring program effectiveness—is unprecedented in federal legislation and welcomed with great enthusiasm. This provision will unquestionably strengthen the legislatures' ability to oversee the administration of their Medicaid program. Moreover, it should spur greater interest on the part of the appropriate committees to continually evaluate the performance of their own state agencies. I would make only one suggestion in this area for the consideration of the members of this Committee. Hopefully, the kinds of monitoring of Medicaid administrative performance carried out in my own State, as I described earlier in my statements, can be replicated in other states. However, the cost of legislative oversight and monitoring in an area as complex as Medicaid can be quite high. We would recommend, therefore, that state legislative committees become eligible for Medicaid administrative matching funds for the purpose of exercising an oversight and monitoring function of the state's Medicaid program.

2. Requirement that resources of Medicaid applicants include assets disposed of at substantially less than fair market value.

Just two weeks ago, the Human Resources Committee of the NCSL addressed the problem of transfer of property for the purpose of acquiring Medicaid eligibility. The Committee unanimously agreed with the Section 24 provision in S. 505.

The Committee also addressed the equally troubling issue of relatives' responsibility under Medicaid. The Committee concluded that the income "deeming" provision under SSI, whereby income is "deemed" to be mutally available between spouses or from parent to child only so long as they live in the same household, operates as an incentive to institutionalize an elderly spouse or disabled child in order to reduce the financial burden on the family.

Such a policy penalizes families that do not institutionalize a seriously ill member; it conflicts with many state laws regarding relative responsibility; and it leads to the expenditure of scarce Medicaid resources or persons who are not always the most financially needy.

Our organization, therefore, strongly urges Congress to modify its requirements governing deeming and relatives' responsibility to include provisions for spouses and parents of child recipients to share in the cost of care for those immediate relatives who are institutionalized.

3. Permitting an experimental period during which states could purchase laboratory services for Medicaid recipients through competitive bidding arrangements.

The "freedom of choice" provision of the Medicaid law has effectively restrained states from utilizing cost-saving approaches, such as contract bidding, for the purchase of laboratory services. It seems to us, however, that the "freedom of choice" concept is grossly distorted when it is applied to such areas as laboratory services

which are once removed from direct patient care. The patient is basically indifferent as to who does their urinalysis or blood work, so long as they can be assured that minimum standards are adhered to. We are convinced that competitive bidding arrangements for the purchase of laboratory services will mean significant savings to both Federal and State Medicaid budgets.

4. Payments to promote closing and conversion of underutilized facilities.

5. Allowing states the option, when computing reimbursement rates under Medicaid to a skilled Nursing Facility or an Intermediate Care Facility, to include reasonable allowances for the facility in the form of incentive payments related to efficient performance.

6. Extending the time period by which an HMO, which contracts with a state to provide prepaid health services under Medicaid, must meet the condition of having no more than one-half of its members covered by Medicaid and/or Medicare.

The law presently allows HMO's a three-year period from the date of their contract with the state Medicaid agency to comply with the fifty percent requirement. However, many HMO's are finding it difficult to meet the three-year deadline. Hence, we would support the provision in S. 505 which would give HMOs a three-year period from the date the HMO is formally determined qualified by HEW to meet the requirement, instead of from the date the contract is signed.

With respect to the numerous suggested alternatives for possible health cost savings developed by Senate Finance Committee Staff and identified in the March 1 Press Release, I must say that many of those alternatives would seem to hold real promise for reducing costs if implemented. Unfortunately, we have not had sufficient time to share these suggestions with the members of our Human Resources Committee and obtain their reactions. However, our staff will be working on trying to provide you with a sense of how these initiatives might be received within the states very shortly.

I can say unequivocally that the suggestions to delete statutory requirements specifying state payment of "reasonable costs" to hospitals under Medicaid and of "reasonable cost related" reimbursement for skilled nursing and intermediate care facilities would be warmly embraced by state legislators and administrators.

States for years have objected to the legislative links between Medicaid and Medicare, particularly in the hospital reimbursement area. They are two programs with some similarities, but also have major differences. Throughout the past few years several states have initiated policies to check hospital cost increases, but they have faced enormous difficulties in securing HEW approval to utilize these systems for Medicaid reimbursement. From the standpoint of the states, the Medicare reasonable cost reimbursement methodology has been one of the primary contributors to hospital cost inflation, yet due to the stringency of federal law and regulations the states have had few options to deal with. While our organization does not endorse any specific alternative to the Medicare methodology, we have believed for some time that states ought to enjoy greater flexibility in formulating hospital reimbursement systems tailored to local circumstances and needs.

Also, I think there is no doubt that states would welcome the opportunity to purchase laboratory services and Medicaid devices for Medicaid recipients through contract bidding and negotiated rates. To date, the "Freedom of Choice" provision in the law has prevented such cost saving approaches. "Freedom of Choice" has been applied to situations where recipient choice of a provider is largely an irrelevant issue, for example, for laboratory work or the provision of eyeglasses and hearing aids.

With respect to the other issues suggested by your staff, we will try to provide a more complete response very shortly.

Mr. Chairman, this completes my testimony. Once again I want to express my gratitude for the invitation to appear before you today and represent some of the broad concerns that have been identified by my state legislative colleagues from around the country. I hope my testimony has effectively conveyed the notion that health care cost containment is a major priority of the legislatures and of the National Conference of State Legislatures.

It has been a special honor for me to have appeared before this Committee—a Committee which everyone regards as unparelled in its commitment to ensuring that good quality health care is provided at a reasonable cost.

STATEMENT OF HON. RAYMOND C. KEHRES, A REPRESENTATIVE FROM MICHIGAN, ACCOMPANIED BY JOHN T. DEMPSEY, DIRECTOR, MICHIGAN DEPARTMENT OF SOCIAL SERVICES; AND PAUL M. ALLEN, DIRECTOR, MEDICAL SERVICES ADMINISTRATION, MICHIGAN

Representative KEHRES. Mr. Chairman, I would like to thank you for hearing us ahead of schedule so we could be heard.

I am chairman of the subcommittee that handles the social services budget in Michigan and this is my 11th year.

I have with me this morning Dr. John Dempsey, director of the department of social services who will give the formal testimony and I also have with me Mr. Paul Allen who is the director of the medical services administration.

We in Michigan have been very concerned over the last few years about the rising cost of medicaid. I have seen this grow from back in 1968 until now and it has been a tremendous growth.

We in Michigan are suffering because of this rising cost and are giving up many other kinds of programs we would like to have as a result.

Dr. Dempsey, would you give the formal testimony, please?

Mr. DEMPSEY. Mr. Chairman, as Mr. Kehres has said, the increasing amounts of money the State has to spend simply to keep up with health care costs inflation makes less funding available for other vital programs.

If we cannot contain medicaid's cost through administrative, reimbursement, and regulatory measures, we are left with two choices, both of which are unacceptable, either to continue with the current rates of cost escalation or drastically restrict the needy population's access to medical care by curtailing eligibility and benefits. As I say, neither of those options are acceptable.

Back in 1975 when Michigan had a severe recession, we were compelled to adopt emergency reductions in recipients' benefits and practitioners' fees. Since that time, we have made continued and intensified efforts to control costs by more acceptable means.

From our experience, we feel strongly that successful cost containment depends upon coordinated application of a range of controls; reimbursement, supply, utilization, and quality controls. Many of the initiatives described in S. 505 and the related staff document offer an excellent opportunity for the needed broad and coordinated approach.

Let me comment on detail on a few selected initiatives that are under consideration by you.

First, the establishment of limits on reimbursable hospital costs for medicare and medicaid. It seems to us this is the heart of the proposal and we strongly support this effort.

At the same time, we favor the proposal to allow the use of successful State reimbursement control systems when those systems result in payments which do not exceed those which would be made under federally designed methodologies.

We in Michigan have had quite a successful experience with both hospital and nursing home reimbursement controls. Our present hospital reimbursement system is similar in many ways to the program proposed in section 2 of the bill. It covers ancillary as well

as routine costs and is scheduled to cover outpatient department costs.

Since the Department of Health, Education, and Welfare approved the State's system in 1976, the medicaid program has succeeded in lowering the annual rate of increase in hospital costs reimbursed by medicaid by about 5 percent below what it had been previously.

The Michigan medicaid program has developed prospective reimbursement mechanisms for nursing care facilities and for hospitals through negotiation with the nursing home and hospital associations. Our nursing home program is in effect. We have been successful through the cost control efforts in that program in holding increases in nursing home rates to about 7 percent a year for the last 4 or 5 years. The hospital reimbursement program is in the final stages of development.

As we have previously stressed, successful cost containment relies on coordinated controls of different types. Our success with cost containment for nursing homes is based on controls of both reimbursement and supply as well as development of alternatives to institutionalization. In this regard, we endorse the increased flexibility afforded by the expansion of medicare home health benefits proposed in S. 505.

As a result of efforts such as these, Michigan's nursing home population and the number of beds for which Michigan is paying have remained stable for the past 3 years.

Additionally, we provide support for an increasing number of persons in alternative care settings. Specifically, there are about 30,000 medicaid nursing home patients, 19,000 individuals in adult foster care and another 13,000 receiving in-home chore services.

We also support the recommendation in S. 505 to consider the appropriateness of requiring concurrent participation of nursing homes in both medicare and medicaid. In Michigan, the need for this requirement was so clear that under the leadership of Mr. Kehres, the legislature did enact legislation to make dual participation mandatory.

One contemplated proposal about which we are concerned is the removal of statutory requirements for payments on reasonable cost. We are afraid this deletion may result in pressures to increase reimbursement for these services. The potential adverse effects of any proposal to delete that language should be carefully weighed.

Second, payments to promote the closing and conversion of underutilized facilities.

The committee properly recognizes the need to close or convert excess beds in addition to the current trend to restrict opening more beds. We strongly endorse the provision in the bill for medicare and medicaid reimbursement to recognize increased capital and operating costs associated with closure or conversion of excess hospital capacity.

In Michigan, the legislature recently enacted major legislation to identify such capacity and provide a planning process for its removal. These initiatives appear both appropriate and timely.

Recent studies point to a national surplus of acute-care hospital beds ranging to 100,000 or greater. We urge that Federal initiatives be closely tied to the State health planning process and such ties

can assure that Federal payments will complement closure initiatives already undertaken by States.

A third item specifically I would like to comment on is the proposal concerning the transfer of assets to obtain medicaid eligibility.

We support this proposal to restrict gratuitous transfer of assets by persons seeking to obtain medicaid eligibility which cannot be defended. Such action increases costs, especially for institutional care.

Enactment of this section will clarify the confusion current Federal regulations have created with regard to States' authority in this area. We would suggest that consideration be given to allowing this authority to be optional rather than mandatory.

A fourth provision is to adjust hospital reimbursement rates for the provision of long term care services.

We support this proposal which would mandate reduction of reimbursement for inpatient hospitalization when the level of necessary care is reduced. We in Michigan now have a policy like this in place. Under our procedure, reimbursement for inpatient hospital services is reduced to the per diem rate for skilled care or for basic care when appropriate, when acute care is determined to be no longer necessary.

In Michigan this methodology has realized significant savings and has been well accepted by the hospital industry.

A provision concerning incentives for the performance on an ambulatory basis of certain surgical procedures is supported by us.

We presently have a policy whereby physicians are paid more for performing specific procedures in an ambulatory care setting rather than an institutional setting. Although the program pays the practitioner more, it avoids the higher cost of institutional care altogether and we think you should seriously consider it.

The limitation for reimbursement of outpatient hospital care; we support limitations on reimbursement for outpatient hospital care. We are concerned that they not be so stringent that they curtail the availability of services or force the closure of outpatient clinics.

We fear that limiting reimbursement to twice the cost in a physician's office may have that effect. We are now seeking approval to bring outpatient departments under reimbursement ceilings established through application of a hospital cost index. We believe this type of approach should be considered as an alternative.

Utilization review of unnecessary hospital services, we have reviewed your committee's staff proposal that PSROs' review be directed toward avoiding unnecessary routine testing in hospitals and excessive preoperative stays. We strongly encourage development and use of a variety of mechanisms to prevent unnecessary hospital admissions and services of all types.

There are a number of techniques and resources available to conduct such reviews. Michigan has had successful experience with this.

The program limits the circumstances under which medicaid patients may be admitted to hospitals on Fridays and Saturdays thereby reducing lengths of stay by avoiding hospitalization during days when only limited services might be provided. We also encour-

age completion of preadmission testing on an outpatient basis as opposed to the more expensive inpatient setting.

We have also experienced considerable success in reducing average lengths of stay through a computerized system which enforced limitations on stays to those which are appropriate for diagnoses by age and sex.

We also are participating with Michigan Blue Cross and Blue Shield in a second surgical opinion program.

Finally, we can point out that PSRO's in Michigan presently look at preoperative stays by reviewing whether patients admitted for surgery are scheduled for the next day.

One final comment I would make, Mr. Chairman, that is that management of the program is extremely important and cost containment efforts must be combined with a strong management system.

Michigan is the only large State in the Nation which performs all medicaid administrative and program management functions in-house. The state is its own fiscal agent, utilizing one of the first fully operational, HEW certified medicaid management information systems for claims processing and payment and for program management and control. This system has been fundamental to our achievements in detection and control of fraud and abuse, third party recovery programs and the development of innovative reimbursement techniques and cost containment initiatives.

As an example of the significant benefits accruing from this system, last year claims totaling $24,300,000 were rejected in Michigan because they duplicated previously paid claims or represented ineligible providers or recipients. Further, another $18 million was recovered or payments avoided where the system identified other available health insurance.

Finally, an additional $93,500,000 was saved by reducing amounts billed by maximum payment limits built into the system. When offsets through monitoring and other controls are added to the total, the system avoided costs exceeding $145 million last year.

We truly feel these kinds of savings would not have been achievable without such a management system. Michigan strongly advocates the application of such a system to both medicaid and medicare payment processes and encourages you to consider the implications of this powerful management tool for assuring the optimal benefits from cost containment activities.

We sincerely appreciate this opportunity to discuss the health care cost containment initiatives proposed in S. 505. The potential for success, in light of Michigan's experience in these areas, is significant.

I extend an invitation to you to review our programs in more detail.

Representative Kehres, Mr. Allen and I would be pleased to respond to any questions you may have at this time.

Thank you.

Senator WALLOP. Thank you. I only have two questions and one is that you are not a medical doctor, is that correct?

Mr. DEMPSEY. No, sir, I am not.

Senator WALLOP. Is it not true that when you begin to limit the rate of reimbursement under medicare and medicaid the rest of the

consuming public must pick up whatever slack this change has caused in the expense system of operating a hospital?

Mr. DEMPSEY. It is true if the costs of operating hospitals continues to rise higher than the rate in which medicare and medicaid is presently.

Senator WALLOP. Is that not true that this limitation set on reimbursement of M/M is one of the reasons hospital costs have continued to rise faster than the normal rate of inflation? Because this system allows for no profit somewhere or another, the cost of operating that hospital has to be picked up. If the reimbursement level is not adequate to fund the cost of operating that hospital, then the public has to pay for it. That is one of the real inflationary pressures that is on hospital costs right now.

Mr. DEMPSEY. Senator, I would agree with you except obviously the public pays one way or the other because medicare, medicaid and Blue Cross are all supported by the public as well.

The dilemma was described partially by Mr. Kahn and Secretary Califano in the sense that a good portion of the costs are paid by third party payers and there is really no incentive by them to reduce costs and therefore, no incentive for the hospitals.

Senator WALLOP. There is one. It is the fact that someone is having to pick up the less than fair proportion that the Federal Government is paying for the operation of medicare and medicaid.

Mr. DEMPSEY. If you assume that is a less than fair proportion, yes, sir.

Senator WALLOP. If the level of reimbursement is less than the cost of the services someone picks up the tab whether it is someone paying his own hospital bill or through his insurance.

Mr. DEMPSEY. The key part of our position is that a prospective reimbursement system is better because it tells the hospitals and the industry in advance how much they can increase costs. It gives them not only an incentive but it gives them a tool to use in their negotiations with unions and in their purchasing activities and so forth.

Senator WALLOP. It will not give them the tool with the pass through. One of the problems with the administration proposal as it lays on the table is that there is no tool with the pass through.

Mr. DEMPSEY. We are here largely to endorse S. 505 and your staff recommendations.

Senator WALLOP. I thank you very much for your testimony.

Senator DeNardis?

Senator DENARDIS. Senator Wallop, if I may, we did indicate in our testimony several of the features of S. 505 that we especially like and endorse. There is one that I would like to highlight because I think you will appreciate it as a former State Senator and that is really what I think may be an unprecedented provision in a piece of Federal legislation and that is the difference of what it pays to the legislative branch of State governments in terms of the oversight of the major program.

An unique feature and one that I hope is enacted because it will give us an opportunity to do on a national scale what some States are already doing and that is utilizing State legislative oversight committees to monitor the expenditure of state funds in this area.

Senator WALLOP. I do appreciate that. One of the great problems I have with this whole area is your reference to 93641. I do not know what possessed the Congress to utterly bypass the elective structure at every single level, not the legislature, not the Governor, not even the President. It is a deal between a private organization and the Secretary of Health, Education and Welfare. That does not fit my concept of elective accountability.

Senator DENARDIS. I share some of those concerns about 93641.

Senator WALLOP. Thank you all very much.

Mr. Kehres?

Representative KEHRES. I would just like to add one point that I do not think was stressed anyplace this morning as much as it should be stressed in this whole cost containment element. The big thing that we are dealing with is the doctor that admits the patients and when he keeps them there and for how long he keeps them there and the kinds of tests he requires them to have.

I think that is the overriding thing we have to deal with in the total cost containment.

Senator WALLOP. I do not disagree with that. If you are going to discuss that and I think you should, then we are going to have to deal with the entire business of malpractice suits and the extraordinary explosion of generosity on the part of the American juries.

Representative KEHRES. I understand that totally and I have often thought about it and I have talked to doctors about it. I think if we are really going to get at the problem, we are going to have to get at that issue of the doctor relationship with the patient.

Senator WALLOP. The doctors will be testifying tomorrow.

Thank you very much, Mr. Kehres.

Begging the indulgence of those who have come to testify, part of my reason for taking over the Chair for Senator Talmadge was so we would have the Rural States Health Panel on at this moment.

Messrs. Miller, I would appreciate it if you would indulge me in this.

I will call Mr. Ernest Rumpf, Jr., Director of Medical Services, Department of Health and Medical Services, State of Wyoming; Dr. Claude Williams, O'Keene Clinic, O'Keene, Oklahoma; Renee Brereton, Director, Mountain Plains Congress of Senior Organizations, Wyoming, Montana, North Dakota, South Dakota, Utah, and Colorado and Keith Campbell, Administrator for Seward General Hospital, Seward, Alaska.

May I say, Mr. Rumpf, it is a singular pleasure for me to be able to welcome you here. I look forward to hearing your testimony concerning the problems which are unique to Wyoming in the medicaid/medicare system.

STATEMENT OF ERNEST RUMPF, JR., DIRECTOR, MEDICAL SERVICES, DEPARTMENT OF HEALTH AND MEDICAL SERVICES, STATE OF WYOMING, ACCOMPANIED BY DR. CLAUDE WILLIAMS, O'KEENE CLINIC, O'KEENE, OKLA.; RENEE BRERETON, DIRECTOR, MOUNTAIN PLAINS CONGRESS OF SENIOR ORGANIZATIONS AND KEITH CAMPBELL, ADMINISTRATOR, SEWARD GENERAL HOSPITAL, SEWARD, ALASKA

Mr. RUMPF. Thank you, Senator.

Mr. Chairman, my name is Ernest Rumpf. I am director of the medicaid program for the State of Wyoming. I am testifying as a director of a small program in a sparsely populated State.

I appreciate the opportunity to testify because I do believe because of fiscal requirements, the larger States are looked at more frequently and it can be forgotten that the same legislation and regulations affect small States, sometimes causing havoc with our necessarily small staffs.

I have written comments on S. 505. I would ask they be made a part of the record.

Senator WALLOP. Without objection, your statement will be inserted into the record at this point.

Mr. RUMPF. I agree with most of the bill but for the sake of brevity and at the risk of sounding negative, I have limited my written remarks to some of the areas where I see problems and my oral remarks will be limited to three which I particularly wish to address.

I would like to discuss section 5, the agreement by physicians to accept assignment. I would agree with the principle and recognize that physicians not accepting assignment presents a major problem to many individuals under the medicare program.

I do not believe the approach taken in this bill will accomplish anything simply because the incentive is insufficient.

Using the averages for our State, the physician who normally bills medicare $5,000 on 82 claims during the year would gain $82 if he became a participating provider under the provisions of this bill. If he remains a nonparticipating provider and does not take assignment, he stands to gain $1,450.

I believe the recognition by the committee that this is a major problem is good but I frankly do not feel the solution offered will do anything except increase the administrative costs for the intermediary.

The second section of the act which I wish to address is section 15, medicaid certification and approval of skilled nursing and intermediate care facilities.

I feel strongly that medicaid is a State-administered program and sincerely believe that States can sometimes do a better job than the Federal Government. I look at this section as a trend toward the taking over of the medicaid program by medicare or HEW.

I sincerely believe a State with people who intimately know a facility, who intimately know the staff and patients in a nursing home, are better able to determine whether or not a facility should be certified than can be done several hundred miles away in the regional office, reviewing a document with check marks as to whether or not the facility meets certain conditions.

As is stated in the report on the bill, there may be inequities in the manner in which facilities are being certified between States. HEW currently has the authority and the structure to correct these inequities and I do not think a change in the law is necessary.

The third section which I wish to address is section 24, resources of medicaid applicant to include assets disposed of at substantially less than fair market value.

I am most pleased that the committee was considering action to correct this inequity which allows people of some means to be eligible for medicaid. I would like to suggest an alternative method of correction.

Presently, for example, a person 65 years of age with $10 million in A.T. & T. stock but with no other income, can turn over his stock to a child and immediately become eligible for both SSI and medicaid. I do not feel this individual should be eligible for SSI any more than he is for medicaid. I therefore believe this change should be made in the SSI law about disposal of assets.

As the bill now stands, it will not correct the inequity in the SSI, only in medicaid. It also will mean in a State such as Wyoming, where we rely on SSI determination of eligibility, that we will have to set up a whole new eligibility structure to make the second determination of eligibility.

I thank you, Mr. Chairman, for the opportunity to comment.

Senator WALLOP. Thank you, Mr. Rumpf.

I would like to ask you one question. In Wyoming, what is the average cost per visit to a doctor's office, a GP?

Mr. RUMPF. The average claim we receive is $61.

Senator WALLOP. That is a Wyoming figure?

Mr. RUMPF. Yes.

Senator WALLOP. That is a claim. What is the average cost per visit? Is there such a visit?

Mr. RUMPF. Are you talking about an average hospital visit or an office visit? An office visit is about $7.

Senator WALLOP. Would not the $1 incentive payment be more significant on that basis than on the claim?

Mr. RUMPF. It would be significant if you allow it for a visit, Mr. Chairman. The way I read it, it is by claim.

Senator WALLOP. The staff explains it is one visit per week that the $1 was based upon.

Would that make a difference in the incentive?

Mr. RUMPF. Yes, Mr. Chairman, on that visit, it would. On the surgery on which the bill is $500, it would be very insignificant.

Senator WALLOP. Is there any value in turning over the certification of nursing homes wishing to participate in medicare and medicaid to the Federal Government as section 115 of this bill if passed would require?

Mr. RUMPF. Mr. Chairman, I see no advantage in turning over this certification. As I stated, I believe HEW can straighten out any inequities that may exist under current law.

I sincerely believe the State can do a better job with certification themselves.

Senator WALLOP. Does the State of Wyoming now have an effective program through the State health office or your office for certification of nursing homes wishing to participate in medicaid?

Mr. RUMPF. Mr. Chairman, I believe we have a very effective certification program. We have eliminated all of the old-type nursing homes since some 9 years ago. We have not had a nursing home in the State of Wyoming that was not constructed to be a nursing home.

I believe we have an excellent program for certification and would be most reluctant to see it change.

Senator WALLOP. Thank you, sir. I very much appreciate your coming all this way. It is significant to me to have a representative of my State participate in the hearing process on legislation which has interesting complications that are unique to Wyoming as well as to other States.

Dr. Williams?

Dr. WILLIAMS. Mr. Chairman, I am a practicing physician in the western part of Oklahoma.

Senator WALLOP. Dr. Williams, if I may interrupt you for a moment. I see Senator Boren is here and he might perhaps want to introduce you.

Senator BOREN. Mr. Chairman, I am pleased to have Dr. Williams here. He is one of the leading physicians in our State. He practices at O'Keene, Okla., and has been outstanding in the leadership he has given, particularly to the community hospitals in the small towns. He is very knowledgeable in pointing out the problems for the smaller communities and the less populated areas.

He was one of the real innovators and leaders in setting up our own Oklahoma utilization review system.

It is certainly a pleasure to have him here today. I know what he has to say will be of interest to the committee.

Dr. WILLIAMS. Thank you, Senator Boren and Mr. Chairman.

I would like to submit my written report for the record and confine myself to a few comments, if I may.

Senator WALLOP. Without objection, your written comments will be inserted into the record.

Dr. WILLIAMS. We share your concern about the rise in medical costs, both me and my patients.

I have emphasized in my written report the vital role of the rural hospital and the community health centers. I certainly agree with the comments of my colleague in regard to the importance of these.

We have heard talk this morning of all kinds of new regulations. I think one of the big problems in talking about 20 to 50 bed hospitals with one to five doctor staffs, one of the things that has put more or less a ceiling on us for further reducing the costs is the current regulations that are oppressive that are in existence at this time.

Can you realize that a hospital of one to two doctors having to generate the same number of reports and staff the same number of committees as larger hospitals? This is time consuming.

It takes time away from our patients. It takes the time away from home life or from our civic duties. Most of all, it discourages our replacement by young physicians in the rural areas.

It costs Oklahoma rural hospitals on the average from $25,000 to $50,000 a year just for new regulations that are coming down. There should be some point in time that we should be declared safe.

As it has been mentioned, we endorse hospital reimbursement policies that rewards efficiency and rather than penalize us for being efficient. We must get away from the cost plus philosophy that is helping us to accelerate these costs.

To kind of emphasize my point, Mr. Chairman, we have coming down which Secretary Califano mentioned this morning, a simple

term that a standard hospital reporting system—our hospital receives 68 legal-sized documents. This is reports generated as Mr. Califano alluded to this morning. This is three reports for every hospital bed in one hospital.

How can this help medicine? How can this help us reduce costs?

We have a plan. We have one of the best PSRO situations in the Nation. We monitor every hospital. We pick up monitor costs, monitor physician. We have 100 percent cooperation of the key hospitals and we have 100 percent in the enrollment of the doctors.

My opinion, gentlemen, is deregulate us to the extent in the hospital that we can help, give us general guidelines, some objectives, but let us solve the current problem of price control. We are doing it in Oklahoma.

Thank you, sir.

Senator WALLOP. Thank you, Dr. Williams.

Senator Boren?

Senator BOREN. I wonder, Doctor, if you might tell us some of the problems first encountered with the original utilization reviews and how we managed to come out.

Dr. WILLIAMS. Four years ago, HEW guidelines for utilization review were first released. Some of Oklahoma's rural hospitals, because of small staffs, could not abide or could not get along with this set of regulations.

We appealed to HEW in the State of Oklahoma through the original legislation that allowed a superior plan. Congress must have foreseen this.

We pressed this issue. They told us to go back to Oklahoma and write our own plan considering the utilization review. The first year we had a budget of $180,000, and we generated savings in the State of Oklahoma in the amount of $15 million.

We were accepted as a provisional PSR and brought back under the Federal regulations but our costs for this rose from $180,000 to $1.5 million. This is the point. We cannot base our performance on what is said. There is always newly generated legislation and regulations which puts on a whole new burden particularly in our rural States and our rural hospitals.

We have kept up with the guidelines that have been issued here this morning. Our PSRO has not reached its peak. We have the cooperation.

I think if you will give us the chance, the medical profession and the medical community, we can do it.

Senator BOREN. We are very proud of the success that program has had and I hope the committee will take a careful look in detail as to how that program functions, how some of the savings were achieved, and make a comparison with the Federal program.

Dr. WILLIAMS. Senator, you were not here this morning but in looking at all these charts where Secretary Califano was picking out the troubled hospitals and with regard to good hospitals, I think he has stolen some of our ideas.

Senator BOREN. We have talked about the problems of paperwork. This is a very serious problem, especially for the smaller hospitals. What do you think of the approach, not necessarily all the details, of the Talmadge plan which goes more toward a target, rather than a cost-based rate, which would appear to require less

paperwork? Do you think it would require less paperwork to go to a target-base plan?

Dr. WILLIAMS. I think it would, Senator. I think this is a good approach. As I alluded, we must get out of this idea of this plus-cost or cost-plus philosophy. We must be given incentives so if we do save some money, we can keep it. We cannot now. We are penalized for efficiency.

Senator BOREN. Mr. Chairman, I certainly appreciate Dr. Williams taking the time to come and to testify before the committee. I hope there will be consideration given to his written remarks and hopefully written questions may be addressed to him at a later time, giving us a chance to get more into the record about what we have done through this program.

Dr. WILLIAMS. I would be delighted.

Senator WALLOP. Dr. Williams, I share that and I only wish the Secretary had been here to hear firsthand what the burden of regulations has done in that short period of time. That is somewhat staggering of a figure of the costs of compliance as you stated.

Dr. WILLIAMS. It did not increase our program efficiency one bit.

Senator WALLOP. I am sure the result was quite the contrary.

Dr. WILLIAMS. Yes, sir.

Senator WALLOP. Thank you.

Ms. Brereton?

Ms. BRERETON. I have also submitted written testimony for the record.

Senator WALLOP. Without objection, your written comments will be submitted into the record.

Ms. BRERETON. My comments this afternoon are basically focused on part B of S. 505. Part B, the reimbursement of medicare, is not a uniform system. This observation is based on two points. One is the significant variation in the number of medicare claims which are accepted for assignment.

Medicare claims not accepted for assignment, the senior citizen pays 20 percent in cost sharing with the additional excess charge beyond the medicare allowable fee.

The variations in assignment are drastic. For instance, Senator Wallop, in the State of Wyoming, which is the lowest assignment in the Nation, the rate is 17.7 percent. This ranges all the way up to 67.6 percent for the Boston area.

There is also a significant geographic variation in the medicare allowable reimbursement rate. For instance, a cataract operation done in the State of Utah is reimbursed at the rate of $426; and in the State of Wyoming, $562.70; and in New York, $814.20; and in Alaska, over $1,000.

This low acceptance of assignment by physicians is clearly viewed as the single most threatening health concern for older citizens.

The geographic variations are too extreme to be based solely on cost of living differences and the malpractice insurance.

The assignment rate has significantly decreased over time. In 1967, the rate of assignment rate was 64 percent and we are currently at 50.5 percent.

The medicare system part B is completely unpredictable. A beneficiary has no prior knowledge of medicare's reimbursement levels

are to reimburse himself or herself or the physician at the time of the procedure.

The category of inhospital surgery presents the patient with the greatest financial risk.

Our research for all cataract procedures performed in the State of Colorado show the out-of-pocket variations was $94 as compared to $350 for the same procedure.

In rural States, with the documented shortage of physicians, the medicare reimbursement rate tends to be substantially lower than the national average.

I have figures for four medical procedures showing the 20 percent copayment and the mean out-of-pocket expenditures increasing the cost to older people by about 50 percent when physicians do not accept assignments for the four procedures we have the data for.

One of the unfortunate things with the nonacceptance of assignment has been for senior citizens purchasing additional health care insurance. This additional health care insurance pays only 5 percent of the total health care cost and never pays the excessive charge I am speaking about today.

Senate bill 505 outlines numerous methods of assignments to increase assignment. The provision to process assigned claims on a simplified basis with priority handling should be extended to all claims.

The provision to encourage assignment by financing the $1 incentive payment to the physician would have very little impact. The national average inhospital patient charge for 1976 was $356.33. The average reasonable medicare payment was $282.

It seems unlikely that a physician would accept $1 and give out $75 as a result of the way this bill is written.

The provision to control the increasing prevailing charges between localities would have a negative impact on rural areas.

To conclude, Senate bill 505 does not endorse the low reimbursement rates and nonacceptance of medicare assigned rates. The incentives offered in Senate bill 505 will not alleviate the crucial problems which deserve immediate legislative attention.

Thank you.

Senator WALLOP. Thank you, Ms. Brereton.

I do not want to suggest that I do not have any questions but I do have a problem because the vote light just went on. I would like to submit some questions to you at a later date.

I have just enough time to finish this panel. Mr. Campbell, if you would proceed, I would appreciate it.

Mr. CAMPBELL. Thank you, Mr. Chairman.

I am Keith Campbell, administrator of Seward General Hospital in Seward, Alaska. I am pleased to have the opportunity through the auspices of Senator Gravel, to testify here today on S. 505, S. 507, and S. 570.

As the administrator of a 33-bed hospital, I would like to highlight in my testimony the concerns of small rural hospitals which predominate in my State.

Community hospitals in Alaska are committed to reducing the rate of increase in health care costs, while delivering high quality services to a widely scattered population. All of Alaska's communi-

ty hospitals are a part of a nationwide voluntary effort of which you are aware.

We are using this effort to contain costs. I am pleased to say that the activities of our committee have been endorsed by our State senate and we are to make a report one year from today to that senate on the status of the voluntary effort.

I would like to outline three very effective hospital techniques that our association is using and the hospitals within that association.

We have very effective group purchasing plans, we are sharing on a basis of scarce technical and professional people, we have a very effective inservice education program, both for the technical fields and for all of our employees making them aware and keeping them up in their fields of endeavor and also cost cutting techniques.

These activities illustrate methods which small isolated hospitals are using on a voluntary basis to contain costs while providing services which would not otherwise be available.

Mr. Chairman, Senator Gravel is well aware of these activities through his frequent contacts with hospital administrators and trustees in the field.

I would like to comment on S. 505. I would like to bring our discussion to a few items of special concern to small rural hospitals.

Section 2 of the bill provides for hospital reimbursement changes. For example, my hospital is a general facility with 33 beds located in a town with 2,100 permanent residents and it is a sole community provider with an occupancy rate ranging from 10 to 30 percent with patients from a service area of 450 square miles plus potential patients from a large domestic and foreign fishing fleet within the 200-mile coastal zone.

From May through October, the service population more than doubles, due to a large influx of tourists which gives a varied patient mix which influences our reimbursement patterns.

Due to the pattern of medical practice in my community, the average length of day was 3.6 days and this is much shorter than the national average.

It is hard for me to conceive how my hospital can be grouped with like institutions under Secretary Califano's system, and reflect any sense of fair play. It would not be fair to us and it would not be fair to a like hospital or like hospitals that might be grouped with us.

Mr. Chairman, section 13 of S. 505 would permit small rural hospitals to be reimbursed under medicare and medicaid for long-term care provided to patients in acute-care beds. On behalf of the small and isolated hospitals in Alaska, I endorse this provision which would add flexibility to our provision of services.

For example, when the skilled nursing home in my community is filled, as it is most of the time, patients needing long-term care must be transferred a minimum of 130 miles, at times it is several hundred miles for this case, even though beds are available in my facility.

Section 6 of S. 507 would allow the Secretary of HEW to flexibly apply certain personnel standards for small rural hospitals pro-

vided such hospitals are making good-faith efforts to comply with those requirements and to waive certain fire and safety standards, provided such waivers would not jeopardize the health and safety of patients.

Hospital administrators in Alaska want their facilities to meet the highest standards in order to provide high-quality care. Even though our institutions are for the most part small, we do not want a separate set of medicare standards but rather flexible interpretation of those that exist.

Finally, I would like to comment briefly on S. 570.

Even though hospitals like my own with fewer than 4,000 annual admissions would be exempted from controls, we oppose the legislation preferring to maintain our incentive under the voluntary effort.

We believe the concept of controls, even with exemptions, is unfair and unrealistic particularly since such controls would be applied to one industry.

Our beliefs are shared by the Anchorage *Times* as pointed out in an editorial earlier this month. I would like to submit a copy of this for the record. It is a copy of the editorial and a copy of the Senate resolution as passed by legislation.

Senator WALLOP. Without objection, they will be inserted into the record at this point.

[The documents follow:]

Introduced: 2/13/79
Referred: Health, Education & Social Services

IN THE SENATE BY HACKNEY

SENATE JOINT RESOLUTION NO. 22 HS 5-3787 HS 5-3788

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - FIRST SESSION

Applauding the Alaska hospitals voluntary cost containment efforts and requesting a progress report to the legislature."

BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF ALASKA:

WHEREAS every American is entitled to quality hospital care at a cost he or she can afford; and

WHEREAS the cost of hospital care in America is spiraling up at a more rapid pace than many other items in the consumer budget, placing such care out of the price range of many Americans; and

WHEREAS the high costs of hospital care are paid by all of us in the form of higher taxes, higher health insurance premiums, and increased out-of-pocket expenditures by consumers; and

WHEREAS this high cost pattern has been the subject of much debate on the federal level, and the potential of federal mandatory cost containment controls for all 50 states appears imminent if this pattern continues; and

WHEREAS Alaska's hospitals would be subject to such federal cost containment plans that do not always address the unique problems and needs of Alaska; and

WHEREAS many of Alaska's hospitals, through the efforts of the Alaska Hospital Association, have joined with other state hospital associations in a voluntary effort to moderate the rate of increase in health care expenditures without reducing the quality and accessibility of health care; and

WHEREAS 87 per cent of Alaska's hospitals have demonstrated substantial support and commitment to this voluntary effort, and this participation rate

is far above the rates experienced in many other states;

BE IT RESOLVED that the Alaska State Legislature wholeheartedly applauds the voluntary cost containment efforts of the Alaska Hospital Association to moderate the rising cost of Alaska's hospital care, thus eliminating the need for future federal intervention which may not be in the best interest of Alaska's citizens and hospitals; and be it

FURTHER RESOLVED that the Alaska State Legislature believes the continued exchange of information with the Alaska Hospital Association Voluntary Effort Committee is essential to the legislature's understanding of this issue, and respectfully requests the committee to report to the legislature no later than January 15, 1980 regarding its progress toward, and problems in, meeting cost containment goals.

COPIES of this resolution shall be sent to the Alaska Hospital Association Voluntary Effort Committee and the National Hospital Association Voluntary Effort Committee.

EDITORIAL PAGE

The Anchorage Times

ROBERT B. ATWOOD
Editor and Publisher

WILLIAM J. TOBIN
Associate Editor
And General Manager

CLINTON T. ANDREWS JR.
Managing Editor

Page 6 Wednesday, March 7, 1979

Threatening Quality Care

ON THE SAME DAY that President Carter issued a new call for mandatory ceilings on hospital costs, his administration announced an increase in the charges that will be imposed on people who enter and use national parks. In some cases the national park fees are to be doubled.

It was a curious pairing of announcements.

On the one hand, the president said costs to the public are too high and must be controlled. On the other, he said costs were not high enough and would be raised.

Higher maintenance costs were given by the White House as the reason national park fees must be raised.

The conclusion is interesting, because higher maintenance costs also are one reason hospitals say their rates have escalated in recent years.

PRESIDENT CARTER is correct is concluding that people are unhappy about rising hospital costs. And there is no question that it costs a bundle for good hospital care. But there are two sides to this expensive coin, and only one is being heard from the White House and from Joseph Califano, Mr. Carter's secretary of Health, Education and Welfare. The other aspect is that if hospital charges to patients are to be controlled, there also should be consideration given to controlling the costs hospitals must pay if they are to continue to provide the level of care that critically ill people demand and expect.

Just as in the case of national parks, hospital maintenance costs are up. So is the cost of complying with government regulations — an increasing burden not only for hospitals but for all businesses.

So, too, has there been a steady increase in what hospitals must pay for all kinds of goods and services — food and dietary supplies, bandages, disinfectants, electric utilities, operating room equipment, oxygen, postage stamps, towels, laundry soap and a hundred thousand other things that keep a modern hospital functioning.

Mr. Carter's hospital cost containment program, while certainly a desirable goal, does nothing to place a ceiling on the cost of such supplies and services and doesn't take into account the continuing pressure for annual wage increases for hospital nurses, technicians, clerks and other employees who need to meet inflation's impact on their own cost of living.

A REAL FEAR exists that if Congress grants the president's request for a mandatory lid on hospital charges, there is only one place that cuts can be made. That is in the quality of care.

Nobody wants that to happen — not hospital administrators, not the doctors who commit their patients to hospitals for care and treatment, and not — to be sure — President Carter and Secretary Califano.

But such a result could come if arbitrary cost ceilings are imposed without taking into account other inflationary factors that are beyond the control of hospitals.

Mr. CAMPBELL. Mr. Chairman and members of the subcommittee, I urge you not to report S. 570 to the full Senate.

This concludes my presentation. I appreciate the opportunity you have given me to present the views of the Alaska State Hospital Association and I would be pleased to respond to any questions.

Senator WALLOP. Thank you, Mr. Campbell. With the same apologies I gave to Ms. Brereton, there is a vote on now and I will have to leave.

Under the rules of the Senate Finance Committee, I can appoint the staff to hear the remainder of the testimony. I will do so while we try to find a Senator to come in under the circumstances that are now existing.

With that, I will appoint Mr. Jay Constantine to hear the remainder of the testimony. I thank you all as a panel very much for coming. There will be questions which we would like to submit to you in writing. I am intrigued with your problems with the legislation and with the circumstances which now exist.

Thank you all very much.

[The prepared statements of the preceding panel follow:]

THE STATE OF WYOMING,
DEPARTMENT OF HEALTH AND SOCIAL SERVICES,
Cheyenne, Wyo., March 8, 1979.

Hon. HERMAN TALMADGE,
U.S. Senator, Chairman Health Subcommittee, Senate Finance Committee, Senate Office Building, Washington, D.C.

DEAR SENATOR TALMADGE: I am Director of the Medicaid Program for the State of Wyoming. I appreciate the opportunity to comment on the Medicare/Medicaid Reform Bill which has been introduced in the United States Senate. I would ask that these written comments are made a part of the record.

My basic concern is the effect which this Bill would have on states such as Wyoming which are sparsely populated and have small Programs. Most legislation and regulation regarding Medicaid is passed with the large states in mind. This is certainly understandable due to the amount of expenditures. However, the same legislation and regulation applies to small programs and can be devastating when we have a necessarily small administrative staff.

A portion of the Bill is directly pertaining to the Medicaid Program and there are also indirect effects on Medicaid brought about by changes in Medicare regulations. Many of the sections of this Bill are very positive and are changes with which I agree. Since the Committee is obviously aware of these points I see no need to take up your time in commenting on them. For the sake of brevity my comments therefore will sound negative because I am raising questions only on portions of the Bill where I see a possibility of problems.

Section 2—Criteria for determining reasonable cost of hospital services

I first wish to make a point of which I believe everyone is aware but is not pointed out in the report. That is that by eliminating from this section ancillary charges it automatically eliminates approximately 50% of the total cost of hospital care. I am not suggesting any change but only pointing out a fact of which I think everyone should be aware.

The Bill states that hospitals are to be placed in categories by bed size and type of care provided to establish target rates for routine costs. I would urge that geographical classification also be included. Wyoming has always ranked 49th or 50th in the average daily cost of hospital care. Therefore, if we were to lump our hospitals by bed size with those of other states with higher costs I believe the target rate could be high enough for our hospitals that the trend may be to increase the cost of hospitalization rather than decrease it.

Section 5—Agreement by physicians to accept assignment

The fact that a physician did not accept assignment can cause a financial burden on the Medicare patient. This is brought about because the patient becomes responsible for the billed charges even though the Medicare payment may be considerably less. I do not feel, however, that the approach taken in this Bill will alleviate the

situation. This portion of the Bill simply does not offer enough incentive to induce physicians to accept assignment.

Our records indicate that, if hospital based physicians are excluded, only 10 to 15 percent of Medicare claims are assigned. This 10 to 15 percent is made up, in great part, by those patients who also are eligible for Medicaid. Obviously, it is rare for a practicing physician in Wyoming to accept assignment on a private patient. The reason for this is fairly simple. Under the Medicare method of reimbursement to physicians statewide average payment is approximately 71 percent of the physician's billed charges. If a physician accepts assignment he must accept this Medicare payment as full payment. However, on non-assigned claims he does not deal with Medicare at all and collects 100 percent of billed charges from the patient. I do not believe that an additional $1 incentive fee would have any affect on this physician's decision as to whether or not to take assignment.

In the Committee Report it quotes an example of a $10 charge on which the doctor receives an additional payment of $1 or 10 percent increase in his reimbursement. However, our records show that the average claim received from a physician is $61. Based on this, an additional $1 incentive payment is an increase to him of less than 2 percent. For example, a "participating physician" accepting assignment files a claim for $100. Assuming that our statewide average holds true Medicare would pay this physician $71 as a "reasonable charge" and an additional $1 for administrative saving giving him a total of $72 for this service. Even the additional incentive of a simplified billing and faster processing would not help this case very much because no matter what form the simplified billing takes it cannot possibly be simpler than the physician's routine billing to a private patient. I therefore do not believe the additional $1 nor simplified billing will be any incentive to the physician to agree to accept assignment on claims.

It also should be pointed out that there will be additional administrative costs to the intermediary to keep track of billing separately from "participating" and "non-participating" physicians and a separate mechanism for processing the two. I believe this section of the Act would merely add to the administrative cost with nothing to be gained. I believe the only way in which physicians can be encourage to accept assignment under Medicare is a more realistic method of determining reasonable cost which more closely approaches reasonable charges. In Wyoming, depending upon the type of practice, overhead costs in a physician's practice can run between 40 to 50 percent. Again, using a claim for $100, for example, this means that Medicare would reimburse the physician $71 on his claim, overhead would eat up approximately $45 of this amount giving him $26 over and above his cost from Medicare. This would compare with giving him $55 over his cost if he did not accept assignment. The difference in net return in this instance is over 100 percent. With these figures in mind it is understandable why many physicians are refusing to accept assignment and are sometimes reluctant to participate in the Medicaid Program where he must accept Medicaid payment as full payment.

I am pleased that the Committee is recognizing the problem. However, I do not believe the steps taken in this section of the Bill will accomplish its purpose and will only add administrative cost.

Section 9—Certain surgical procedures performed on an ambulatory basis

I am in favor of this section of the Bill as I believe it can give incentive to provide procedures on an outpatient basis rather than inpatient and therefore reducing cost. I do not believe that the waiver of co-insurance and deductible is any incentive for the physician to accept assignment in such a setting. The co-insurance or deductible is collectible by the physician whether or not he accepts assignments. Therefore the beneficiary of this waiver of co-insurance and/or deductible is the patient rather than the physician. I do not disagree with giving this benefit to the patient but do not believe it is an incentive for the physician.

Section 15—Medicaid certification and approval of skilled nursing and intermediate care facilities

This section of the Bill provides that the decision as to whether an SNF or ICF participates in the Medicaid Program or whether an SNF participates in Medicare will be made by the Secretary rather than the state agency as is currently done. I disagree strongly with this proposal.

In Wyoming approximately 60 percent of long term care beds (SNF and ICF) are occupied by Medicaid patients. Less than one-half of 1 percent are occupied by Medicare patients. I therefore do not feel that the agency with such a small participation should be the one who decides whether or not a facility is to be certified. The Medicaid Program is a state administered program. In order to be state administered decisions must be made at the state level. In Wyoming nursing

home care comprises over 60 percent of the Medicaid budget. I feel certain it would be resented by the Legislature if this hugh expenditure of state funds was being made based solely on decisions made by the Department of Health, Education and Welfare rather than on state determination.

If the responsibility for certification were given to HEW these determinations would be based completely on review of documents submitted by the state survey agency. I do not feel that it is possible to make as correct a decision by merely reviewing forms as can be made by the people who are directly involved, who know the facility and its capabilities, who have been in the facility and who have seen the patients and seen the staff of the facility. It would be a disservice to the aged nursing home population to have this decision made by someone merely reviewing paper.

It was pointed out in the Committee Report that there is a lack of uniformity in the application of federal standards. I submit that this lack of uniformity can be corrected by HEW under present regulations. The Health Standards and Quality Bureau reviews all survey documents at the present time. If they see inequities in the manner in which standards are being applied they certainly have the authority to correct them now. If the inequities exist between HEW regions, putting the same people in charge of certification will not change it. In addition, I am quite certain that if Health Standards and Quality Bureau were given the total responsibility of certification, within a very short time they would be requiring a rather large increase in staff to handle this operation. This again would increase the administrative cost of the Program.

Since the state does administer the Medicaid Program, since they do have considerable financial involvement in nursing home care and, I feel, are able to make sounder decisions on certification, I strongly urge that this section of the Bill not be passed. If inequities exist I believe they can be corrected under present administrative structure.

Section 17—Notification to State officials

This section requires notification to the governor and chairman of appropriate legislative committees when the Secretary notifies the state of any "deficiency". I do not object to the concept of this requirement but feel that "deficiency' should be qualified with some adjective such as "substantial". As the Act is written this section would require notification by HEW of all minor deficiencies. The correspondence between the state agency, the governor and the chairman of the legislative committees to explain these insignificant deficiencies would create a deluge of paper work which would be meaningless and would also dilute the effect when the deficiencies were of major importance.

Section 24—Resources of medicaid applicant to include assets disposed of at substantially less than fair market value

The purpose of this section of the Act is to allow the state to declare as ineligible an SSI recipient who disposed of assets in the prior 12 months in order to obtain Medicaid eligibility. I completely agree with the premise that such individuals should not be eligible for Medicaid but would suggest a different approach to this determination.

Wyoming, as did many other states, opted to accept Social Security Administration determination of eligibility for the aged, blind and disabled individuals by accepting all those found eligible for SSI as eligible for the Medicaid Program. The major reason for making this decision was to eliminate the costly duplication of eligibility determination. We saw no need for Social Security Administration to make a determination of eligibility for SSI and then require the same recipients to again apply for Medicaid eligibility with a second determination to be made. We still feel that duplication of eligibility determinations is wasteful. I therefore feel that the proper approach is not a change in Medicaid regulations but a change in the SSI regulations. I believe a change should be made in SSI regulations that requires an applicant to include assets disposed of at substantially less than fair market value. This would have the same affect of making them ineligible for Medicaid and would eliminate a duplicate eligibility determination for states such as Wyoming. In addition, attaching this to the SSI law would eliminate another inequity. The Committee Report correctly states that these people should not be eligible for the Medicaid Program when they have disposed assets in this manner. I also believe that they should be ineligible for the SSI Program when they have made this disposition of assets.

I have not had time to estimate the cost, but as written this bill would require a considerable increase in the number of eligibility workers to make these determinations.

I strongly agree with the concept of this section but would urge that the change be incorporation into SSI law both to eliminate the abuse to SSI and to Medicaid without requiring a duplicate eligibility determination which would increase considerably the cost to the Medicaid Program.

Section 34—A study of availability and need for skilled nursing facility services under medicare and medicaid

I only wish to comment on this section that under the previous Bill, where certification of SNF's was required for both Medicare and Medicaid, I had a disagreement. However, under this Act where only a study is required, I have not disagreement.

I hope, Mr. Chairman, the Committee will consider these comments in their deliberations of this bill. I again wish to thank you for the opportunity to present my opinions as a representative of a rural state Medicaid Program.

Very truly yours,

ERNEST A. RUMPF, Jr.,
Director, Medical Assistance Services.

STATEMENT OF C. H. WILLIAMS, M.D., OKEENE, OKLA.,

Mr. Chairman and members of the committee, I am Claude H. Williams, M.D., from Okeene, Oklahoma. I have practiced family medicine in Okeene and surrounding Oklahoma communities for 29 years. I am an active member of five hospital staffs in Oklahoma—Fairview, Woodward, Waynoka, Seiling, and Okeene. Each of these hospitals has 50 beds or less. I am also on the Board of Directors of the Oklahoma Foundation for Peer Review, the PSRO in our state, and I am Chairman of the Utilization Review Committee for northwest Oklahoma. This committee represents 26 rural Oklahoma hospitals.

I consider it a great honor to be here today representing rural medicine before this Committee and testifying on S. 505, The Medicare-Medicaid Administrative and Reimbursement Reform Act of 1979.

Mr. Chairman and members of the committee, during the course of these hearings you will hear from a number of medical experts who are far more knowledgeable about the specifics of this bill than I am. During the time allotted me, I would like to describe some specific situations, created by federal rules and regulations that make it extremely difficult for our small hospitals to survive and for me to care for my patients. In my closing remarks I will offer, what many of us consider, a reasonable solution to these problems.

As a family physician who practices in a rural community, I know well the problems my patients face. I know these people personally, and I share their concern and yours over the rising cost of health care. I feel as you do that steps must be taken to lower the rate of increase in health care costs.

I sincerely believe that our rural hospitals and community health centers are America's front line defense against illness and disease. It is at this level of medical care that the public gets the most value for its health care dollar. It is here that medical care is delivered and health care dollars are saved through preventive medicine, early diagnosis and treatment. America's rural doctors and small medical institutions are the entry point into the health care system for millions of our citizens. They are America's first line of medical care. But today our rural community hospitals and health care centers, manned by medical staffs of two to five doctors with 50 beds or less, face a desperate situation . . . desperate because of oppressive, burdensome, cost escalating rules and regulations that have been developed by and for someone else. These rules and regulations are directed at larger medical complexes, but unfortunately, they are rules and regulations that all of us are required to follow.

Rural medicine is unique. To some degree rural physicians must be all things to all people. We must conduct active out-patient clinics. We must admit, diagnose, and treat acute and self-limiting illnesses. We must practice preventive medicine. We care for the terminally ill, and we refer patients who need sophisticated treatment or diagnostic procedures to larger metropolitan centers. To a large degree we must be self reliant, and during a typical day we may be called upon to perform a number of different medical roles. To accomplish our mission, however, we must have relief from the ominous regulations that take too much of our time from patients. We are burdened with massive paperwork and the compliance with federal regulations that creates a severe drain on our professional manpower and keeps most of our hospitals in a financial crisis year after year.

Let me cite some specific examples.

I. For example, the hospitals at which I practice . . . all small hospitals with 50 beds or less . . . are required to staff the same number of committees, maintain the same kind of records, and generate the same number of reports to HEW as a 1,000 bed hospital with hundreds of doctors on its staff. This not only places a tremendous time burden on our current staff, but it also makes it difficult to recruit new doctors to the area.

Now, in addition to our medical-record keeping, our administration has been told that it must organize its accounting records to conform with the new "SHUR" regulations. This overwhelming record-keeping system will create havoc for an already strained administrative staff. Further, it is difficult for me, as a physician, to understand how this tremendously complex accounting process, requiring 68 legal size reports, can benefit patient care or reduce hospital costs.

II. The life safety code, while well intended, presents unrealistic burdens for a small, one-story, rural hospital such as those in my area. Meeting these codes costs rural hospitals between $25,000 and $50,000 per year. While the intentions of this code are good, we all know that it is the consumer, my patients, who ultimately must bear the financial burden created by these costly regulations.

III. Under the present fiscal reimbursement policy of Medicare and Medicaid, hospitals are never fully reimbursed for their costs. Even if a hospital is frugal and builds up a surplus through efficient buying and good management, Medicare will then demand that we return this surplus. This happened in one of the hospitals at which I practice even though a large percentage of the surplus was generated by patients other than Medicare and Medicaid. In this particular case our rate of return from Medicare was lowered from 82 percent to 75 percent until we again showed a deficit. At this point our rate of return was increased again to 82 percent. This practice is both counter-productive and in direct conflict with the principles of good business practice. In a not-for-profit hospital such as those where I practice, room rates are only increased in order to meet a financial crisis. Medicare's reimbursement policy makes it impossible to deal with these problems. It is a vicious circle in which rural hospitals and our patients are the losers.

IV. The regulations which have been placed on laboratories in rural hospitals are simply unworkable. Our laboratories are small and yet they perform a vital service for the people of rural America. The quality control system and daily logs which were designed for sophisticated laboratories in metropolitan health centers are simply unworkable in Okeene, Oklahoma.

These are only a few of the many problems we physicians in rural parts of the country face. There are many others, but for the sake of time, I mention only these.

Ladies and gentlemen, I sincerely hope that I have adequately explained to you the plight that rural hospitals face today because it is indeed serious. To be blunt, relief from these regulations is a must. Otherwise, America's rural health care problems will only worsen.

As I stated before, I share your concern about rising costs. I share your desire to help our hospitals run more efficiently. I share your desire to improve the type of health care which is delivered. I share your desires, but I do not necessarily endorse your methods. In the past the federal government has attempted to legislate these changes . . . to force them upon us through legislation or regulation. I share your desires, but I would much rather work with you in accomplishing common goals.

Four years ago 50 Oklahoma hospitals were faced with the very real prospect of closing their doors. Utilization review regulations handed down from Washington were forced upon the people of my state. Unfortunately for us, however, 50 of our hospitals simply could not meet these regulations. But with the help of our Senators and Representatives and Members of the Staff of this Committee, we were able to put together a superior utilization review plan. We were exempted from the unworkable federal regulations, and today these hospitals are still delivering vital care to our rural residents.

Because we were allowed to implement our own solution to the problem in the manner best suited for Oklahoma, the Oklahoma Utilization Review System proved to be one of the nation's most effective. It was implemented in its first year at a cost of $180,000 and it generated savings in the neighborhood of $15 million. Incidently, after OURS was approved by HEW as an operational PSRO and after complying with HEW's organization standards and its rules and regulations, the OURS budget jumped from $180,000 to $1.5 million. In spite of this, the Oklahoma plan which was devised and operated by Oklahoma doctors is one of the most efficient in the nation. We accomplished the regulatory objectives of utilization review without all of the burdensome regulations. We are proud of this and we believe it proves we can accomplish more by working together than we can by opposing each other.

We have similar accomplishments in our Voluntary Effort. Our rate of increase in cost per patient stay last year was 11.3 percent, down 4.6 percent from 1977. This reduction was gained without additional federal administrative effort. We think we can further decrease cost voluntarily, which is superior to several of the cost containment proposals pending before the Congress.

Ladies and gentlemen, while this presentation does not address specific sections of the legislation pending before the committee, the general theme of this testimony should be obvious—we need freedom from regulation. We need to set common goals but then be given the opportunity to develop our own methodology for accomplishing them. We need to provide incentives for improving rural health care services, not the disincentives that encumber our medical practice. We urge that you give serious consideration to the cost of implementing cost containment programs and other regulatory proposals that often serve only to place additional unwanted and unnecessary restrictions on the practice of medicine and to cause corresponding increases in its cost. We further urge you to give serious consideration to the savings which would result from deregulating the profession.

STATEMENT OF

RENEE BRERETON, DIRECTOR

MOUNTAIN PLAINS CONGRESS OF SENIOR ORGANIZATIONS

MPCSO

TESTIMONY PRESENTED BY THE MOUNTAIN PLAINS CONGRESS OF SENIOR ORGANIZATIONS.

The Mountain Plains Congress of Senior Organizations (MPCSO) is a six state senior citizen advocacy group in federal region VIII. MPCSO is comprised of six state based senior citizen membership organizations.

Health care has been a primary concern of MPCSO since its inception. The organizations advocacy thrust has previously addressed generic drug reform, Medicare supplemental insurance problems and hospital cost containment issues at the state and national level.

The MPCSO Board of Directors and staff recently have reviewed the Medicare system. The MPCSO examination of Medicare involved the interviewing of older people, examination of Medicare reimbursable levels, numerous meetings with the Federal Region VIII Medicare and H.E.W. officials, utilization of the Freedom of Information Act to obtain specific data, and other research techniques. The project was developed in response to senior citizen constituency which documented non-acceptance of Medicares assigned rates as the single most serious failure of the health system.

The research outcome as outlined in this testimony has significant meaning to Senate Bill 505, Medicare, Medicaid Administrative and Reimbursement Reform Act. MPCSO has completed an extensive research project which provides a substantive indication of the severity of the Medicare problem as it relates to physician non-acceptance of assignment. The research project included examinations of four medical procedures frequently required by older citizens. The data provided MPCSO with an opportunity to document procedural frequencies; percentage of physicians charging beyond the Medicare fee schedule; the average out-of-pocket expenditures by procedure; and the range of physician charges. The research project is particularly applicable to two sections of S.B. 505: agreements by physicians to accept assignments and criteria for determining reasonable charge for physicians' services. The following testimony outlines the research results of the MPCSO project and applies the findings to S.B. 505.

MOUNTAIN PLAINS CONGRESS OF SENIOR ORGANIZATIONS
431 West Colfax, Suite 2A
Denver, Colorado 80204
(303) 628-7270

(I) Non Acceptance of Assignment

Under the regulations for Medicare Part B, which is the voluntary part of Medicare paying for doctors' and related services for older and disabled people, doctors can accept an "assignment" of the medical bill or not as they so choose.

If the doctor does accept an assignment of the bill, he agrees to accept as payment in full the amount that the disbursing agent or "intermediary" says is a "reasonable charge. The intermediary usually is Blue Cross/Blue Shield or a private insurance company appointed by Social Security to handle claims in a specific area.

If the doctor refuses to accept the assignment he can charge what he wants and the patient himself must apply for reimbursement. The fact is that only about half the Medicare claims now are accepted as assignment by doctors, and patients often receive only half or less the amount the doctor charges.

The refusal of the majority of doctors to accept assignment and the resultant higher cost to Medicare patients has become the most bitter medical grievance of senior citizens.

The problem is growing. In 1967, nationally about 64% of all Medicare claims were accepted. Each year since then the proportion has declined until it reached 50.5% in 1977.

But the regional variations are even more striking and seniors and their families in regions with low acceptance rates are becoming increasingly resentful.

The assignment rates for the nation (by region) are as follows: (1977 data).

Region	Assignment Rate
Boston	67.6%
New York	50.2%
Philadelphia	60.9%
Atlanta	49.1%
Chicago	46.8%
Dallas	51.0%
Kansas City	39.3%
Denver	40.2%
San Francisco	52.9%
Seattle	32.5%

Even more astounding is the fact that the assignment rate varies considerably within a given region. The Denver region has the following net assignment rates by state. (1977 data)

State	Assignment Rate
Colorado	51.7%
Montana	21.6%
North Dakota	31.6%
South Dakota	30.3%
Utah	42.9%
Wyoming	17.7%

The truth is that Medicare doctor-bill insurance cannot be considered a uniform system. Whether you or an elderly or disabled relative get full reimbursement depends to a large extent on which doctor you use and where you live.

The following example outlines the extent to which non-acceptance of assignment can financially impact an older citizen. The 1978 Medicare reimbursement rate for extraction of a lens (cataract removal) was $600.00 for Colorado. If a physician charges $800.00 for the procedure, Medicare will reimburse $480.00 and the senior citizen is responsible for $320.00. This is based on Medicares 80% reimbursement of the allowable charge (80% x $600 = $480). The Medicare beneficiary pays the required 20% of the allowable charge (20% x $600 = $120) in addition to the $200 overcharge.

Whatever the reason for the significant variation in reimbursement rates between and within the federal regions, it is unfair to ask the elderly to pay higher out-of-pocket medical expenses based on a poorly designed Medicare system.

(II) Regional Variations of Medicare Reimbursement Fees.

The regional variation in levels of assignment acceptance is directly correlated to Medicare variations in reimbursement rates. While MPCSO concedes that reimbursement fees should reflect the geographic differences in the cost of living, the Department of Health, Education and Welfare has allowed the situation to become extreme.

The following chart indicates the severe fluctuation in Medicare allowable reimbursement rates for two surgical procedures. (1978 data).

PREVAILING FEE SCHEDULE
1978

Extraction of Lens State		Prostatectomy State	
Alaska	$1,009.60	Alaska	$ 960.00
New York	814.20	New York	1,085.60
Illinois	800.00	Illinois	860.30
California	787.50	California	1,153.45
Georgia	590.30	Georgia	607.00
Wyoming	562.70	Wyoming	613.90
Delaware	494.10	Delaware	518.40
Utah	426.00	Utah	355.00

The inexplainable geographic differences in fees and the fact that a large number of physicians are receiving fees substantially below the national average suggest the need for a general reform of physician reimbursement practices which would eliminate the differences and lead to a more consistent and equalized system.

The geographic variations in Medicare reimbursement rates are too extreme to be based soley on cost of living differences and malpractice insurance. These unjustifiable geographic differences have influenced the willingness of physicians in given regions to accept assignment. The result has been a Medicare system that insures beneficiaries at varying rates/ levels.

For a detailed explanation of the prevailing reimbursement system, see appendix #1.

(III) Unpredictable Quality of Medicare Part B.

The Medicare system Part B is completely unpredictable. A beneficiary has no prior knowledge of Medicares reimbursement level. The category of in-hospital surgery presents the greatest financial risk to the patient because the low assignment rates and actual cost incurred. Older people have no bases to negotiate a fee under the complicated reimbursement system. The market functions of supply and demand in addition to wise purchasing do not function as variables with the system. It is unfortunate that an older person will clip food coupons to save 10¢ but is not able to compare medical costs to save $200 - $300. The MPCSO research validated this point. For all the cataract procedures performed in Colorado in 1977, a beneficiary could be charged out-of-pocket expenses ranging from $94 to $350.00. (See Appendix #2 for specifics)

(IV) Medicare Supplemental Insurance Problems.

Based on Medicare gaps and the unpredictable circumstances surrounding physician refusal of Medicare assignment, the majority (55%) of older citizens purchase one or more Medicare supplemental insurance policies from private insurance companies. This type of coverage becomes increasingly popular in relation to the declining protection of Medicare.

However, Medicare supplemental policies are not the solution to fill the Medicare "gap". This is easily proven by the fact that supplemental policies collectively cover just over 5% of the total health care cost of older people. The Federal Trade Commission has recently prepared reports presented to congressional committees on the improprieties of this type of insurance.

MPCSO has also researched this subject by reading/analyzing over 100 policies and surveying 15,000 elderly. The research indicated the following major problems: low loss ratio figures (poor return on investment); lack of comparability between policies; fear-oriented sales practices; lack of policies that cover Part B of Medicare; a complete absence of policies to address the aforementioned assignment problem; rampart and excessive purchasing of policies; and the sale of single-oriented policies (i.e. cancer etc.).

(V) Correlation of Medicare Reimbursement Rates and Assignment Acceptance.

In more rural states with a documented shortage of physicians, the assignment rates tend to be substantially lower than the national average. This is indeed unfortunate due to the fact that rural elderly have less health care services available and they tend to have lower annual incomes from which to finance proportionately higher priced health care.

(VI) Specific Research Results.

MPCSO requested pertinent data from the Department of Health Education and Welfare for four medical procedures frequently utilized by persons over age sixty five. The data outlines the number of procedures performed and the charge for Medicare beneficiaries. (Appendix #2 details the statistical information).

From the information received, MPCSO has documented:

(a) The range distribution for physicians charges for the four procedures tested are significant.

Cataract	low $475 - $700	Percentage Spread	158%
Gallbladder	low $375 - $800	Percentage Spread	213%
Hernia	low $165 - $450	Percentage Spread	273%
Prostatectomy	low $500 - $800	Percentage Spread	160%

(b) The percentage of physicians whose initial charge is beyond the Medicare reimburseable rate is extremely high. This would be a good indication that the reimbursement levels are extremely low.

Cataract	85%
Gallbladder	72%
Hernia	87%
Prostatectomy	92%

(c) The percentage variation between the procedural mean charge and the Medicare reasonable charge was also significant. The fifth column on the following chart indicates the average out-of-pocket expenditure based on the mean charge. Column 7 represents the maximum out-of-pocket expenditures to the individual beneficiary.

MEDICARE DATA 1977

COLUMN 1	COLUMN 2	COLUMN 3	COLUMN 4	COLUMN 5	COLUMN 6	COLUMN 7
Procedure	Mean Charge	Medicare Prevailing Reimbursement Rate	20% CO-Payment	Mean Out-of-Pocket Expense	Mean Excess Charge	Maximum Out-of-Pocket Expense
Cataract	$620	$550	$110	$180	$70	$350
Gallbladder	$593	$530	$106	$169	$63	$270
Hernia	$305	$265	$ 53	$ 93	$40	$238
Prostatectomy	$687	$600	$120	$207	$87	$320

(d) The average additional charge for Part B of Medicare to the older person within region VIII was 18% or $29,276,409. This additional expense is a result of non-acceptance of Medicare assignment. Medicare requires a co-sharing payment for Part B of Medicare of 20%. The older person in federal region VIII was charged the 20% co-sharing in addition to the 18% excess charge. An example is helpful: assuming a Medicare beneficiary had $800 in Part B reasonable charges, the beneficiary pays 20% of the $800 ($160). In federal region VIII the same individual had an additional charge of $144 (18% x 800) in excess charges resulting in out-of-pocket expenses of $304. The 18% excess charge accrues to senior citizens whose doctors refuse to accept assignment. The following chart elaborates the problem:

PERCENT OF TOTAL MEDICARE PART B CLAIMS REDUCED IN NUMBERS AND DOLLARS (1977 data)

	Claims Reduced		Charges Reduced		Assignment Rate
REGION	$1,836,683	(76%)	$29,276,409	(18%)	
COLORADO	865,606	(80%)	12,556,414	(19%)	51.7%
MONTANA	234,732	(77%)	2,771,377	(19%)	21.6%
NORTH DAKOTA	269,544	(80%)	4,529,761	(19%)	31.6%
SOUTH DAKOTA	165,083	(77%)	3,448,541	(19%)	30.3%
UTAH	238,030	(77%)	4,651,825	(18%)	42.9%
WYOMING	63,588	(79%)	1,318,491	(22%)	17.7%

(VII) Prevailing Reimbursement System.

The prevailing design of the present Medicare structure encourages physicians to charge substantially higher fees regardless of their assignment practice. By physicians collectively raising their fees, the prevailing charges are set at a higher rate for the coming year. Two conclusions from this procedure are possible: (1) physicians in higher prevailing reimbursement areas have learned how to manipulate the system to their advantage and are more likely to accept assignment; (2) physicians in more rural areas have been slower to learn of the prevailing system and are hesitant to accept the lower fee payment. Whatever the reason, the state and regional variations in reimbursement are high enough to merit correction.

(VIII) S.B. 505 As applied to Region VIII (Colorado, Utah, Wyoming, Montana, North and South Dakota).

Senate Bill 505 provides several recommendations in the area of Practitioner Reimbursement Reforms. MPCSO has analyzed these provisions and provides the following conclusions:

(1) The bill provides incentives for physicians to accept assignment for all their Medicare claims. The first incentive provides the participating physician with the opportunity to submit claims in a simplified basis and the claims to be given priority handling. Medicare has an administrative overhead of 12%; surely the goal of cost containment should address the fact that all claims should be processed in the most simplified and expedient method possible.

(2) The bill provides for a payment of an "administrative" cost savings allowance of $1 per eligible patient to a participating physician covering all services included in a multiple billing listing. This incentive may be successful for the category of office visits and other less expensive medical care. For example, the mean service charge for a 1976 office visit was $13.10. The mean service reasonable charge allowed under Medicare was $10.43. In this category a $1.00 incentive payment may provide the incentive necessary to encourage a physician to accept Medicare fees. However, a majority of physicians are specialists whose fees are generated through surgical procedures performed in hospitals. The $1.00 incentive payment could very rarely provide the incentive necessary for physicians to accept assignment. In 1978, 74% of physician charges were above the Medicare reasonable charge. The mean physician in-hospital charge for 1976 was $356.33 while the mean Medicare service reasonable charge for the same time period was $281.97. It is unlikely that a physician would accept a $1.00 incentive and have his/her fee reduced by $75 on the average.

If the incentive method is to be feasible, it must be more realistic about what the medical community will respond to. In 1978, 42% of Medicare Part B was in the category of in-hospital surgery while 58% was for other services. A more uniform negotiated fee would be preferable to both the elderly and physicians. A set fee schedule would make public what Medicare reimbursement rates are. This knowledge would be useful to older citizens who could discuss the cost of a medical procedure prior to performance of that procedure.

(3) The bill also changes the criteria for determining reasonable charges for physician's services. The bill states:

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

The proposed provision could have a negative effect on rural states who currently have low reimbursement rates and only one locality for reimbursement. The philosophy to control the rapid increase in the prevailing cost increases is a good provision; however, in areas where the assignment rates are currently low the control mechanism will serve to further lower the assignment level. The same gap that is now present within and between states and regions will continue even though the rate of increase may subside.

Recommendations

MPCSO developed this research project in response to its older constituency. The 25,000 older citizen constituency of MPCSO have become increasingly vocal about the increasing Medicare gap, the unpredictable nature of Medicare, and the necessity to purchase numerous supplemental health insurance policies.

There are numerous alternatives to assist in increasing the assignment rate by physicians. MPCSO offers the following suggestions as a potential starting point for legislative reform:

(1) Change the Medicare reimbursement mechanism to be based solely on the Consumer Price Index and the variations in malpractice insurance. This would have the effect of averaging the drastic variations which now exist in the reimbursement rates between states.

(2) Develop a financial incentive which would encourage physicians to accept assigned rates. H.E.W. has the staff, data, and research capabilities to design a system that would meet with the approval of the medical community, control the flucuations of Medicare, and provide older people with improved Medicare benefits.

(3) The Medicare system could be re-designed so that physician reimbursement payments of the coming year are not predicated on charging higher fees during the current year. The current method serves only to increase the out-of-pocket expenses for the older person.

(4) Physicians and Medicare beneficiaries would benefit from public access to information regarding reimbursement fee schedules. Under the current Medicare system, older people have no prior knowledge of Medicares reimburseable rates. The majority of older people do not understand the meaning of physicians accepting assignment. The complexity and secrecy of the system precludes physician/patient communication about the cost of medical procedures. If the fee schedules were available to the consumer, the elderly would be able to negotiate assignment on a personal basis with their physician.

APPENDIX 1

The Medicare program uses a method based on "actual", "customary", "Prevailing", and "reasonable" charges, which is similar to the "Usual and customary" system.

Although the statistical computations used to generate a fee by the "Usual and customary" method vary from program to program, the Medicare "reasonable charge" system is typical: (1) First, the average of all "actual" fees charged by an individual doctor for a procedure, called the "customary" charge, is determined; (2) The "prevailing" charge is the charge which is below the highest 25 percent of the customary charges of all the doctors in the local area but above the lowest 75 percent; i.e., it is set at the 75th percentile of all customary charges; (3) The physician cannot be paid more than his customary charge or more than the prevailing charge, if it is lower than the customary charge. Whichever is lower is called the "reasonable" charge.

Under some private insurance plans and under Medicare, physicians can agree that the third party reimbursement will be payment in full for their services, i.e., that they will not attempt to collect additional payment from the patient. Under Medicare, this is called "accepting assignment." More than half of all Medicare doctors now refuse to accept assignment. If a physician not on assignment charges a fee higher than the reasonable charge, he can collect the reasonable charge from the Medicare carrier and bill the patient for the rest.

Prevailing charges reflect what physicians in the area have actually been charging. If a significant proportion of physicians raise their fees for a particular procedure, then the prevailing charge for the subsequent year will be higher. Though prevailing charges do not reveal what individual doctors are charging in particular cases, they are statistically based on an aggregation of individual fees and therefore reflect the general level of physician fees in the area, at least for Medicare patients.

The physician's financial incentive under such a system is always to charge more than both his customary charge for the previous year and the area prevailing charge. His customary charge will then stay above the prevailing charge and the next year's prevailing charge will be higher (assuming other physicians in the area behave the same way). The only limitation on increases in prevailing charges is an overall "Economic Index" which now allows prevailings for fiscal 1977 to be no more than 27.6 percent higher than fiscal 1973 prevailings. In fact, for about 70 percent of all Medicare claims, physicians charge more than the prevailing charge. The amount billed is typically 20 to 25 percent higher than the prevailing charge.

If the physician also refuses assignment and the patient can afford to pay, he can collect amounts in excess of the reasonable charge in the current year. This approach increases the physician's income at the expense of the taxpayer and frequently the patient.

CATARACT

Charge	Frequency
750	12
720	10
700	145
660	145
650	150
640	66
630	17
620	4
600	449
560	15
550	119 *
520	9
500	35
480	8
475	9

n : 1,193

ΣX : 739,875

ΣX^2: 462,238,425

$\frac{\Sigma X}{n}$: 620.18

Mean : 620.18
Median: 600
Mode: 600
S.D: 53.27
VAR. 2836

SKEWNESS $\frac{M - MD}{S.D}$ = .378

GALLBLADDER

Charge	Frequency
800	4
747	4
700	4
697	11
680	4
675	7
665	17
664	19
660	11
650	8
614	18
600	18
588	5
581	15
580	4
564	6
560	6
550	21
531	10 *
518	28
500	11
498	14
450	5
375	4

n : 254

ΣX : 150,638

ΣX^2: 90,877,436

Mean : 593.06
Median: 588
Mode: 518
S.D. 78.01
VAR. 6081

SKEWNESS = .303

HERNIA

Charge	Frequency
450	6
400	8
375	5
357	7
350	19
340	56
315	11
314	14
306	4
300	21
298	6
297	25
290	5
280	20
275	22
272	29
270	4
265	23 *
255	8
240	5
165	4

n : 317

ΣX : 96,795

ΣX^2: 30146791

Mean: 305.35
Median: 297
Mode: 340
S.D. 43.24
VAR. 1963

SKEWNESS = .196

PROSTATECTOMY

Charge	Frequency
800	89
780	14
760	7
750	78
740	8
720	23
700	300
680	221
660	146
640	118
600	48 *
560	39
500	5

n : 1,096

ΣX : 753,720

Σy^2: 521,581,000

Mean: 687.70
Median: 680.00
Mode: 700.00
S.D. 54.46
VAR. 2963

SKEWNESS = .141

Number of [illegible]: 4

Prevailing Charge: 750

[illegible]: 6

Enclosure III

JOB 5502 PART 06 OPERATION 0602

TABLE SPQ6

CY ENDED YEAR 1976 US TOTALS TYPE OF SERVICE	PLACE OF SERVICE	NUMBER OF SERVICES	SERVICE REASONABLE CHARGE LESS THAN SERVICE CHARGE NUMBER OF SERVICES	 PERCENT OF SERVICES	COUNT OF SERVICES WHERE THE NUMBER OF SERVICES IS 1 AND SERVICE REASONABLE CHARGE IS LESS THAN THE SERVICE CHARGE	TOTAL SERVICE CHARGES	MEAN SERVICE CHARGE	TOTAL SERVICE REASONABLE CHARGES	MEAN SERVICE REASONABLE CHARGES	PERCENT REDUCTION OF SERVICE CHARGES
ALL TYPES	ALL	301910220	223829300	74.1	46265560	6420450820	21 27	5128190340	16.99	20.1
MED CARE	ALL	174811180	138108360	79 0	25545560	2632517300	15 05	2084978740	11 93	20 8
	MED CARE--OFFICE	87441560	68397340	78 2	20346600	1145199980	13 10	912157220	10.43	20.3
	MED CARE--HOME	3467020	2297220	66.3	561740	52567100	15 16	42202440	12 17	19.7
	MED CARE--INPAT HOSP	72007640	59790160	81 9	1093840	1258901480	17 24	1001668640	13 72	20 4
	MED CARE--SNF	6832160	5321640	77 9	2401320	100991940	14 78	72138420	10 56	28 6
	MED CARE--OUTPAT HOSP	3059720	1739640	56 9	1088900	62861500	20 54	47299620	15 46	24 8
	MED CARE--OTHER	706380	382360	54 1	22600	5455080	7 72	4779760	6 77	12 4
	MED CARE--HHA	396560	175650	60 6	30480	6569420	22 14	4732640	15 95	28 0
SURGERY	ALL	12553685	8163620	63 0	4622140	1906871880	147 35	1513300240	116 82	20 7
	SURGERY--INPAT HOSP	4526600	3404220	75 2	2043320	1612943260	356 33	1270359200	261 97	20 9
	SURGERY--OTHER	8427060	4759400	56 5	2578820	295728620	35 09	236941140	28 12	19 9
[illegible]	[illegible]	3474220	2266400	65 2	2107780	163458640	47 05	129673500	37 32	20 7
[illegible]	[illegible]	21320620	15092760	70 5	4945900	411633320	19 29	346516700	16 33	15 3
[illegible]	[illegible]	60265780	42670320	67 5	5429360	488486540	8 11	412042080	6 84	15 6
[illegible]	[illegible]	2759420	1789540	64 8	72200	57787600	20 94	48669340	17 64	15 8
[illegible]	[illegible]	1714620	1506660	78 0	1508600	296615420	172 99	211662160	123 46	28 6
[illegible]	[illegible]	654100	496860	76 0	392220	95706200	146 32	72084640	110 20	24 7
[illegible]	[illegible]	21936220	15133320	69 2	1641800	365560520	15 27	307230640	12 83	16 0
[illegible]	[illegible]	1060	440	41 5	440	84600	79 81	65580	61 87	22 5

JOB 5502 PART 06 OPERATION 0602

TABLE SR 3 B

CALENDAR YEAR 1977 US TOTALS		NUMBER OF SERVICES	SERVICE REASONABLE CHARGE LESS THAN SERVICE CHARGE		COUNT OF SERVICES WHERE THE NUMBER OF SERVICES IS AND SERVICE REASONABLE CHARGE IS LESS THAN THE SERVICE CHARGE	TOTAL SERVICE CHARGES	MEAN SERVICE CHARGE	TOTAL SERVICE REASONABLE CHARGES	MEAN SERVICE REASONABLE CHARGES	PERCENT REDUCTION OF SERVICE CHARGES
TYPE OF SERVICE	PLACE OF SERVICE		NUMBER OF SERVICES	PERCENT OF SERVICES						
ALL TYPES	ALL	278462940	204586140	73 5	45527740	6564929260	23 58	5294391420	19.01	19.4
MED CARE	ALL	149860180	117648740	78 5	24678+0	2526232720	16 87	2027221620	13 53	19.8
MED CARE	OFFICE	75496020	58125840	77	19695030	1113810440	14 75	900980680	11 93	19 1
MED CARE	HOME	2617680	1726120	65 9	493780	44233420	16.90	35261040	13.47	20.3
MED CARE	INPAT HOSP	62360880	51124740	82 0	997160	1195715620	19 17	962845100	15.44	19.5
MED CARE	SNF	5912060	4678900	79 1	2325930	95428600	16 14	68465460	11.58	28 3
MED CARE	OUTPAT HOSP	2934120	1719200	58 6	1116480	66759780	22 75	50051080	17.06	25.0
MED CARE	OTHER	268780	84120	32 3	11130	3881740	14 89	3462440	13.28	10.8
MED CARE	ICF	276640	190660	68 4	33480	8403120	30 16	6155820	22.09	26.7
SURGERY	ALL	17721000	11837180	67 2	5234120	2064034580	116 47	1654066520	93 34	19.9
SURGERY	INPAT HOSP	7303660	5351940	73 3	2558100	1644398980	225 15	1317931840	180 45	19.9
SURGERY	OTHER	10417340	6555240	62 9	2636020	419635600	40 28	336134680	32 27	19.9
CONSULTATION		4500880	2719300	60 4	192810	174367740	38 74	143212900	31 82	17 9
DIAGNOSTIC X RAY		19339960	14642660	75 9	4603120	417307440	21 58	352568840	18 23	15 5
CLINICAL LABORATORY		53976480	35627920	66 4	5038450	479575000	8 88	404898200	7 50	15 6
RADIATION THERAPY		622480	434760	69 9	32100	94264500	15 14	78319400	12 58	16.9
ANESTHESIA		2149800	1800410	83 7	1800410	321702500	149 64	232975760	108 37	27 6
ASSISTANCE AT SURGERY		601040	458420	76 3	343040	55173320	158 35	73297340	121 95	23 1
OTHER MEDICAL SERVICES		24082140	15193620	63 1	1579560	390271460	16 20	32 80040	13 61	16 0
BLOOD CHARGES		1180	380	32 2	380	102420	86 80	91700	77.71	10.5

Senator WALLOP. I will call Mr. Andrew Miller, President of the Federation of American Hospitals.

STATEMENT OF MICHAEL D. BROMBERG, EXECUTIVE DIRECTOR AND ANDREW W. MILLER, PRESIDENT, FEDERATION OF AMERICAN HOSPITALS AND HOSPITAL CORPORATION OF AMERICA

Mr. BROMBERG. I will take less than 5 minutes and Mr. Miller will take less than 5 minutes to summarize the statement which we will submit. I will just make a few points which came up during the morning.

First of all, let me start by saying that for about the fifth year in a row, we endorse the Talmadge/Dole bill, S. 505. We think it is the only bill pending that at least seeks to address the underlying causes of inflation in the hospital field by getting away from cost reimbursement, at least one step, toward a target rate. That is the major reason we endorse it.

In contrast, we are very much opposed to S. 570 for it does not address the underlying causes of inflation but rather seeks in a very unfair way to impose stand-by caps.

We have always tried to cooperate with this committee and the chairman and the staff in terms of having endorsed with recommended modifications, measures like PSRO, planning, medicare and even national health insurance. We have never come before any committee in Congress until now and said that no amount of amendments can make a concept unacceptable but we say it today about stand-by controls.

The problem is it would impose rationing. When you take a labor intensive industry that is close to 55 percent labor oriented in terms of its costs and you then pass that through and you pass through the input prices we pay for goods and supplies, the only thing left you have to control is medical service. That is called rationing by Government and that is a physician ordered element of the hospital.

It is staggering to note that the $53 billion the administration claims this bill would save in 5 years equals nearly 200 million patient days and by 1983, it equals about 10 million admissions, one of every five expected that year.

Without arguing the merits of duplication or unnecessary services, it gets down to who shall decide and our major objection is there would be a bureaucratic nightmare here if the Secretary of HEW were made a super planner and a super hospital administrator.

One quick example; if you took a hospital in Wyoming or anywhere else with a $3 or $4 million budget, 9.7 percent would give them only about $300,000 to $400,000 to increase their costs. That is not enough to buy one major X-ray machine.

Even if planning approved it and even if the Governor approved it, they would have to fly to Washington for an exception from the Secretary of HEW and that is a major change and shift in planning from the bottom up to the top down and would be bad legislation.

The voluntary efforts have been mentioned. I would refer you to the three charts in the back of my statement which shows the major increase in hospital costs has not been price but has been

demand. As Mr. Kahn stated, S. 570 would have one-tenth of 1 percent impact on the CPI, and it could not possibly be the lynchpin of the anti-inflation program.

If they are looking at Federal spending, it is medicare and medicaid and that is what we are advocating, reforming those two programs.

Mr. Miller will summarize the end of the testimony.

Mr. MILLER. Mr. Chairman, my remarks begin on page 10 and I will move very quickly through the remaining 30 pages of our written testimony.

With all due respect to Mr. Kahn and Secretary Califano, we feel it is unfortunate that the administration has clouded the debate about hospital costs by referring to this as the key to the general inflation problem.

According to our analyses, this is simply not the case. Direct controls on hospitals would not significantly ease general inflation. In truth, such legislation would only minimally impact overall inflation in our economy.

Hospital room charges represent less than one-fifth of 1 percent of the overall CPI. All hospital charges total less than 2 percent of the Consumer Price Index. By contrast, food represents 18 percent, housing accounts for 44 percent.

The difference of the voluntary efforts goal of 11.6 and the administration guideline of 9.7 percent, once that administration guideline is adjusted up for the true inflation rate in 1979, will in all probability be less than one-tenth of 1 percent impact on the Consumer Price Index, if that.

Making hospital costs containment to lynchpin of inflation fight while not even establishing guidelines for food or housing is misleading and we think it will certainly prove ineffective.

While we all agree we cannot allow health costs to consume whatever increase in proportion of our national resources, we must exercise great care as we decide how to contain the rate of escalation in these costs, because these expenditures have significantly improved the health status of this Nation.

From 1950 to 1967, our national mortality rate stayed at around 9.5 to 9.6 per 1,000. By 1977, that rate dropped to 8.8 per 1,000, that is an 8 percent decrease and life expectancy improved from 70 years in 1967 to 73.2 years in 1977. That is a 5-percent increase.

Adjusting this data for the increase in aged population, the decrease in mortality from 1970 to 1975 which is only a 5-year period, was a full 10 percent. For our aged population, the increased longevity achieved during the last 10 years represents more than one-third of the increase in longevity achieved during this entire century to date.

This increase in life expectancy is a result of increased use of common procedures such as lab and X-ray procedures as well as development and utilization of highly specialized procedures.

We estimate that the increase in the specialized cancer treatment, special care units, open heart surgery accounts for as much as 4 percentage points of the 15 percent increase in total costs in the period of 1969 to 1977.

This is real growth. That is not inflation as some would have us believe.

Certainly since we now have laws controlling the dissemination of new services and facilities so as to meet community need without duplicating expensive services, we believe that the arbitrary rationing of medical services by HEW as proposed in Senate bill 570 is not in the public interest. Not only would this proposal add a new layer of bureaucracy and red tape on top of an already cumbersome and costly Government control process, but it is a clear conflict of interest where the major purchaser of services, that is, Government, sets a ceiling on prices, the technology. the quality and the quantity of health services that are to be made available to the public.

If Congress votes to place controls on hospital revenues, even on a stand-by basis, then Congress will be voting to establish HEW as the judge of the dollar value of increased life span, fewer fatal heart attacks, reduced infant mortality and every life saving device and technique.

Community health needs cannot be determined in advance by a Government mandated dollar ceiling. Rationing can be forced through that approach but if Congress adopts that methodology of resource allocation, it will be telling the American people that our health values have changed from assuring community health needs are met to reducing medical advances to a level set by the Federal Government based upon the advice of a few HEW economists and a select health panel, instead of by community representatives, community based consumers and professionals in the health delivery system across this Nation.

On the cost push side of our inflation problems, it is important to note that controllable costs in hospitals, wages, administrative costs, hotel costs, have been increasing at a much slower rate than those over which a hospital has little or no control and those include medical services, drugs, intensity of care, malpractice insurance, the cost of regulations and patient mix.

It is ironic that the proposed legislation under consideration today in the form of Senate bill 570 would place a ceiling on noncontrollable costs to the hospital while exempting the largest cost component, the one which is controllable by the hospital and that is labor costs.

This proposal would also memorialize an unfair advantage in favor of those States whose hospitals have heretofore consumed a disproportionately high share of health resources. Massachusetts is the best example of that and that point was made earlier.

I was going to give a compliment on the staff's paper which was attached, the recommendations document.

Mr. CONSTANTINE. Do not hesitate on our account.

Mr. BROMBERG. I thought you would allow me the time.

We have included comments on that paper in pages 25 through 40 of our testimony. The conclusion of our testimony is that we feel the HEW plan is indeed dangerous to the Nation's health because it would control and restrict not only price but the quality and availability of health services to all Americans.

We urge the Congress to exercise its oversight authority and monitor the industry's voluntary effort during 1979.

Stand-by controls are unnecessary because the Congress will always be here to pass mandatory controls when and if they become necessary.

In addition, we urge the Congress to reform the medicare and medicaid reimbursement system by passage of S. 505 to provide incentives for cost containment. We urge the gradual phasing out of cost reimbursement and increased experimentation with predetermined rates established by competitive formula and negotiation.

Thank you.

Mr. CONSTANTINE. Just one question. The emphasis has been that one of the primary reasons for inflation is the so-called cost plus reimbursement by third party payers and that 90 percent of hospital bills are paid by third parties.

One of the things the staff has been exploring is the idea of tying any overall limitation to a reimbursement approach rather than a regulatory approach. That is, if a rational approach could be developed under medicare for reimbursement or medicaid, why could we not then permit third party payers, such as the private health insurers, to voluntarily contract with the Secretary of HEW and then reimburse hospitals on that controlled basis with the hospitals having to accept that reimbursement as full payment, adjusted for certain items of expense which they are willing to recognize and which medicare does not, such as maternity, corporate overhead, bad debts. The insurers would have to agree to pay the hospitals on the same incentive and penalty basis as is proposed in S. 505.

That would keep it on a reimbursement basis. It would mean the private health insurers would have an opportunity to gain the same cost control benefits as the millions of people under medicare and medicaid have and it would be a means of providing efficient and inefficient differentiation essentially across the board.

Mr. BROMBERG. I think it would take a long time to answer that question adequately.

There is a very simple explanation in the Congressional Record in a speech by Senator Dole which I think in part starts to get at it. He said if the Government is going to buy a fleet of cars, he wants someone to go out and make the best deal possible. Let's assume it would be GSA.

That does not mean we should put controls on the automobile industry.

What he did not say is if you go out and buy an automobile for $5,000 and I follow you into the store and buy 100 automobiles or a fleet, and I get a discount and buy them at $4,000 each, in effect, you are subsidizing my $4,000 purchase price. I am getting a really good deal and indirectly you are paying a hidden tax and subsidizing my purchase.

That is what is happening with medicare and medicaid.

If what you propose happened to hospitals, they would all go bankrupt. We could do it with one-third of our patients because medicare deserves some kind of a discount for volume. We can argue as to whether it has been abused already.

People who buy in large quantities get a discount. If everybody did it, hospitals would go under.

The real question is why do we need to go beyond medicare and medicaid? The commercial insurers and the Blues have the power

to contract on their own. They are not using it and we have to find out why.

Second, if the only reason for this bill, if Mr. Kahn and the administration say they do not want stand-by controls for anyone else because it is inflationary, the only reason I have heard today is because we are noncompetitive. Who made us noncompetitive? The reason for the noncompetitiveness, according to Mr. Kahn, is 60 percent of our revenues come from cost base plans, 90 percent from third parties but 60 percent of it is cost reimbursement.

Forty percent or 80 percent of the 60 percent comes from medicare and medicaid. They are the ones that said we are going to go cost reimbursement and maybe for good reasons at the time.

If they would change to a Talmadge/Dole approach with a target rate, that would end that argument and it is the same Government that made us noncompetitive that is now saying because you are noncompetitive, we need to regulate you.

Mr. CONSTANTINE. It would be interesting to see the response of the private health insurers to an opportunity to move along on a costs, penalty-incentive basis and whether their reaction would be different.

I know I speak for Senator Talmadge in apologizing for his not being here. He got jammed up in a hot debate going on in the Senate. I know he and other members wanted to hear you and I am sure you will be calling on them in their offices anyway.

Mr. BROMBERG. I hope you tell Senator Talmadge how pleased we are to see him back and also how pleased we are to be here testifying in a real legislative committee room in the Senate Office Building for a change.

I would ask that our statement be incorporated in the record.

Mr. CONSTANTINE. It will be inserted into the record at this point.

[The prepared statement of Mr. Bromberg follows:]

STATEMENT OF MICHAEL D. BROMBERG, EXECUTIVE DIRECTOR, AND ANDREW W. MILLER, PRESIDENT, FEDERATION OF AMERICAN HOSPITALS

FEDERATION OF AMERICAN HOSPITALS SUMMARY OF RECOMMENDATIONS ON S. 505

In contrast with the Administration proposal, the Medicare-Medicaid Reimbursement Reform bill, reintroduced by Senators Talmadge and Dole, represents a major step forward in making those programs more cost efficient. It is an innovative, imaginative plan reflecting an examination of both cause and effect as a necessary adjunct to proposed solutions. The measure correctly presupposes that incentive-based competition—not self-defeating caps—is essential to alleviate escalating costs in the health sector.

We endorse the general approach of Section 2 which includes economic rewards for efficiency. By establishing a target based on average routine costs, the proposal, as already noted, seeks to inject competition among similar facilities.

The staff recommends immediately imposing standby controls on ancillary services. While less drastic than the Administration's plan, this recommendation presents the same difficulties and inequities. Standby ceilings on ancillary service revenues per admission absent any incentives for efficiency would once again cause the standby ceiling to become the floor, penalize those who have been efficient in the past, be ineffective as a cap if appropriate exceptions for intensity are granted, and cause confusion and additional expense for hospitals attempting to comply with complicated new controls.

Any proposal to expand cost containment to Medicare ancillary services should include the reform provisions of S. 505 classifying providers, setting of target rates and financial rewards for efficiency.

The hospital-medical industry is the only major sector of the economy that can point to a significant deceleration of inflation during 1978. If Congress responds to our good faith effort by imposing standby controls on the only industry to successfully reduce its inflation rate, then the faith of hospitals in the objectivity of Congress will be shattered and the result will be another increase in size and regulatory power for HEW.

The Administration's program would require a massive new layer of bureaucracy to administer controls—the very thing the President claims he wants Congress not to legislate for all other industries. If standby controls are a good idea for hospitals, then why not impose standby controls on food, housing, and education which are experiencing an inflation rate in excess of the hospital rate?

For these reasons no amendments can make standby revenue controls logical, practical, or acceptable.

We are convinced that S. 505, as presently drafted, offers the best legislative hope for moderating cost increases without harming the quality of hospital care. We also believe that if Medicare-Medicaid reimbursement reforms are effective, then private charges and revenue increases will be contained automatically since overall hospital revenues and costs bear a reasonable relationship.

On behalf of the members of the Federation of American Hospitals, we would like to thank the Committee for this opportunity to present our views on proposed reforms of the Medicare and Medicaid programs and on hospital cost containment.

I am Michael D. Bromberg, Executive Director of the Federation. Accompanying me is Andrew W. Miller, President of our organization and Senior Vice President for Administration of Hospital Corporation of America, one of the world's largest hospital management companies.

The Federation of American Hospitals is the national association of investor-owned hospitals, an industry with 1,000 hospitals in the United States and over 110,000 beds. In addition, our member hospital management companies now manage under contract over 250 additional hospitals, including teaching institutions, public, religious and other community non-profit hospitals.

As tax paying institutions, investor-owned hospitals have been particularly interested in modern professional management of our nation's health facilities. S. 505 recognizes the need to amend the Medicare and Medicaid programs in order to provide economic incentives for effective and efficient management systems in participating hospitals. We commend the Subcommittee Chairman and the ranking Minority Member for their leadership in proposing these meaningful incentives.

S. 505

In contrast with the Administration proposal, the Medicare-Medicaid Reimbursement Reform bill re-introduced by Senators Talmadge and Dole, represents a major step forward in making those programs more cost efficient. It is an innovative, imaginative plan reflecting an examination of both cause and effect as a necessary adjunct to proposed solutions. The measure correctly presupposes that incentive-based competition—not self-defeating caps—is essential to alleviate escalating costs in the health sector.

INCENTIVE REIMBURSEMENT

We realize that much of the impetus for reform of Medicare-Medicaid stems from increasing Congressional insistence that these programs operate in a manner that is as cost efficient as possible. Replacement of the current, highly inflationary system of retrospective payment would be our primary recommendation for reforming institutional reimbursement.

The Federation of American Hospitals has long favored increased experimentation with prospective payments for hospital services based on negotiated rates or target rates established by a formula. Our association favors a major overhaul of the Medicare-Medicaid reimbursement system for institutional providers; however, we also believe that experimentation on a national basis involving several prospective payment methods is necessary to determine appropriate long range systems.

We generally support the determination of a target rate for routine operating costs as outlined in Section 2 of S. 505, with the following suggested revisions:

We endorse the general approach of Section 2 which includes economic rewards for efficiency. By establishing a target based on average routine costs, the proposal, as already noted, seeks to inject competition among similar facilities.

S. 570

The standby control bill is the only major legislative proposal which the Federation representatives have urged Congress to totally reject during the 13 years in

which we have testified here. On every subject from Medicare to health planning, and from PSROs to national health insurance, we have endorsed the general concept and tried to offer constructive suggestions for shaping legislation which we could support. We cannot do this with regard to proposed federal ceilings on hospital budgets because government rationing of health services is, in our opinion, dangerous and illogical.

The proof that rationing will necessarily result from this bill is as follows:

1. This bill sets a limit on total hospital expenditures of 9.7 percent which is based on an inflation allowance (7.9 percent) plus an allowance for population growth (0.8 percent) and intensity (1 percent). Since the inflation allowance is to be adjusted based on actual inflation, the limit is essentially inflation plus 1.8 percent for volume. Therefore, since volume has been increasing at about 7 percent per year for the past decade, the limit assumes a 5.2 percent gain in total productivity in the very first year and every year thereafter, or else mandatory controls will become effective. Contrast this productivity goal with the fact that in 1978 the overall productivity in the United States was just over 1 percent and is expected to be about 1 percent in 1979.

2. It is clear that hospitals have no realistic hope of achieving this 5 percent productivity goal and, therefore, they will be forced to reduce the quantity and quality of services they provide. This is rationing, pure and simple.

3. The potential amount of rationing required to achieve the 5 percent goal is absolutely frightening. The Administration's stated goal of $60 billion in savings over a five year period is equivalent to over 200 million patient days. In 1983 alone it amounts to a reduction in service equivalent to 10 million admissions, which is one of every five expected in that year.

It is clear that the burden of the cutback in hospital services will fall squarely on the largest and most rapidly growing segment of hospital patients—the elderly and the poor.

Furthermore, this bill assigns to hospitals the job of rationing without any standards being set to govern who shall get what care. In a society where the definition and treatment of illness and disease have been rightly assigned to the physician, any effort to regulate the quantity and quality of treatment without the physician being involved and without standards being set by society raises moral and ethical questions of the first order.

For these reasons no amendments can make standby revenue controls logical, practical, or acceptable.

Most legislators do not want to be "budget busters." However, this legislation goes far beyond federal spending and seeks to place controls on the private sector by covering all patients and all services. Those seeking to reduce federal spending for Medicare and Medicaid would better achieve this goal by reforming these programs, particularly the inflationary cost reimbursement system. The federal government has a responsibility to establish a rational system for paying providers of hospital services for beneficiaries of Medicare and Medicaid. Cost containment incentives and amendments are needed in these federal programs and we urge you to support legislation to achieve those needed reforms but to reject any legislation for controls on non-government revenues.

The President, in his State of the Union message, called upon Congress to reduce federal regulation. The Federation agrees with the President's statement to Congress that "America has the greatest economic system in the world. Let's reduce government interference and give it a chance to work." We are asking for the chance to let the industry's Voluntary Effort program work without counterproductive standby controls.

The Administration's Hospital Cost Control bill sharply contradicts the President's message to Congress. Its unrealistically low voluntary guideline figure would certainly trigger a mandatory program of hospital cost controls. Such a program would require a massive new layer of bureaucracy to administer controls—the very thing the President claims he wants Congress not to legislate for all other industries. If standby controls are a good idea for hospitals, then why not impose standby controls on food, housing, and education which are experiencing an inflation rate in excess of the hospital rate?

VOLUNTARY EFFORT

The Voluntary Effort was organized by the Federation of American Hospitals, the American Hospital Association and the American Medical Association in late 1977 in response to public concerns and governmental challenges for cost containment. A national Voluntary Effort Steering Committee was established including business, supplier, health insurer, county government, and consumer representatives. A fif-

teen point program was adopted including a primary goal of reducing the rate of increase in total hospital expenditures (15.6 percent for 1977) by four percentage points over a two year period.

The 1978 rate of increase in total expenditures will be about 12.8 percent—well below our goal of 13.6 percent and represents a savings of about $1.5 billion. Our 1979 goal is 11.6 percent and industry leaders at the national, state and local level are working hard to achieve this goal. The ultimate goal of the Voluntary Effort is to narrow the gap between the rate of growth in hospital expenditures and the Gross National Product. That gap has been substantially narrowed based on an estimated GNP rate of growth of 11.6 percent in 1978. (See Table I.)

Prices for medical services, including hospital charges, rose 8.8 percent in 1978 compared to the Consumer Price Index increase of 9.0 percent. (See Table II.)

The success of the Voluntary Effort cannot be disputed. The Department of HEW can substitute one data source for another or develop a new index, but the facts are clearly set forth in Medicare-Medicaid outlays for hospital services and in budget savings.

The Administration and Congress deserve much of the credit for prodding the health industry into successfully reducing inflation but it would be dangerous economic and medical tampering to replace the prodding with counterproductive standby controls.

Enactment of standby mandatory controls on hospital revenues will undermine the Voluntary Effort in several ways. It would be an expression of lack of confidence in the industry's proven record of voluntary restraint. That would lead to anticipatory price increases. It would also intensify the adversary relationship between government and hospitals and produce a flood of exception applications rather than fostering a spirit of cooperation and voluntary restraint.

The hospital-medical industry is the only major sector of the economy that can point to a significant deceleration of inflation during 1978. If Congress responds to our good faith effort by imposing standby controls on the only industry to successfully reduce its inflation rate, then the faith of hospitals in the objectivity of Congress will be shattered and the result will be another increase in size and regulatory power for HEW.

INFLATION

The Administration has set Hospital Cost Containment as a legislative priority in the battle against inflation.

Unfortunately, the Administration has clouded the debate about hospital costs by referring to this as an inflation problem. This is simply not the case. For the period 1969-77, hospital inflation (that is, the rate of increase in the average cost of individual hospital services) averaged 8 percent, while the Consumer Price Index averaged 7 percent—a negligible difference. The real reason for the above average growth in hospital expenditures is volume. Over the period 1969-77, the volume of hospital services increased by 7 percent. Thus, the Administration, through failure of analysis or lack of candor, has misleadingly lumped together the 8 percent rate of inflation and the 7 percent growth in volume, to create an utterly false impression that the rate of hospital inflation is 15 percent.

This numbers game has a clear message. Guidelines will be made lower and lower in order to enable government to claim that voluntary efforts are a failure and to pull the trigger which gives broad regulatory power to the Department of Health, Education and Welfare to ration medical services.

Moreover, direct controls on hospitals would not significantly ease general inflation. In truth, such legislation would only minimally impact overall inflation in our economy.

Retail hospital room charges represent less than one-fifth of one percent (0.162 percent) of the overall CPI (Bureau of Labor Statistics). All hospital service charges total less than two percent of the CPI. By contrast, food costs constitute 17.7 percent of the overall CPI and housing accounts for 43.9 percent. (See Table III.) Thus, it is clearly demonstrated that making hospital cost containment the lynchpin of the inflation fight, while not even establishing real price guidelines for food or housing, is misleading and will prove ineffective.

Achieving even the 9.7 percent limit sought by the Administration would not significantly reduce the overall increase in the CPI, since retail hospital charges comprise such a small part of the total CPI figure. It would take a tremendous increase in hospital prices to even impact perceptibly on the inflation problem as measured by the CPI. Rather than singling out the hospital industry, which through its Voluntary Effort program has efficiently reduced its rate of growth, the Administration should direct its resources and legislative efforts towards segments of the

economy that greatly affect the consumers of this nation. Only by focusing on the major factors contributing to inflation will the President be able to bring the general rate of inflation under control.

We strongly oppose the Administration's proposal because it would add inflationary and complicated standby revenue controls over hospitals and would adversely affect the success of the health industry's voluntary program to contain hospital costs. If mandatory controls are triggered, an arbitrary and unnecessary "cap" on hospital revenues would be imposed.

Under such a standby cap, hospitals would actually be encouraged to raise their costs and charges expecting to have a revenue limit implemented the following year.

Briefly, there are ten basic reasons for opposing the Administration's proposed standby mandatory revenue controls on hospitals.

(1) Revenue controls on a single industry are unfair. If the prices paid by hospitals for supplies, equipment, services, construction, interest, and labor are uncontrolled, the cost of providing hospital care cannot be controlled.

(2) Revenue controls on a standby basis dependent upon a triggering mechanism will cause anticipatory price increases similar to those which occurred throughout the economy in 1971 when Congress authorized such controls.

(3) Revenue controls which place a ceiling on volume of care but which exempt wages are in fact controls on medical practice. Hospital management has no legal authority to restrain physician ordered care.

(4) Hospital controls mean an increased HEW bureaucracy, more regulation, and more paperwork, exception requests and litigation in an industry already overregulated at costs estimated up to 25 percent of the daily cost of a hospital.

(5) The hospital industry was the only major industry which voluntarily reduced its rate of inflation in 1978.

(6) Passage of a standby control bill would undermine the successful Voluntary Effort and would be a negative response to good faith efforts by the health industry to reduce inflation.

(7) The proposed legislation contains no positive incentives or basic reforms in the government cost reimbursement system which has fueled inflation.

(8) Hospital controls would do little to restrain general inflation because hospital prices are less than two percent of the Consumer Price Index compared to food—17.7 percent, housing—43.9 percent, and transportation—18 percent.

(9) Limits on hospital revenues will block needed life saving technology and postpone modernization projects, even though these projects will cost much more at a later time because of inflation in construction costs and equipment.

(10) The threat of future Congressional action is an adequate incentive to make the Voluntary Effort successful, but standby controls based on data gathered by and decisions made by HEW would be counterproductive.

Examining the voluntary guideline for limits on hospital expenditures proposed by the Administration, we find several serious flaws.

According to the Congressional Budget Office estimates, the 7.9 percent rate of inflation for the market basket of goods and services purchased by hospitals assumed by the Administration is optimistically low. The Congressional Budget Office predicts that this rate of inflation will climb to 8.9 percent and others believe it will be higher. Consequently, the program would not achieve the HEW predicted savings of $1.7 billion.

The voluntary guideline figure also fails to account for the expected increase in the aged population of this country and their need for more frequent and more costly hospital care than those under age 65.

The guideline sought by the Administration would place the hospital industry below the GNP rate of growth (11.6 percent for 1978). The ultimate goal of the Voluntary Effort and the White Paper on Inflation published by the Council on Wage-Price Stability is to eventually narrow the gap between hospital expenditure increases and the GNP rate of growth.

When Medicare and Medicaid were first enacted 14 years ago, and until quite recently, Congress perceived its role to be one of increasing and assuring access for the elderly and the disadvantaged to quality health care. That public policy decision combined with a cost base payment mechanism triggered the demand-pull inflation which is the major reason for these hearings.

The hospital industry has simultaneously been hit with severe cost-push inflationary pressures for the past ten years and, in particular, following the expiration of the economic stabilization program in early 1974. Those major pressures included catch-up wages in a labor-intensive industry; escalation of prices for the goods and services purchased by hospitals, particularly in food, fuel and malpractice insurance; a rapidly changing medical technology in which new diagnostic and therapeu-

tic techniques and expensive new equipment are centered in the hospital; inflated material costs for hospital modernization and expansion programs; the increased cost of borrowing capital; and most importantly, increased cost of compliance with government regulations.

Many industries have been faced with similar cost-push inflationary pressures, but none, to our knowledge, have been subjected simultaneously to the demand-pull pressure similar to that triggered with the Medicare and Medicaid programs. These programs pay each hospital based on that hospital's actual operating cost. This obviously provides no incentives for efficient management and it encourages every hospital to provide every service. Hospitals are actually under a Congressional mandate to make only the best and latest in services available to our elderly and indigent populations. It should be a surprise to no one that hospital cost increases substantially exceeded the general economic growth rate over the last 14 years.

These expenditure increases have, however, significantly improved the health status of our total population and dramatically improved the health status of our over 65 population.

From 1950 to 1967 our national mortality rate stayed at 9.6 to 9.5 per 1,000. By 1977 that rate dropped to 8.8 per 1,000 (an 8 percent decrease) and life expectancy improved from 70 years in 1967 to 73.2 years in 1977 (a 5 percent increase).

Adjusting this data for the increasing aged population, the decrease in mortality from 1970 to 1975, only a five year period, was a full 10 percent.

For our aged population, the increased longevity achieved during the last ten years represents more than one-third of the increase in longevity achieved to date during this century.

The increase in longevity is the result of the increased use of common procedures such as lab tests and X-rays as well as a rapid growth in the development and utilization of highly specialized procedures. Specialized treatment includes organ transplants, open heart surgery, intensive care and coronary care units, renal dialysis, radiation and chemotherapy techniques, microsurgery, neonatal intensive care, burn units, hip replacements, and heart pacemakers. Taken together, these specialized procedures have significantly increased the quality of health care in the United States. They also provide a rational explanation why total costs are growing. To be more specific, we estimate that the increase in specialized cancer treatment, added special care units, open heart by-pass surgery, and renal dialysis account for almost four percentage points out of the fifteen percent increase in total costs over the period 1969-77.

While we all agree that we cannot allow health costs to consume an ever-increasing percentage of our national resources, these costs have generated substantial benefits and great care must be exercised as we decide how to contain the rate of escalation. In recent sessions the Congress has very methodically and deliberately addressed these problems. Duplication of services and the proliferation of expensive equipment were dealt with very effectively with the passage of Public Law 93-641, which is taking effect according to the legislative timetable and which is beginning to achieve the desired results. Utilization review and quality assurance problems were addressed with Public Law 92-603. While the impact of that law has not been as significant as some would have expected, improvements are being achieved. We are hopeful that this Congress will deal with the need for reform of the Medicare and Medicaid program to the extent of implementing incentive payment mechanisms which would penalize inefficiency and reward the effective providers.

Certainly since we now have laws controlling the dissemination of new services and facilities, so as to meet community needs without duplicating expensive services, we believe that the arbitrary rationing of medical services by the Department of Health, Education and Welfare as proposed in S. 570 is not in the public interest.

Not only would this proposal add a new layer of bureaucracy and red tape on top of already cumbersome and costly government controlled processes, but there is a clear conflict of interest when the major purchaser of services—government—sets a ceiling on the prices, the technology and the quality and quantity of health services to be made available to the public.

If Congress votes to place controls on hospital revenues, even on a standby basis, then Congress will be voting to establish HEW as the moral judge of the dollar value of increased life span, fewer fatal heart attacks, reduced infant mortality, significant survival rates for cancer patients, and every life saving device or technique.

Community health needs cannot be determined in advance by a government mandated dollar ceiling. Rationing can be forced through that approach, but if Congress adopts that approach to resource allocation, it will be telling the American people that our values have changed from assuring that community health needs

are met to reducing medical advances to a level set by the federal government based on the advice of a few HEW economists and a select panel instead of community representatives, consumers, or health professionals all across this nation.

On the cost-push side of our inflationary problems, it is important to note that controllable costs in a hospital (wages, administrative, hotel services) have been increasing at a much slower rate than those over which the hospital has little or no control (medical services, drugs, intensity of care, malpractice insurance, cost regulations and patient mix). It is ironic that the proposed legislation under consideration today would place a ceiling on non-controllable costs of the hospital while exempting the largest cost component and one which is controllable by the hospital—labor costs.

Certainly the proposed bill would do nothing to decrease the cost of goods and services hospitals must purchase, and to our knowledge, government regulation has never been shown to improve the efficiency of an industry. In fact, the opposite is often the case. The deregulation of the airline industry is the most recent example. If we assume that HEW is not going to tell us how to operate our hospitals more efficiently, then how will the savings projected for this bill be realized?

In our opinion, the projected savings can be achieved only if hospitals:

Postpone replacement of obsolete equipment;

Postpone modernization of antiquated physical plants;

Postpone the addition of new services, regardless of community needs;

Eliminate services again regardless of community needs;

Eliminate high cost, low profit services regardless of need;

Eliminate services requiring long length of stay, regardless of need; and

Postpone elective surgeries.

In other words, only by decreasing the quality and availability of health services can any savings be realized.

In addition, hospitals would be rewarded under this bill if they could:

Increase unnecessary short-stay, low cost admissions;

Decrease the number of high risk intensive care patients treated; and

Decrease the level of indigent care provided.

Further, this ceiling with its automatic wage pass-through would encourage higher wages.

Mr. Chairman, this proposal calls for a major reduction of hospital services, with no standards as to what groups shall bear the brunt of the reductions, except the elderly who are a certain target. It also memorializes an unfair advantage in favor of those states whose hospitals have heretofore consumed a disproportionately high share of hospital resources.

Such states will, throughout the duration of the guidelines established by this legislation, receive a fixed percentage of their historically higher hospital expenditures, while other states, whose historical consumption of hospital resources has been considerably less, will receive that same fixed percentage increase on a much lower expenditure base.

Using a proposed 9.7 percent guideline, for example, in 1979 Massachusetts will be allowed expenditure increases per admission of $233 compared to $106 in Utah, a difference of $127 per case. Surely this difference cannot be accounted for by a cost of living difference. Moreover, the difference expands in future years. By 1982, Massachusetts will be allowed an increase of $288 per case versus $137 for Utah, a difference of $151 per case.

Those who claim that deceleration in hospital expenditure increases has largely resulted from existing mandatory cost controls in nine states fail to take into consideration the fact that most of those states rank among the top ten in highest cost per case. Massachusetts has achieved the dubious distinction of having the highest hospital costs of any state in the Union, while New York leads the nation in hospital bankruptcies and insolvency with 80 percent of its hospitals running at a deficit. Other states with no mandated controls over hospitals have achieved reductions in total expenditure increases which are better than those of the regulated states.

Other objections to S. 570 include the following:

There is no time limit or sunset provision on the trigger or the controls once triggered.

There is no administrative appeal procedure.

There is no procedure for challenging the Secretary's data or decision to impose mandatory controls.

There is no adjustment under the individual hospital trigger for increased population, patient mix, increased admissions, approved expansion of services, modernization or any other item of needed but unique cost.

Once mandatory controls are triggered, there is no recognition of increased intensity in calculating the ceiling on revenue per admission.

There is no exception for insolvency.

There are no guidelines on how the Secretary is to develop the various numerical ceilings in the bill.

There is no coverage of Veterans Administration, military or public health service hospitals.

S. 505 SUGGESTED MODIFICATIONS

The incentive feature of Section 2 should be amended so that the bonus payment is not restricted to 5 percent of the average routine operating costs. Instead, hospitals whose costs are below the target should be reimbursed for actual costs plus one-half the difference between their costs and the average for their category. Thus a hospital whose costs are $80 per day, as opposed to a $100 group average, would receive a bonus payment of $10, rather than $5. We believe that the 5 percent limit lessens the potential impact of the program and can be deleted without impairing its overall cost effectiveness. Barring this, we recommend that the incentive features of Section 2 be broadened to provide for provider retention of savings of up to 7.5 percent of the first $100 of routine operating costs and up to 5 percent of any excess. This would place even greater emphasis on efficiency by reducing the reward for high cost institutions compared to lower cost facilities. A sliding scale for incentive payments is more equitable because it would make the dollar rewards more uniform for all hospitals.

The legislation provides for an adjustment to the average per diem routine cost for are a wage differentials. This is a most important adjustment since payroll costs represent about 55 percent of total hospital costs. We recommend that the bill be clarified by including a definition of the word "area" to assure that the adjustment is made for community differentials within states.

The restrictions on reimbursement for those hospitals with routine costs more than 15 percent above the group average should be more flexible. The exception procedure should assure that no institution is penalized for costs beyond its control. Inefficiency should be penalized but unforeseen or uncontrollable events should be defined and recognized as justifiable causes for cost increases.

Where the restrictions on reimbursement are imposed, the facility should be allowed to charge the program beneficiary for the difference between the reimbursement ceiling and its actual costs. This is particularly important since the bill stipulates that hospitals may not increase their rates to other payors in order to offset Medicare and Medicaid reductions resulting from implementation of the legislation. Without such relief, hospitals would be forced to absorb these extra costs. The rising cost of health care should be a matter of concern—and shared responsibility—to all of us. That includes stimulating public awareness through increased out-of-pocket expenses, and government recognition that someone must pay for increased Medicare-Medicaid benefits.

The legislation would exempt from the proposed reimbursement system those states which have effective rate setting agencies with authority over all classes of purchasers. The bill requires that the state program results in lower aggregate Medicare and Medicaid costs than would otherwise be incurred. If the federal costs turn out to be higher than under the federal formula, the state exemption provisions of S. 505 provide for recoupment of excess payments by the federal government through reduction of the adjusted target rate for all hospitals in the previously exempted state. This sanction should not be applied to hospitals whose reimbursement from the state was less than it would have been under the federal formula. Otherwise, efficient hospitals would be penalized twice.

An evaluation of the long-range efficacy of state rate review programs has yet to be completed. We would, therefore, recommend that this exemption for state programs be deleted. If an exemption for state programs is provided, we recommend that only those states with a minimum of two years of experience in rate review prior to enactment of S. 505 be considered for an exemption. At least that much time would be required to establish a workable system generating sufficient data for the Secretary to review.

Furthermore, the test should not be whether or not the state system results in lower Medicare and Medicaid costs alone, but if the system is expected to result in a long-range reduction in the total cost increases of all classes of purchasers. Otherwise there is an incentive for states to mandate further discounted rates for government subsidized programs, with hospitals forced to absorb the difference.

With regard to the method for determining a group average, we believe that as this average decreases over time, due to the incentives incorporated in the bill, it

may become too harsh. Ultimately, more and more hospitals could be penalized. To prevent this, we recommend that two years after the program is in place the target per diem be based on the average plus 10 percent.

We strongly recommend a change in the provision in S. 505 allowing the Secretary, on advice of the Health Facilities Cost Commission, to modify methods of Medicare-occupancy of more than 5 percent.

Another concern is that recognition needs to be given to difference in treatment modality for psychiatric facilities. The legislation should require the Secretary to take into account the treatment modality of psychiatric hospitals and give recognition to the variation in personnel needs demanded by the different programs.

For example, a psychiatric hospital that has extensive shock treatment modality will have a very different pattern of personnel requirements than a psychiatric facility that has programs which have millieu therapy treatment. Yet these are all accepted and recognized treatment modalities for mental health care.

We urge the Committee to recommend a "hardship" exception for other "unforeseen and uncontrollable" events which cause significant cost increases.

CONTINUED EXPERIMENTATION

We believe that the performance-based reimbursement system outlined in S. 505 represents a major step in making Medicare and Medicaid more cost efficient. However, it is essentially not a system of prospective rates. We believe that if payments are to be closely related to actual costs, they should be made on a predetermined basis. Therefore, although we favor the implementation of the target rate scheme proposed in S. 505, we recommend that the Secretary be directed to engage in an intensive program of experimentation along prospective lines. Experimentation on a national basis involving several prospective rate methods is necessary to determine appropriate long range systems.

The concept of a predetermined rate for specific treatments on a per diem or per admission basis by diagnosis is one example of the type of prospective rate system we believe should be developed and tested. Other examples include a negotiated rate; a negotiated discount from billed charges with a negotiated inflation rate for subsequent years; and a rate review process limited to facilities whose rates exceed a percentile of group charges or costs.

RATE OF RETURN

We urge the Committee to amend the Medicare law to create a mechanism for the annual determination of a reasonable rate of return on investment. The Medicare rate of return should be equal to investments of comparable risk in other industries.

Adequate rate of return is necessary for a number of reasons, most importantly to: (1) protect the hospital's financial integrity and maintain its credit; (2) reward investors at a level commensurate with the risk assumed in making their investment; and (3) attract new capital for maintenance and needed expansion.

In no other industry are income taxes not recognized as an operating expense for purposes of cost based reimbursement or rate of return. By eliminating income taxes as a reimbursable cost, the Department of HEW has effectively reduced the return on equity for investor-owned hospitals to approximately 12 percent on a pre-tax basis or an after-tax return of approximately 6 percent.

The Federation recently contracted with ICF, Inc., a Washington based consulting firm, for an in-depth study on rates of return on equity in industries comparable to the investor-owned hospital industry.

The summary of findings by ICF includes the following conclusions:

(1) For comparable risk industries, the estimated range of an after-tax return on equity was between 11 percent and 16 percent.

(2) For investor-owned hospitals, this range implies a multiplier of 3.7 of the Hospital Insurance Trust Fund rate, rather than the rate in the proposed legislation.

(3) Depending upon the level of Medicare cost adjustments which represent necessary costs of doing business but unallowable by Medicare, the multiplier required to achieve reasonable returns for investors would be between 5.2 and 8.6.

We urge you to consider these alternative approaches to improve the current Medicare rate of return on investment:

(1) Provide for an annual determination by the Secretary of a return equal to rates of return on investments in industries of comparable risk;

(2) Recognize income taxes as an allowable cost of doing business, reimbursable under Title XVIII; or

(3) Increase the current formula to at least 3.7 times the trust fund yield.

CONVERSION ALLOWANCE

The Federation supports that provision of the bill which encourages closing or converting under utilized beds or services by including in the hospital reasonable cost payment reimbursement for costs associated with closure or conversion. However, in the case of for-profit hospitals, only increased operating costs would be recognized; capital costs would be disallowed.

We believe that regardless of ownership, hospitals should have both their capital and increased operating costs associated with closure or conversion recognized. To differentiate on the basis of ownership raises serious constitutional questions. If there are two hospitals located in a community—one a non-profit, the other investor-owned—and the community believes that the investor-owned facility should be closed or converted to another use, the provision as presently stated provides no incentive for the investor-owned hospital to acquiesce. No facility can be expected to shut down and retire its debt without benefit of income. The question should be "What is best for the community?" Then all costs connected with closing or converting the facility—regardless of ownership—should be recognized.

This provision is initially experimental, limiting transitional allowances to only fifty hospitals prior to January 1, 1983. The Secretary would review all recommendations forwarded by the Hospital Transitional Allowance Board; however, there would be no appeal to the Secretary's final decision. We recommend that when the program becomes more than experimental, these decisions become subject to judicial review.

In addition, we recommend that total hospital closures be given priority under this voluntary program. Little or no dollar savings will be realized from closing some beds within an institution, but significant savings can be realized if an entire facility is purchased for fair value and closed.

HOSPITAL-BASED PHYSICIAN REIMBURSEMENT

Insofar as control of physician reimbursement is concerned, we can understand the desire to discourage potential abuse or excessive payments by limiting the reimbursement for certain hospital based physicians. However, we believe that the actual method of payment—be it fixed fee, or percentage, lease, or direct billing arrangements—should be left to the discretion of hospital management. By restricting payments to a fixed fee, many rural areas might be unable to attract the services of these specialists.

We would not, however, be opposed to screens being applied to the final result of the hospital physician negotiations using a technique similar to the 75th percentile of the prevailing payment levels in the area.

Finally, there should be a "grandfather" clause covering all contracts made prior to enactment of S. 505 between hospitals and hospital based physicians.

HOSPITAL CONTRACTS

Section 19 provides that no cost or charge will be considered reasonable for purposes of reimbursement under Title XVIII or XIX if it represents a commission or finder's fee or an amount payable under rental or lease arrangement where payment is based on a percentage arrangement. The Federation objects to this provision which covers consulting and management contracts for the same reasons it rejects the restrictions imposed on contracts with hospital based physicians. We believe that these are matters properly left to the discretion of the hospital's administrator and board of trustees.

Section 2 of the bill precludes the need for the kind of line-by-line budget examination proposed in Section 19. Under the proposed target rate, the concern is properly placed with the total cost, not with all the individual components that go into that final figure. Hospitals are given incentives to come in under the target rate, or at the very least make sure that their per diem routine operating costs do not exceed 115% of the average rate determined for their category. This factor in itself serves to prohibit the negotiation of contracts that are excessive. We, therefore, recommend that Section 19 be deleted altogether from S. 505.

HOSPITAL PROVIDERS OF LONG-TERM CARE SERVICES

We believe that the stated purpose of Section 13 of S. 505—to make better and more flexible use of under utilized hospital beds in rural areas by permitting their conversion to long-term care beds with appropriate reimbursement—is an excellent one. We would suggest, however, that this provision be amended to delete the requirement that limits the section to hospitals with less than fifty beds. Since a certificate of need would be required prior to conversion, planning authorities would not be faced with a surplus of long-term care beds. Therefore, we do not think that

the potential success of this provision should be blunted by the currently suggested fifty bed limitation.

STAFF ALTERNATIVES

"Prudent buyer" of supplies

The Committee staff recommends establishing a maximum allowable cost limit for routine supplies based on median prices. We agree that hospitals should avoid costly and wasteful purchasing practices. Many investor-owned providers presently save costs by shared purchasing through chain organizations with which such hospitals are affiliated. However, current tax provisions prevent independent investor-owned hospitals from joining with non-profit providers to jointly purchase goods. Non-profit hospitals might risk losing their tax exempt status. We recommend Congress change this discriminatory provision in the tax code. This would allow investor-owned providers to expand their use of shared purchasing of supplies, aiding their efforts to reduce hospital expenditures.

Plus payment factor

The Finance Committee staff also recommends eliminating any plus payment factor unless the Secretary approves payment based on specific evidence. The staff believes that Medicare and Medicaid reimburse hospitals for a disproportionate share of costs related to malpractice insurance and routine nursing care.

However, there are many hidden costs for which the Medicare and Medicaid programs do not presently reimburse hospitals. The federal government, for example, does not pay fully for the personnel hospitals require to handle the additional paperwork related to Medicare and Medicaid. These programs also do not reimburse hospitals for any share of non program bad debts incurred, although these are patient incurred costs.

Therefore, elimination of any cost plus payments should be balanced against those hospital costs the federal government presently fails to reimburse.

Many existing studies support the nursing differential and we suggest that the Committee conduct or request additional studies before acting on this provision.

Proposed expansion of S. 505

The staff recommends immediately imposing standby controls on ancillary services. While less drastic than the Administration's plan, this recommendation presents the same difficulties and inequities. Standby ceilings on ancillary service revenues per admission absent any incentives for efficiency would once again cause the standby ceiling to become the floor, penalize those who have been efficient in the past, be ineffective as a cap if appropriate exceptions for intensity are granted, and cause confusion and additional expense for hospitals attempting to comply with complicated new controls.

In addition, the specifications for expanding S. 505 to revenues from ancillary services share these inequities with S. 570:

Hospitals have no legal authority to control the volume of services ordered by physicians which a cap on revenues ignores;

Standby controls would lead to anticipatory price increases; and

Passage of standby controls would undermine the successful Voluntary Effort and would be a negative response to good faith efforts by the health industry to reduce inflation.

Any proposal to expand cost containment to ancillary services should include the reform provisions of S. 505 classifying providers, setting of target rates and financial rewards for efficiency.

We are convinced that S. 505, as presently drafted, offers the best legislative hope for moderating cost increases without harming the quality of hospital care. We also believe that if Medicare-Medicaid reimbursement reforms are effective, then private charges and revenue increases will be contained automatically since overall hospital revenues and costs bear a reasonable relationship.

CONCLUSION

The HEW plan is potentially dangerous to our nation's health because it would control and restrict not only price, but the quality and availability of health services to all Americans.

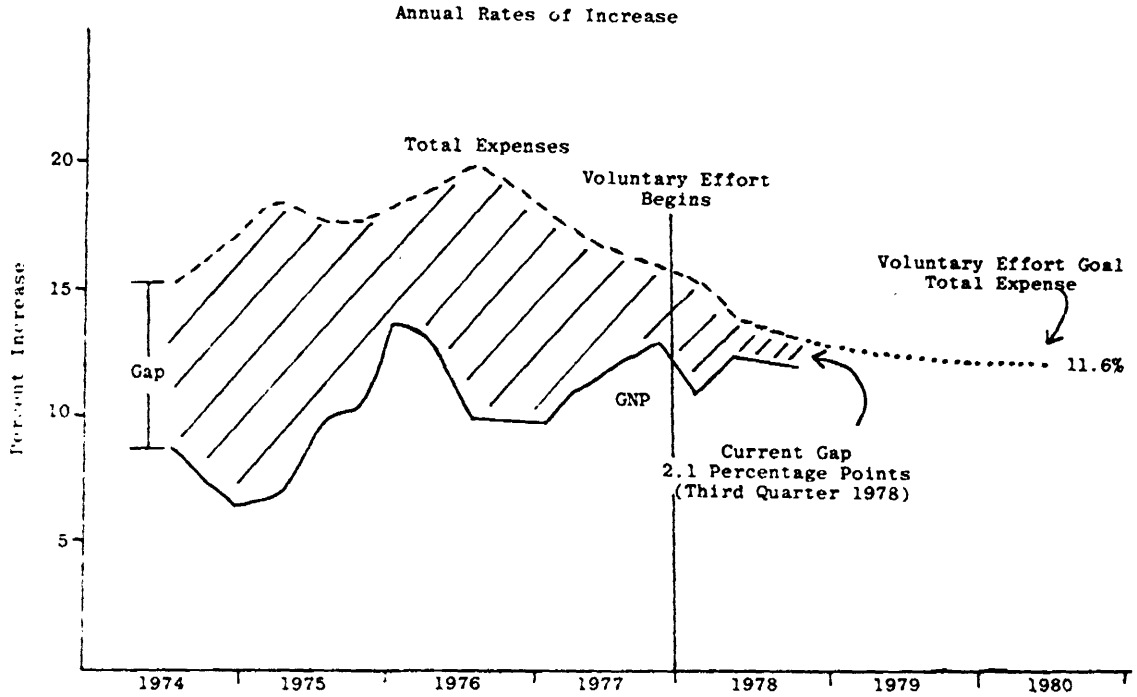
We urge the Congress to exercise its oversight authority and monitor the industry's Voluntary Effort during 1979. Standby controls are unnecessary because Congress can always pass mandatory controls if and when it is considered necessary.

In addition, we urge Congress to reform the Medicare and Medicaid reimbursement system by passage of S. 505 to provide incentives for cost containment. We also urge a gradual phasing out of cost reimbursement and increased experimentation with predetermined rates established by formula or negotiation.

We thank you for this opportunity to present our views on hospitals costs.

(TABLE I)

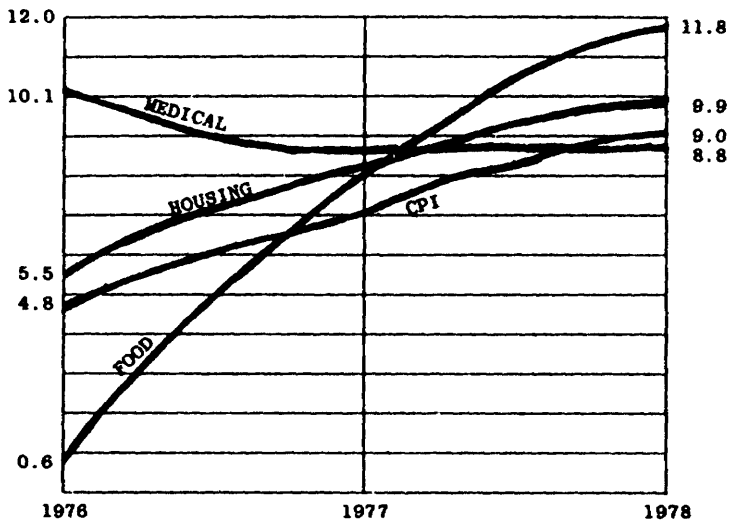
GROWTH RATES OF TOTAL COMMUNITY HOSPITAL EXPENSES
AND GROSS NATIONAL PRODUCT (GNP)



Source: National Hospital Panel Survey (Total Expenses)
U. S. Department of Commerce (GNP)

(TABLE II)

Food	0.6 to 11.8
CPI	4.8 to 9.0
Housing	5.5 to 9.9
Medical	10.1 to 8.8



Source: Consumer Price Index

(TABLE III)

MAJOR WEIGHTS/RELATIVE IMPORTANCE CPI COMPONENTS

		Percentage			
All Items					100
I.	Food and Beverage				18.814
	Food			17.719	
	Alcoholic Beverage			1.095	
II.	Housing				43.908
	Shelter			29.183	
	Fuel, other utilities			6.510	
	Household furnishings and operation			8.215	
III.	Apparel and Upkeep				5.800
IV.	Transportation				18.028
	Private (new, used cars, gasoline, maintenance, repair)			16.931	
	Public			1.097	
V.	Medical Care				4.969
	Drugs and Prescriptions			.858	
	Medical Services			4.111	
	Professional Services (phys., dentists, etc.)		2.008		
	Other Medical Services		2.103		
	Hospital and other medical services	0.355			
	Hospital Room	0.162			
	Health Insurance	1.748			
	HMO	0.144			
	Comm./Phys.	0.187			
	Comm./Hsp.Rm.	0.184			
	Comm./Other	0.201			
	Comm./Retrained earnings	0.150			
	BC/BS-Phys.	0.212			
	BC/BS-Hosp.Rm.	0.206			
	BC/BS-Other	0.225			
	BC/BS-Retrained earnings	0.041			
	Other unpriced	0.197			
VI.	Entertainment				4.086
VII.	Other Goods and Services				4.395
	Tobacco			1.202	
	Personal Care			1.752	
	Education			1.441	

Source: U. S. Department of Labor, Bureau of Labor Statistics News Release, December 22, 1978, Table I, Page 6, CPI - 11/78.

Mr. CONSTANTINE. The next witness is Morton D. Miller, vice chairman of the board of directors of Equitable Life on behalf of the Health Insurance Association of America. I might point out Dr. John Cooper who is president of the Association of American Medical Colleges has agreed to postpone his testimony today. The committee will schedule the AAMC and the Council of Teaching Hospitals as the initial witness tomorrow morning.

STATEMENT OF MORTON D. MILLER, VICE CHAIRMAN, BOARD OF DIRECTORS, EQUITABLE LIFE ASSURANCE SOCIETY ON BEHALF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. MILLER. Thank you. It is a pleasure for us to be here before you today. I thought in the interest of time that maybe we ought to abbreviate our statement and have it entered into the record. I will merely refer to our conclusions at the end of our statement.

We are as concerned as anyone with the rising costs of health care and have looked at this matter very seriously in the past. We have in our testimony some specific comments with respect to both S. 505 and S. 570. They are responsive to the concerns that we all have and each has much to offer.

As our testimony suggests, we feel both are deficient in a number of respects as you will see. Having said that, I would say we join very strongly with Senator Nelson and Senator Talmadge in the hope that the best provisions of both of these bills can be melded into one legislative proposal which all of us can support and therefore assure the speedy passage of this most necessary legislation.

In that respect, the Health Insurance Association through its staff and its member companies would be pleased to assist the committee and its staff to perfect such a proposal and assist in any other appropriate way.

We would also like to have your permission to submit a somewhat lengthy statement commenting on other aspects of the bill for the record.

Mr. CONSTANTINE. Yes. Your prepared statement will be inserted into the record.

Senator Dole had several questions. Did you have an additional statement, Mr. White?

Mr. WHITE. I would like to submit a statement later with respect to medicaid and medicare provisions. I have not had a chance to meet with the other companies involved in medicare. We will do that and submit a statement later.

[The following was subsequently supplied for the record:]

COMMENTS WITH RESPECT TO THE MEDICARE PROVISIONS OF S. 505, SUBMITTED BY THE HEALTH INSURANCE ASSOCIATION OF AMERICA

Section 4—Federal participation in hospital capital expenditures

We support the linkage of the capital expenditure review procedure for Medicare and Medicaid reimbursement to the health planning structure created by Public Law 93-641, The National Health Planning and Resources Development Act of 1974. We are concerned about the provision granting the Secretary of DHEW authority to include, as an allowable item of reimbursement, costs associated with unapproved capital expenditures under certain circumstances. We feel that proper review and appeal procedures established by Public Law 93-641 are a preferable solution.

Section 5—Agreement by physicians to accept assignments

The concept of "participating" and "nonparticipating" physicians seems logical on the surface. The proposed simplified billing form could be an administrative monstrosity if all other requirements under existing rules and regulations must be met.

An alternative approach which might have more appeal to the physicians would be to provide that reasonable charge determinations for participating physicians be based on the 90th percentile rather than the 75th percentile. To improve administrative procedures, it might be required that participating physicians code all claims. We recommend that a participating physician agreement may be terminated only upon 90 days' notice to the Secretary in order to provide sufficient time for the carrier to make the necessary administrative changes in its participating physician profile.

Section 6—Hospital-associated physicians

We note with approval that this section now applies to both Medicare and Medicaid and encompasses all hospital-based physicians.

We are in agreement with the need for further control and, from a conceptual viewpoint, the provisions address themselves to real problems.

We repeat our recommendation that consideration should be given to providing that reimbursement to all hospital-based physicians be made on the basis of reasonable cost to the hospital with payments to the hospital under Part A of Medicare.

Section 7—Use of approved relative value schedules

Recent consent decrees secured by the Federal Trade Commission pertaining to the use of relative value schedules by several professional societies have caused confusion as to the legality of the usage of such schedules. They are, however, an essential element in claim processing and clarification permitting usage, as outlined in this provision, is most welcome. We share the goal of achieving uniform coding and terminology, but suggest carriers be given sufficient leeway to add, delete or modify such coding and terminology, as required by administrative exigencies.

Section 9—Certain surgical procedures performed on an ambulatory basis

We endorse this provision.

Section 10—Criteria for determining reasonable charge for physicians' services

We agree with the provision in this section for the improvement of the reimbursement to physicians in physician shortage areas, but we do have some concern about other provisions of this section.

The application of a new limit on locality prevailing charges in addition to the limit established by the economic index factor may further discourage the acceptance of assignments by physicians. We do not have a statistical evaluation of the impact of this proposal as set forth in this section of the bill. While it is understandable that the Federal Government wishes to control increases in benefit payments, the impact on beneficiaries should be considered. If the proposed approach does, in fact, further limit annual increases in prevailing charges, with further decreases in the assignment rates, the elderly beneficiary will be hit even harder than he now is for out-of-pocket expenses. Because of the unknown degree of impact, perhaps this proposal should be deferred. Alternative methods of determining benefit payments under Medicare should be investigated to arrive at the best possible solution from the beneficiary's standpoint.

We recommend that existing law be changed to provide for the updating of physician profiles and prevailing charges on a semi-annual basis. The current system of annual updating on July 1 of each year based on charges rendered during the prior calendar year produces an excessive time lag. This is a disincentive to the physician in his consideration of whether to accept assignment of benefits.

Section 11—Payment for antigens under part B of medicare

We support this provision.

Section 12—Payment on behalf of deceased individuals

We completely endorse this proposed change.

Section 18—Repeal of section 1867

Perhaps consideration should be given to a restructuring of this council in order to provide input to the Secretary of Health, Education, and Welfare with respect to the problems of Medicare and Medicaid and other governmental health programs from interested and knowledgeable public representatives.

Section 20—Ambulance service

We agree with this provision.

Section 23—Disclosure of aggregate payments to physicians

Routine disclosure of such information serves no useful purpose. Therefore, we wholeheartedly endorse this proposal.

Section 24—Resources of medicaid applicant to include assets disposed of at substantially less than fair market value

We endorse this provision.

Section 25—Rate of return on net equity for for-profit hospitals

We support this provision.

Section 27—Payment for laboratory services under medicaid

We endorse this provision.

Section 29—Repeal of 3-day hospitalization requirement and 100-visit limitation for home health agencies

We support this change.

Section 30—Payment for durable medical equipment

We have serious reservations about the proposed new reimbursement method for durable medical equipment. In addition to customary charge calculations, highly variable supplier operating data must now be included such as acquisition costs, overhead and a "reasonable margin of profit." This latter term requires a more precise definition. These data elements are also difficult to determine and could require a supplier cost report to substantiate. In addition, reasonable charges would be calculated on a prospective basis.

If prospective calculations are used in an attempt to reduce the difference between the suppliers charge and the Medicare allowance for an item, then we would suggest other medical specialties will insist upon the same consideration. Just as some Medicare beneficiaries face payment gaps in durable medical equipment they frequently face even larger differences in the reimbursement for surgery due to the time lag in allowable charges.

Section 31—Development of uniform claims forms for use under health care programs

We endorse this provision.

Section 32—Coordinated audits under the Social Security Act

We agree with this provision.

Section 36—Coverage under medicare of optometrists services with respect to APHAKIA

We support this provision.

Mr. CONSTANTINE. These are Senator Dole's questions.

He wondered if you would comment on the recent action of Blue Cross Association with respect to a policy concerning payment for routine laboratory tests which were considered unnecessary, given the patient's diagnosis and so on.

Has your association encouraged similar actions?

Mr. MILLER. I would say in a general way. Our contracts state that we are only paying for such services as are necessary for medical treatment and care. Through our claims review process, we look very closely at each of the claims submitted to us and pay only when we satisfy ourselves that the procedure or the X-ray or test was necessary for the situation.

Mr. CONSTANTINE. I suspect the question, and this is my comment and not Senator Dole's, was more toward Blue Cross' assuming a more aggressive policy now and whether your people are adopting or considering adopting a somewhat similar policy with respect to routine testing.

Mr. MILLER. We have something of a disadvantage with respect to Blue Cross and Blue Shield. They have contracts with the providers which we do not have. Under present trust law, we cannot enter into those.

Mr. CONSTANTINE. You heard the staff's suggestion about a voluntary means of contracting.

This is another question from Senator Dole. The commercial insurance industry has indicated in the past an interest in legislation to permit them to work more cohesively as a group without antitrust liability.

He wanted your comments with respect to your present position regarding antitrust immunity or authorization for joint activity.

Mr. MILLER. We do have an interest in such an authorization. We have had such a proposal before the Judiciary Committee and I might say this matter first came up when we testified before Senator Kennedy about a year and a half ago. We brought out the fact that we do have this impediment in not being able to aggregate our activities and our support for certain things by reason of the fact that the antitrust law prohibits such activity.

In response to Senator Kennedy's suggestion, we have advanced a proposal for a limited exemption from antitrust liability for the steps that we might take. They are all outlined in what we have proposed with respect to claims cost control.

If you have not seen those, we would be pleased to submit them to you.

Mr. CONSTANTINE. I think the committee would like that for the record.

[The following was subsequently supplied for the record:]

AUTHORIZING INSURER JOINT ACTION FOR HEALTH COST CONTAINMENT

I. BACKGROUND

The health insurance industry is regularly asked why it does not use its massive buying power to help control rising health care costs.

Insurers agree that it would be desirable and in the public interest for this to happen. But although the health insurance industry has made important contributions toward cost control through benefit plan design, involvement in health planning, support for Health Maintenance Organizations, and health education, insurers have been unable to use their buying power leverage to accomplish much in the way of genuine cost containment.

The reason lies in the highly competitive structure of the industry. In 1976, the largest health insurer, Prudential, underwrote only some 3½ percent of the health insurance business measured by premium volume. The business of the top ten insurance companies totaled only 21½ percent and the top twenty companies totaled less than 28 percent. (See Appendix A.) Since these companies operate in 50 states and may have insured patients in any of 7,000 hospitals, their individual buying influence in any particular hospital is limited.

As stated by Alain C. Enthoven, Marriner S. Eccles Professor of Public and Private Management, Graduate School of Business, Stanford University, at the June 6, 1977 Federal Trade Commission Conference on Competition in the Health Field:

"The creation of organized systems that can compete effectively requires a certain amount of aggregation of consumer buying power in a market area, so that someone can negotiate for economies in the hospitals and for fees and utilization controls with the doctors. If there are too many third-party intermediaries, then none of them will represent a large enough percentage of hospitals' or physicians' business to be able to influence the providers' behavior."

Why then don't the insurance companies combine their efforts and negotiate jointly with the hospitals?

The answer lies in health insurance industry concern that joint efforts to exert effective cost control measures in the health care system might be alleged by

affected providers of health care or by enforcement agencies to be acts in restraint of trade. The statutory prohibitions against anti-competitive action contained in the Sherman Act and the Federal Trade Commission Act have been given broad application by the courts.

Any formal or informal agreement or concerted action to fix prices or to shape products, undertaken by persons normally considered to be competitors in a given area of commerce, is very likely to be found in violation of the antitrust laws. Laudable motives may not constitute a defense. Thus there is reason to be concerned that actions taken with regard to benefits paid by insurance companies, charges for health services made by health care providers, and the sharing and exchange of cost control data might result in costly litigation and damages under these statutes unless an appropriate exemption is provided.

The practical result of this antitrust limitation is that insurers are hamstrung when it comes to working jointly to constrain health care costs. They can collect data, educate and (to some extent) exhort, but they must stop short of anything that could be construed as informal agreement or concerted action in restraint of trade. For example, insurers already collect considerable data regarding physicians' fees and treatment patterns in the process of determining what constitutes reasonable and customary charges. That data could be used to establish common schedules or ceilings for reimbursement to providers or to establish utilization guidelines, but that would likely violate current law.

Ironically, this constraint faced by health insurers (and self insurers) is not a problem for the other major payors of health care—the Blue Cross/Blue Shield plans, and the Medicaid and Medicare programs. In the case of the Blues, the plans have been able through their individual and collective buying power to negotiate hospital discounts, physician fee schedules backed up by assignments, and utilization standards setting out limitations on certain procedures. The government has likewise been able to exercise sufficient bargaining and regulatory power in the Medicaid and Medicare programs so that its reimbursement levels have been below the rates charged to other payors. The effect of this has been to leave the commercial health insurance industry and its policyholders to "take up the slack"—paying hospitals and physicians at rates in excess of those paid by the Blues or by government. Commercial insurers and their policyholders are being effectively forced to cross-subsidize other payors because these insurers cannot collectively use their buying power to bargain with providers. As a result, in some parts of the country the differentials between "charge patients" (those insured by commercial companies or by self-insurers, or self-paying individuals) and "cost patients" (the Blues and the government enrollees), are in excess of 30 percent. Not only does this situation badly skew the competitive process between the Blues and commercial insurers, but it reflects a gross inequity forced on certain policyholders as a result of governmental law and regulation.

II. A PROPOSAL FOR A LIMITED ANTITRUST EXEMPTION

The health insurance industry believes that it should be authorized to engage in joint cost containment activities. Such an authorization, providing a limited exemption from the antitrust laws, would serve the public interest through helping to contain the rise in health care costs, would improve competition among classes of payors, and would return basic equity to a system in which commercial insurance policyholders are being forced to bear unfair cross-subsidies.

Specifically, insurers should be authorized to undertake three types of cost containment activities.

A. *Health information activities.*— Insurers should be authorized jointly to collect, analyze and use information on the quality, cost or utilization of health care services, including the development of customary, reasonable or preferred fees or utilization practices as guides for insurance reimbursements to providers. In other words, commercial insurers should be able to join together, as other payors now do, to assemble data and to decide what and how much to pay.

B. *Negotiations and agreements with providers.*— Insurers should also be empowered collectively to negotiate with health care providers to develop fee schedules and utilization standards. It should further be possible for insurers jointly to contract with review organizations to provide binding peer review and concurrent hospital review for private patients and to provide data to such organizations.

C. *Benefit provisions.*— Agreements among insurers should be authorized to permit the elimination of benefit provisions which have become cost-ineffective (e.g., replace any requirement of prior institutionalization before surgery with an ambulatory surgical benefit), or to permit the addition of new provisions which have cost containment potential (e.g., second opinion surgery or pre-admission testing). Insur-

ers should be permitted to agree to include such provisions in all contracts; in this way, no one insurer would face a competitive disadvantage by making such a move.

The proposal is not limited to insurers, but includes all third-party payors, including self-insured employer plans, union welfare plans, and HMO's. These payors should be included not only as a matter of equity but because of the significant role they have to play in the medical economies of many communities.

This proposal is not a cure-all and will not solve all the problems of rising health care costs. Many hospitals will understandably be reluctant to negotiate with insurers even if insurers are permitted to negotiate jointly. And in some areas of the country all the commercial insurers combined do not have a sufficient leverage to negotiate effectively with hospitals. This is particularly true in parts of the industrial northeast where Blue Cross dominates the private under-65 market through its hospital discount and there is a high proportion of Medicare and Medicaid patients. As a result charge patients in many large northeastern urban hospitals now represent less than 10 percent of the patient population. (Charge patients include not only the commercially insured but those under employer or union self-insured plans, and self-paying individuals.)

The insurance industry, therefore, strongly recommends the enactment of federal legislation requiring each state to establish hospital prospective budget review in addition to the proposed amendment. Under such a system each hospital would only have one negotiation with the hospital cost control commission. The state would control the system in the public interest and the insurance industry could participate in the process and monitor the system. Hospitals would have lower administrative costs since they would have only one audit and one negotiation. The commission would set charges equitably among payors to the benefit of all citizens within the state.

If legislation enabling third-party payors jointly to undertake cost containment activities is passed, it will take considerable lead time to develop, test, and perfect the mechanisms to carry out this new responsibility. The industry, therefore, strongly recommends its early consideration and enactment as an amendment to the pending hospital cost control legislation.

ATTACHMENT A

Health insurance data derived from the National Underwriter, May 28, 1977

1. All health insurance except Blue Cross/Blue Shield, et al. (premiums earned less dividends)	$22,808,380,470
2. Blue Cross and other hospitalization organizations (earned subscription income)	13,737,743,000
3. Blue Shield and other medical-surgical organizations (earned subscription income)	9,155,880,000
Total	45,702,003,470

NU health insurance rankings by company (total health premiums) for 1976

Company:	*Percentage of total*
1. Prudential	3.64
2. Aetna Life	3.25
3. Travelers	3.20
4. Metropolitan Life	2.19
5. Connecticut General	2.11
6. Equitable Life	2.00
7. Mutual of Omaha	1.76
8. Provident Life & Accident	1.16
9. John Hancock	1.14
10. Continental Assurance (CNA)	1.09
Top 10 companies total percentage	21.54
11. Occidental Life of California	0.89
12. Lincoln National	.86
13. Bankers Life & Casualty	.73
14. New York Life	.72
15. Combined Insurance of America	.61
16. Bankers Life, Iowa	.58
17. Washington National, Illinois	.52

	Percentage of total
18. Allstate	.49
19. Pacific Mutual Life	.49
20. Union Labor	.48
Second 10 companies total percentage	6.37
Top 20 companies total percentage	27.91

DRAFT STATUTE FOR AN ANTITRUST EXEMPTION FOR HEALTH COST CONTAINMENT ACTIVITIES

Section 1. Short title

This chapter may be cited as "The Health Care Cost Containment Act of 1978."

Section 2. Declaration of policy

The availability of high quality health care in the United States is a national priority of the highest magnitude that is being frustrated by the dramatic, disproportionate and continual increase in the cost of such care. The availability and shared use of detailed information concerning the quality, utilization and cost of health care services and the cooperative efforts of persons in the private sector are crucial to the containment of rising health care costs. Yet, federal and state antitrust laws currently inhibit efforts by insurers, health benefit purchasers, and health care providers to undertake effective health cost containment activities. It therefore is the policy of Congress to retard the growth of health care costs and to help assure the availability of high quality health care by encouraging cooperation in the public interest among insurers, health benefit purchasers, and health care providers.

Section 3. Definitions

As used in this chapter:

(a) "Antitrust law" means the Federal Trade Commission Act and each statute defined by 15 U.S.C. 44 (1970) as "Antitrust Acts," all amendments to such Act and such statutes, any other statutes in pari materia.

(b) "Fees or fee schedules" means any amounts, or any schedules specifying or formula for determining the amounts, to be charged by health care providers, or to be paid by insurers, for the provision of particular health care services.

(c) "Health benefit purchaser" means any employer, labor union, agency or employee representation committee, association, or any other organization or group of any kind which purchases insurance or provides payment or reimbursement for health care services for a group or groups of individuals.

(d) "Health care provider" means any person or entity which provides health care services, or any association of such health care providers.

(e) "Health care service" means any item or service encompassed within the definition of "medical care" in 26 U.S. C. 213(3)(1)(A), or such other item or service as determined by the Secretary.

(f) "Health cost containment activities" means the participation in, or development, negotiation, establishment, use, publication or review of—

1. Fees or fee schedules;

2. Treatment and utilization standards;

3. Insurer reimbursement arrangements or insurance policy provisions;

4. Insurer arrangements for the reporting, acquisition, storage or processing of information on the quality, cost or utilization of health care services; the analysis and interpretation of such information, including the determination of past, present, prospective, prevailing, customary, reasonable, acceptable or preferred levels of the quality, cost or utilization of such health care services, or the dissemination, publication or use of such analyses and interpretations; or the centralized collection or distribution of insurance claims for such health care services; or

5. Any combination of the foregoing.

(g) "Insurer" means any person or entity authorized to write insurance or administer plans for payment or reimbursement for health care services under the laws of the United States or of a State, territory, district or possession thereof, or any association of such insurers.

(h) "Person" means an individual, group of individuals, partnership, corporation, association, company, firm, trust or any other form of entity.

(i) "Plan" means any Plan for participation in health cost containment activities, or amendment to such Plan, pursuant to section 4 of this chapter, or any subsequent amendment to this chapter.

(j) "Secretary" means the Secretary of Health, Education and Welfare.

(k) "Treatment and utilization standard" means the level of health care services, including but not limited to the type, length, number, nature and quality of such services, provided or recommended for the treatment of particular health problems by health care providers or to be paid for or reimbursed by insurers.

Section 4. Authorization of cooperative health cost containment activities

(a) Insurers may (either individually or through the formation and cooperation with one or more organizations), pursuant to any Plan approved by the Secretary in accordance with this chapter, join with one another, with one or more health benefit purchasers, health care providers, or agencies of government, for the purpose of participating in health cost containment activities.

(b) Insurers may submit to the Secretary one or more Plans for engaging in health cost containment activities consistent with the provisions and policies of this chapter. The Secretary shall approve such a Plan within 90 days of its submission to him unless he finds that—

1. The Plan will not provide reasonable protection for the privacy of patients;

2. The Plan does not provide that all analyses and interpretations of health information disseminated thereunder (other than information concerning individual patients or providers) will be made available to the Secretary on request and that such data will be made available to the general public subject to reasonable conditions;

3. The long-run effect of the Plan will be materially to increase the cost or diminish the quality of health care services; or

4. The benefits of the Plan in fulfilling the policies of this chapter will be outweighed by any potential or actual detriment to competition from such Plan.

A Plan shall be deemed approved if the Secretary fails to make any such finding within 90 days of the submission of such Plan.

(c) Within 30 days of the submission of a Plan, the Secretary shall—

1. Publish in the Federal Register a list of the insurers participating in the Plan and a summary of the Plan;

2. Transmit a list of such participating insurers and a summary of the Plan to the Commissioners of Insurance (or the Governor, if a State has no Commissioner) of the States affected; and

3. Transmit a list of such participating insurers and a summary of the Plan to the Attorney General who shall evaluate the potential effect of the Plan on competition and report his conclusions to the Secretary within 30 days. If the Attorney General fails to report such conclusions within 30 days, the Secretary shall proceed as if he had received such conclusions.

(d) Insurers may, after approval of a Plan pursuant to this chapter, submit to the Secretary amendments to such Plan. The Secretary shall approve such amendments within 15 days after their submission to him or notify the insurers in writing of his objections. The Secretary shall approve said amendments within 20 days after so notifying the insurers unless within that time he makes one or more of the findings specified in section 4(b) of this chapter.

(e) Any participation in or act, agreement or omission pursuant to a Plan approved by the Secretary in accordance with this chapter shall be exempt from the operation of the antitrust laws, and shall be inadmissible as evidence of the violation of any antitrust law, and shall be exempted from all other restraints, limitations and prohibitions of state or municipal law insofar as may be necessary to carry the policies of this chapter into effect.

(f) The Secretary may suspend his approval of any Plan approved pursuant to this chapter or any portion thereof, after due notice and hearing, if he finds that the operation of such Plan or portion results in a detriment to competition which clearly and significantly outweighs the contribution of such Plan or portion to the policies of this chapter. The provisions of subsection (e) of this section shall not apply to any act, agreement or omission which occurs more than 15 days after the publication of such suspension in the Federal Register.

(g) Approval or suspension of approval of a Plan or portion thereof under this chapter shall be treated as a licensing proceeding subject to the provisions of the Administrative Procedure Act, 5 U.S.C. 558, except to the extent such provisions are inconsistent with the provisions of this chapter. Such approval or suspension of approval shall become effective 15 days after publication in the Federal Register.

1. The commencement of a judicial proceeding challenging the Secretary's approval of any Plan shall not stay the effectiveness of such approval unless the reviewing court shall otherwise specifically order.

2. The commencement of a judicial proceeding challenging the Secretary's suspension of approval of any Plan or portion thereof shall stay the effectiveness of such suspension of approval unless the reviewing court shall otherwise specifically order. The scope of judicial review shall be as provided by the Administrative Procedure Act, 5 U.S.C. 706. A trial de novo by the reviewing court shall be appropriate only in the review of a suspension of approval of a Plan or portion thereof.

(h) The Secretary may make such rules and regulations as are necessary to carry out the provisions of this chapter and may cooperate with any department or agency of the Government, any State, territory, or possession, any department, agency or political subdivision thereof, or any person with respect thereto; and he may call upon any other federal department, board or commission for assistance in carrying out the purposes of this chapter.

Mr. CONSTANTINE Senator Dole also wanted to know what your experience has been with usage of second opinions, second surgical opinions, in terms of deterring avoidable or unnecessary surgery.

Mr. MILLER. I would have to say that the experience is quite mixed. Most of the programs which I believe the insurance industry is associated with are so-called voluntary programs by which we mean the individual who sees the necessity for a surgical operation has on his own to seek a second opinion or a third opinion.

We find the participation among those to whom this option is offered is realtively small. I do not know what that does mean.

We have not tried and I do not know if there are too many mandatory programs. We feel a mandatory program would have its own difficulties. By mandatory, I mean saying we would not pay for or authorize the payment for a given surgical procedure unless you the individual have sought one or more second or third opinions as to whether that surgery is needed.

I would say our feeling is, although we are still trying to get a handle on this second and third opinion surgery matter, that the answer is not yet in as to just how effective those programs are. We are still working with them. We are still trying to find out how we can make them more effective. We are still trying to interpret the results.

One of the problems of interpreting the results is that you do not always have the whole story. A second opinion may say no and then the claimant drops away and sometime after, the operation is actually performed. We don't get a count of how many times this takes place because of the way the process is spaced out over time.

I would say from our point of view the answer is not yet in, not that we knock the program, but we have not got much that is concrete information at this point.

Mr. CONSTANTINE. We just have one technical question. I think it was Senator Talmadge who raised the question of apples and oranges in the comparisons of data. The staff has had a great deal of difficulty coming up with indices that indicate change.

As Senator Talmadge pointed out, the CPI measures unit price changes and you cannot compare that with the rate of increase in gross hospital expenditures.

The only available measurement CPI utilizes is a per day charge but most hospital days are paid for on a costs basis and not on a charges basis. Not only that, the CPI does not measure decreases in hospital days per admission, that is as the length of stay decreases, you get a further distortion by measuring change on charges per day.

Based upon your experience, Prudential and Equitable, what experience did you have in your costs per case, assuming no coverage changes and no significant changes say 1978 over 1977, that is the percentage rate of increase?

Do you have any information on that?

Mr. MILLER. I think it is our impression that we also have soft data and much of what I am going to say is an impression that they have been going down in 1978 as against 1977.

Mr. CONSTANTINE. Per hospital stay?

Mr. MILLER In aggregate.

Mr. ROBBINS. Jay, one of the things we build into our ratemaking structure is what we call a trend factor. We have observed a decrease in the rate of increase. As a result, a number of our companies, if not all, are beginning to reduce their trend factor.

Mr. CONSTANTINE. We know there has been a decrease in the rate of increase. That is the voluntary effort which claims credit for it. That is not an issue.

Do you have any kind of percentage change that you have noted?

Mr. MILLER. I do not while I am here, Jay. I will be glad to go back home and see what we can offer you.

Mr. CONSTANTINE. I think it might be helpful. It might be a better index than the aggregate expenditures and Senator Talmadge's point about the price of an automobile versus the expenditures of the automobile industry.

Mr. MILLER. We will do that as soon as possible.

Mr. CONSTANTINE. Thank you. Under the rules of the committee and with all modesty, the subcommittee stands in recess until 9 a.m. tomorrow morning.

[The prepared statement of Mr. Miller follows:]

STATEMENT OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA, THE ALLIANCE OF AMERICAN INSURERS, THE AMERICAN INSURANCE ASSOCIATION, THE LIFE INSURERS CONFERENCE, AND THE AMERICAN COUNCIL OF LIFE INSURANCE, PRESENTED BY MORTON D. MILLER

My name is Morton D. Miller, I am Vice Chairman of the Board of Directors of The Equitable Life Assurance Society of the United States. With me are William E. White, Jr., Vice President, Governmental Health Programs office of the Prudential Insurance Company of America, and David Robbins, Vice President of the Health Insurance Association of America. I appear today on behalf of the Health Insurance Association of America and I am joined in this statement by the Alliance of American Insurors, the American Insurance Association and the Life Insurors Conference.

The companies we represent, which provide health insurance protection for over 100 million Americans, have long been intimately concerned with the cost of health care in this country. In that connection, we have striven hard to see that the health care dollars entrusted to us are spent in a manner consistent with the delivery of quality care at an affordable price.

Our attempts to obtain those twin objectives in our role as insurers have included:

(1) Encouraging the use of less costly ambulatory care instead of expensive in-patient institutional services;

(2) Paying for tests performed prior to admission to the hospital so that they need not be duplicated;

(3) Experimenting with reimbursement for second opinions prior to elective surgery;

(4) Encouraging reimbursement for the cost of care rendered under an organized home care program and in skilled nursing home facilities, both of which provide less costly alternatives to in-patient care; and

(5) The use of claim cost control programs to assure the level and appropriateness of both the cost and quality of the services provided.

Furthermore, in our role as corporate citizens, we have lent our active support to community health planning, the development of ambulatory care facilities and other alternative delivery systems, the dissemination of health maintenance and education materials and programs, the extension of professional standards review organizations, and better distribution of health manpower.

My comments today relate to S. 570, the Hospital Cost Containment Act of 1979, and S. 505, the Medicare/Medicaid Administrative and Reimbursement Reform Act of 1979. Because of time restraints, my testimony will be limited to a discussion of the hospital reimbursement reforms proposed in Section 2 of S. 505 and the hospital cost containment system proposed by S. 570. With your permission, for the record we would like to file a lengthier written statement which includes supporting material for these comments, as well as observations with respect to other sections of S. 505.

Rapid inflation has been a fact of life in the health care sector of our economy since the passage of Medicare and Medicaid in 1965. Health care cost inflation is a paramount concern of every one. We are all familiar with the interrelated web of factors involved.

One such factor contributing substantially has been the rapid growth of both private and public third party payment for health care services. For example, third party financing now accounts for over 90 percent of total hospital revenues. Because of our success in expanding and extending coverage to more than 9 out of 10 Americans, the American public has been shielded to a large extent from the direct impact of rising health care costs. As a consequence, the economic forces of the marketplace do not operate to a significant extent in the health care sector. This has caused us to accept the fact that further regulatory measures are necessary to compensate for the absence of normal market forces.

COMMENTS ON S. 505, THE MEDICARE/MEDICAID ADMINISTRATION AND REIMBURSEMENT ACT OF 1979

Section 2 of S. 505 is one such regulatory approach. Senator Talmadge, in his remarks introducing S. 505, indicated that the bill "does not involve government in its role as regulator—it is government in its role as a purchaser of hospital care, the government as a prudent buyer."

Mr. Chairman, we agree with the concept that any purchaser of a service, including government, should receive a dollar of value for a dollar spent. However, the sums that hospitals receive from the states and federal governments for the cost of Medicare and Medicaid patients does not now cover the costs to the hospitals. The net result is that the hospitals set their charges so as to recoup their loss in revenue for Medicare and Medicaid patients from the private sector. A study by the California Hospital Association showed that short term non-profit hospitals in California recovered 80 percent of their revenue shortfall from Medicare and Medi-Cal through increased charges to private pay patients. The provisions of Section 2 of S. 505 can only lead to a further exacerbation of this phenomenon.

Cost escalation affects not only the Medicare and Medicaid programs but also extends to the entire health care financing system and all of the American people. This leads us to feel strongly that Section 2 should be broadened so as to extend its provisions to encompass all payors of hospital costs and charges.

Section 2 of S. 505 as drafted is deficient in another respect. Its controls are based upon the per diem cost of hospital services. Under such an approach hospitals would be able to increase the average length of stay for patients to offset any loss of revenue by reason of the limitations on per diem increases. It would also be possible for hospitals to increase the price of ancillary and outpatient services as well. To be effective any system of cost control must be applied to total hospital revenues.

COMMENTS ON S. 570, THE HOSPITAL COST CONTAINMENT ACT OF 1979

The Administration's Bill, S. 570 The Hospital Cost Containment Act of 1979, provides an alternative regulatory approach. It differs from S. 505 by recognizing the necessity of dealing with total hospital revenues. We fully agree with that approach.

It is noteworthy that the Administration's proposal, S. 570, would apply to all payors in both its voluntary and mandatory phases. This has the effect of freezing into place the current differential in reimbursement level between government cost payors, and private cost and charge payors. Under S. 570, as opposed to S. 505, the differential in reimbursement levels would not increase. This last statement is based upon our expectation that the mandatory phase of S. 570 would operate in a way so as to maintain the current differential. However, S. 570 does nothing to remedy the

present situation which has the effect of having the private sector provide a hidden subsidy for governmental payors.

It is very gratifying to us to see that the provisions of Section 4 of S. 570 grants an exemption from federal controls for hospitals in any state that has a mandatory state hospital prospective budget review and rate approval program that applies to all payors. These state operated programs being closer to the sources of hospital and medical services in their area can more easily become aware of local needs and concerns and more readily be responsive to them. We believe that these state programs provide the best hope for a long term solution for the mitigation of rising hospital costs. It is for this reason we have helped design and support the establishment of such programs. We feel, however, that there should be federal guidelines for such programs.

State prospective budget review and rate approval programs have a proven record of success. In 1977, the rate of increase in hospital costs for those states without such controls was 15.8 percent, while the rate of increase was only 12 percent in states with suitable control programs. Therefore, we strongly urge that consideration be given to increasing the incentives for states to initiate prospective budget review and rate approval programs.

We support the provisions of S. 570 for the establishment of a National Commission on Hospital Cost Containment. We would suggest, however, that the Commission's responsibilities be broadened to include:

(1) The development of a uniform and equitable system for calculating hospital reimbursement rates;

(2) Validation and concurrence with the appropriateness of the voluntary and mandatory revenue limits to be promulgated by the Secretary.

With regard to the latter, we have a genuine concern that the Administration's announced goal of a 9.7 percent maximum increase in hospital revenues in 1979 may be insufficient to sustain the continued provision of quality health care.

In summary, health care cost inflation is of deep concern to all of us—employers, unions, insurers, providers, government, and consumers. Both S. 505 and S. 570 are responsive to that concern and have much to offer. Each is, however, deficient in a number of respects as we have testified.

It is our hope that the best provisions of both these bills could be melded into one legislative proposal which all of us can support and would thereby assure speedy passage of this most necessary legislation.

The Health Insurance Association of America, its staff and member companies, would be pleased to assist the Committee and its staff to perfect such a proposal and assist in any other appropriate way.

Thank you Mr. Chairman.

[Whereupon, at 12:52 p.m., the subcommittee adjourned, to reconvene the following day at 9 a.m.]

HEALTH COST CONTAINMENT

WEDNESDAY, MARCH 14, 1979

U. S. SENATE,
COMMITTEE ON FINANCE,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met at 9 a.m., pursuant to recess, in room 2221, Dirksen Senate Office Building, Senator Herman E. Talmadge (chairman of the subcommittee) presiding.

Present: Senators Long, Talmadge, Baucus, Dole, and Durenberger.

Senator TALMADGE. The subcommittee will come to order.

As you know, yesterday was rather hectic with Senate voting while we were trying to hold hearings.

Secretary Califano's presentation took longer than we assumed and we did not get to all the witnesses.

Dr. John A.D. Cooper, president of the Association of American Medical Colleges and David D. Thompson, M.D., director of the New York Hospital, were kind enough to postpone their testimony until today.

On behalf of the subcommittee, I desire to express to you our appreciation in that regard. I had an urgent appointment at 12 p.m. and other Senators were not available due to the multiplicity of engagements around here. Yesterday was rather hectic.

Dr. Cooper, we are delighted to have you as well as Dr. Thompson. You may insert your full statement in the record if you see fit and proceed in your own way.

Dr. THOMPSON. Thank you, Mr. Chairman. I will ask that our statement be inserted into the record.

Senator TALMADGE. Without objection, it will be inserted into the record.

STATEMENT OF DR. DAVID D. THOMPSON, M.D., DIRECTOR, NEW YORK HOSPITAL, ACCOMPANIED BY DR. JOHN A. D. COOPER, PRESIDENT, AND JAMES D. BENTLEY, ASSISTANT DIRECTOR, DEPARTMENT OF TEACHING HOSPITALS

Dr. THOMPSON. Thank you, Mr. Chairman.

Mr. Chairman and members of the subcommittee, I am David Thompson, director of New York Hospital and past chairman of the Council of Teaching Hospitals of the Association of American Medical Colleges. This morning I am accompanied by Dr. John A. D. Cooper, president of the Association and James Bentley, assistant director of the Association's Department of Teaching Hospitals.

The association represents 400 of the Nation's major teaching hospitals, all of the Nation's medical schools, and 60 academic societies. Thus, the hospital cost containment and medicare reforms being considered today are of vital interest to the association's members.

In spite of the glowing characterization which the Secretary gave yesterday to the administration's cost containment proposal, The association is opposed to S. 570. In addition to the conflict of singling out one specialized industry for mandatory controls in a highly inflationary economy for which the President is advocating voluntary controls, the administration's proposal has several inherent defects:

First, it is an extremely general legislative proposal which provides the Secretary with overly broad policy and administrative powers. For example, the bill does not include provisions which the Secretary must follow in making volume adjustments, granting exceptions, or calculating adjustments for special circumstances. In another instance, the exception for hospitals in States with rate or budget review programs, conditions approval of the program on "such other conditions as he (the Secretary) may establish." These are but two examples of the unrestrained authority sought by the authors of S. 570.

Second, while I read in the newspapers that the Secretary believes a staff of 100 can administer the proposal, I seriously doubt that estimate. Extensive data gathering and analyses will be required and these tasks must be done for the controlled hospitals and the exempted hospitals. If only a quarter of the hospitals which HEW estimates will be subject to the controls submit exceptions, Federal authorities will have to analyze and review an estimated 620 exception requests.

Third, the modified wage pass through is a logically inconsistent provision for a cost containment bill in a labor intensive industry. It is difficult to see how costs will be controlled if nonsupervisory workers feel the hospital can increase their wages with no real penalty.

Fourth, while the proposal does provide an explicit 1 percent increase for service and program improvements, this is an amount far below the historical average and will not provide adequate revenues for obtaining and introducing new technology.

Fifth, the economic stabilization program demonstrated that some hospitals will respond to economic controls by reducing their most expensive caseload. While S. 570 includes an anti-dumping provision, the provision is meaningless. The hospital receiving the expensive patients does not have the records necessary to demonstrate that its competitor is shunning expensive patients and the Secretary is unlikely to penalize a hospital by withdrawing its participation in medicare.

Last, no one should be deceived into believing that S. 570 combines a voluntary cost containment program with a mandatory program. Both cost containment sections are mandatory because the legislation would set the limits on each. There is a truly voluntary program that is working now, the voluntary effort, and that program should continue to demonstrate the responsiveness of social institutions in a free-market economy.

Mr. Chairman, in contrast to the administration's nonspecific bill to provide the Secretary with a broad license to reduce hospital revenues, this subcommittee continues to develop a thoughtful, careful, and nonprecipitious proposal which will moderate hospital costs by redefining an institution's self-interest. The association expresses its continued appreciation to the chairman, subcommittee members and staff for their willingness to incorporate suggestions made at last year's hearings on this legislation and for their willingness to discuss underlying concepts and prospective provisions for the bill. We believe S. 505 is an improvement over its predecessor and offer our comments as constructive efforts to further refine it.

In the interest of brevity, I will restrict my comments on the Medicare Reform Act to issues of particular importance to the tertiary care and teaching hospitals of this Nation.

First, the association appreciates the flexibility that is being provided for classifying hospitals. In this area, t' at state-of-the-art is rudamentary and the combination of flexible legislation and a Health Facilities Cost Commission should provide for the necessary evolution of applied knowledge in this area.

We are particularly pleased by the flexibility provided for the category for the primary affiliates of accredited medical schools. Across 4 years, association staff have worked with subcommittee staff to develop more precise legislative language. Unfortunately, our efforts were unsuccessful. In this situation, the AAMC appreciates the subcommittee's willingness to recognize the complexity of the problem of classifying tertiary care/teaching hospitals. If the present language of S. 505 is supported by last year's committee report language, we believe the health facilities cost commission will have an appropriate balance of guidance and flexibility.

Second, while the association appreciates the provisions which would adjust a hospital's ceiling to reflect service intensity resulting from an atypical case mix or a shorter than average length of patient stay, an additional type of case mix adjustment merits consideration. Regionalization of hospital services is beginning to stratify hospitals by case complexity. As the more expensive and complex cases are concentrated, costs for tertiary care hospitals will increase greater than hospital costs generally. Where a classification and comparison scheme uses past data to set reimbursement limits, some mechanism is needed to increase the historically generated limit to reflect this growing concentration of high cost patients. Third, as a hospital director in a State with an aggressive rate-setting authority, I am concerned to see that S. 505 allows these programs to continue with only minimal Federal guidelines. I must say that the association's membership is not of one mind on this issue and several distinct attitudes seem to be present. In some areas, where the rate agency is independent of the third party payers and is required to see that rates meet the legitimate cost of necessary hospitals, State rate review is endorsed as an appropriate governmental or quasi-governmental function. In other States, however, where the rate agency functions to help medicaid agencies live within available State resources, State rate review is opposed by the hospitals as simply shifting the burden of inadequate revenue. In the remaining States, where rate review is

presently absent, hospital executives seem to evaluate State rate review according to their expectation of the reasonableness of State vis-a-vis Federal controls. In any case, it should be recognized by this subcommittee that adoption of S. 505 will stimulate each State to evaluate the State rate review approach as an alternative to the comparative approach you have constructed over the past 4 years.

Finally, the association would like to add a word of caution about the direction of hospital cost limitations. The Association recognizes the use of limitations based on comparisons of essentially similar hospitals as one legitimate approach to containing hospital costs. If the program becomes operational, the system of comparing cost centers to determine reasonableness could be expanded to include all or some ancillary service departments. From the perspective of regulatory complexity and more importantly to us, from the standpoint of institutional management, there is a question of how far one might wish to go in this regard. The deeper one gets into comparing specific revenue center and/or ancillary service departments, the more peculiarities of institutional characteristics become important to recognize but difficult to quantitatively define. I believe that one result of such an approach would be to fractionalize the management of the hospital. A hospital is a very complex institution whose many facets need to be carefully coordinated to serve the needs of patients and to accomplish effective cost containment. A hospital control system which establishes many intra-institutional ceilings threatens to undermine this coordination.

Mr. Chairman, we appreciate the opportunity to appear before this subcommittee. In our formal comments, in addition to commenting on S. 505 and S. 570, we have commented on three issues of your staff's March 1 proposal. I would be pleased to comment on these issues or to answer any questions you may have.

Senator TALMADGE. Dr. Thompson, I appreciate your supportive testimony and also the criticisms that you have made of the two bills. I know you have worked with our staff on this issue for several years. You are a man of vast experience in this field.

We are dealing with a very complex and complicated all not black and all not white subject and I want the advice of experts in the field. I consider you an expert in this field. I would appreciate you continuing to work with our staff in trying to devise some legislation that can attack this very troublesome issue with which we have been confronted in our country now for about a decade.

How does the administration's bill propose to treat medical centers? As you know, we have tried to differentiate between hospitals, teaching hospitals in one category, urban hospitals in one category, rural hospitals in another category, and so on.

We are trying to penalize the inefficient and reward the efficient.

Would you give us your comment on that?

Dr. THOMPSON. One of the reasons why we are supportive of the bill which you and Senator Dole have brought forward is the fact that it really has tackled one of the most difficult parts, the comparison of hospitals to provide equity amongst them.

As you point out, hospitals are doing different things and increasingly so. This matter of appropriate classification and com-

parison is increasingly critical to the teaching hospitals as their complex case load increases and will continue to increase.

We think the approach that is taken in your legislation is far superior to what the administration bill has, which really does not, to our satisfaction, define how this might be done.

Senator TALMADGE. The last time I checked it, I think the cost of a private bed in a hospital varied from $70 to $500. Is that a good ballpark estimate?

Dr. THOMPSON. I believe it is.

Senator TALMADGE. Do you think it is fair to say every hospital would be limited to a 9.7-percent increase regardless of their efficiency or regardless of the waste they might have in the operation of that hospital?

Dr. THOMPSON. I do not see any way you can set a single figure which is going to be equitable in the sense of recognizing where a hospital is efficient or where a hospital is inefficient.

Senator TALMADGE. Would it not be grossly discriminatory to have a yardstick that applied statewide to all hospitals, fat, lean and alike and say you cannot exceed that amount?

Dr. THOMPSON. I personally think it is the wrong way to go. You are rewarding the inefficient and penalizing the efficient when you get into the situation of setting a figure.

In the teaching hospital business, the increases in the cost are related to the increasing complexity. We are very concerned about that. We recognize the essentiality of it in terms of any regional planning, it makes a lot of sense, both patient care provision and for economics of the situation.

That means inevitably the costs will rise in those institutions which are providing that kind of care. I think the recognition of that in your legislation is critical to teaching hospitals.

Senator TALMADGE. You indicated in your written testimony that you are concerned that S. 505 would limit medical reimbursement on the percentage arrangements between the hospital associated specialists and hospitals to an amount a salaried physician would have received.

You say you are not opposed to limiting in the open end some of these arrangements. Exactly what sort of limitation or limitations do you have in mind?

Dr. THOMPSON. That is a difficult one. We believe there is a place for individuals in the specialties that are addressed in the bill to still be provided with a fee for service type of arrangement.

On the other hand, when you get into situations where percentages do not relate to direct physician services and analyzing pathology slides or something of that nature, it is probably no longer appropriate to apply a percentage figure for calculating the income of the individuals involved.

I do not know this morning how best to work that out. I think working with the various societies relating to pathology as the staff has been doing is the approach to take. I believe that can be worked out in a way that is satisfactory both for the purposes of cost containment but at the same time it does not penalize these specialties which are extremely critical to the operation of a hospital.

Senator TALMADGE. We have had complete cooperation from the anesthesiologists and the radiologists as you know. Some of the pathologists have been completely cooperative. Others have not.

We are trying to work out a fee for service proposition and pay these doctors exactly as we pay other doctors and not have it like an entertainment where they get a percentage of the gross.

You share that view, do you not?

Dr. THOMPSON. Yes; I do.

I think the association can be helpful and will continue to be helpful in trying to work this out.

Senator TALMADGE. They have been helpful and we appreciate it very much. Thank you, Dr. Thompson and your associates for your cooperation and your beneficial testimony.

Dr. THOMPSON. Thank you.

[The prepared statement of Dr. Thompson follows:]

STATEMENT OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

The Association of American Medical Colleges (AAMC) is pleased to have this opportunity to testify on the Hospital Cost Containment Act of 1979, S. 570 and the Medicare-Medicaid Administrative and Reimbursement Reform Act of 1979, S. 505. In addition to representing all of the nation's medical schools and sixty academic societies, the Association's Council of Teaching Hospitals includes over 400 major teaching hospitals. These hospitals: account for approximately sixteen percent of the admissions, almost nineteen percent of the emergency room visits, and twenty-nine percent of the outpatient visits provided by non-federal, short-term hospitals; provide a comprehensive range of patient services, including the most complex tertiary services; and are responsible for a majority of the nation's graduate medical education programs. Thus, the hospital and physician reimbursement provisions in the proposed legislation are of direct interest and vital concern to the Association's members. In addition to commenting on S. 505 and S. 570, the Association would like to respond briefly to several alternatives that Finance Committee staff have developed to reduce federal expenditures for health services.

HOSPITAL COST CONTAINMENT ACT OF 1979

When the AAMC requested an opportunity to testify before this Subcommittee, it was assumed that the Administration's hospital cost containment legislation would be publicly available by mid-February. Unfortunately, the Association did not receive a copy of that proposal until Tuesday, March 6th. Because the Administration's proposal is very complex and intricate, the AAMC has not completed its analysis of S. 570 and Association comments at this hearing are quite general in character. The Association hopes the Subcommittee will hold additional, detailed hearings on S. 570 at a later time so that the AAMC and other witnesses will have an opportunity to prepare a more extensive comment on the President's proposal.

In broad perspective, the AAMC is opposed to the Administration's proposal. First, while the proposal is written in elaborate detail in some areas, the proposal provides the Secretary with too much discretion. For example, Section 7(C)(1) describes volume adjustments, exceptions, and adjustments for special circumstances as follows: "The Secretary may make further additions to, or subtractions from, the percentage determined with respect to a hospital's accounting period under the preceding subsections to allow for—(A) changes in admissions, or (B) such other factors as the Secretary may find warrant special consideration."

If the Administration's proposal is to provide a fair and equitable control system, adjustments to accommodate particular individual situations are crucial. Public policy for these exceptions should not be left solely to the Secretary. Congress would be abdicating its legislative responsibility if it adopted a proposal granting the Secretary the power to both determine and implement public policy. Moreover, the delegation of such broad authority to the Secretary would undermine subsequent legal actions against the Department, for without established public policy boundaries, the courts would have difficulty determining if the Secretary exceeded his authority.

Secondly, the Association is concerned about the complex administrative structure that would be necessary to implement S. 570. The complexity of the proposal will necessitate a significantly expanded bureaucracy to collect and analyze data, deter-

mine and update voluntary and mandatory ceilings, monitor hospital and state rate agency compliance, and evaluate exceptions and special circumstances. The costs of such a bureaucracy are a direct increase in the number of persons supported by Federal tax revenues and a direct reduction in any savings resulting from the controls.

Third, the voluntary and mandatory controls in S. 570 necessitate vast amounts of data which must be gathered, analyzed and applied in a timely manner. Past practices indicate HEW will have difficulty performing these tasks. In establishing the present routine service limitations authorized by Section 223 of Public Law 92-603, HEW has repeatedly relied on either estimated cost data or dated cost report figures updated using estimating procedures. There is no reason to believe HEW would be able to process data in a more timely fashion for cost control purposes. As a result, future controls will be based upon estimates of recent cost data derived from outdated cost reports. The use of an estimate to describe the current state of affairs compounds errors and increases the arbitrary value of the projected ceilings.

Fourth, the AAMC is seriously concerned that S. 570 allows only a one percent factor for service improvements. Since 1950, Social Security Administration analysis have repeatedly shown that approximately one-half of the increase in hospitals costs has been a result of improvements in hospital services.[1] The Administration proposed only a 1% adjustment for service improvements. The AAMC does not believe the American public wishes to dramatically curtail improvements in hospital services. If the public is to continue to receive high quality patient care using up-to-date techniques and equipment, adequate funds must be provided for modernization and service enhancements.

Fifth, the Administration's proposed cost containment program includes a modified pass through of wage increases for non-supervisory employees. This provision will undoubtedly increase the demands of these personnel for significant wage increases, a demand that is in direct conflict with the bill's cost containment objective. Moreover, wage increases granted for non-supervisory personnel will probably determine the wage increase expectations of all other hospital personnel. Without a similar exemption for these latter employees, the hospital may be unable to fulfill expectations; morale will decrease, turnover will increase, and the relationships between supervisory and nonsupervisory personnel will deteriorate. Thus, the wage pass through provision is undesirable in terms of the bill's objectives and the provision's likely impact on hospital operations.

Finally, the Association believes that the linking of a mandatory program to a voluntary program undermines the allegedly voluntary program. At the individual hospital level, this linkage encourages treating the voluntary ceiling as the floor. While this may be prudent behavior for an individual hospital, it undermines the likelihood that hospitals collectively can meet the initial goal. Few hospitals will have cost increases significantly below the Administration's voluntary goal while there will be some hospitals with costs substantially above the goal as a result of uncontrollable local factors such as local population increases.

In addition to these five general concerns, the AAMC notes that the proposal fails to clearly describe how hospitals under mandatory controls could qualify for voluntary controls in subsequent years, fails to distinguish between gross charges billed and actual revenues collected, makes the Federal treasury the beneficiary of excess revenue collections, and includes an "antidumping" provision that is so harsh that the Secretary may be reluctant to use it. Because of these general and specific concerns, the Association is opposed to the President's proposal and believes that any further consideration of S. 570 should provide ample opportunity for additional testimony.

MEDICARE-MEDICAID ADMINISTRATIVE AND REIMBURSEMENT REFORM ACT OF 1979, S 505

A review of S. 505 clearly demonstrates that the Subcommittee and its staff are committed to establishing equitable reimbursement reforms that effectively address cost containment concerns without arbitrarily disrupting or penalizing health care delivery patterns that have effectively served the public. For this thoughtful approach and the staff's continued willingness to discuss general concepts and tentative positions, the Association expresses its appreciation to the Subcommittee and its Chairman. The Association is also pleased by the Subcommittee's dedication to developing a long-term, basic structural answer to the problem of rising hospital costs. In introducing S. 505, Senator Talmadge noted: "This is not a bill to indiscriminately cut and gut hospital operations. This is a bill, . . . which seeks to do no more—and no less—than to reform Government payment methods to hospitals with a system designed to encourage moderation by rewarding efficiency and not paying

[1] "*Medical Care Expenditures, Prices and Costs: Background Book.*" September 1975 p 39.

for inefficiency." And as Senator Dole, co-sponsor of S. 505, commented in his summary remarks: "The bill being introduced today builds on our experience of the last two congressional sessions. It has been improved by suggestions we have received and starts on a road to long-term, sensible cost moderation policy." It is within the context of these remarks that the Association would like to submit what it believes are constructive comments.

The members of the AAMC's Council of Teaching Hospitals are not a set of homogeneous institutions with similar organizational structures, staffing patterns, financial resources, patient care and educational programs, or facilities. They vary widely on these and other dimensions, for they have evolved to meet local, regional, and national missions within individual organizational and social constraints. Given this broad diversity, the Association has consistently advocated and supported hospital payment mechanisms which recognize the individuality of each institution and which make hospital comparisons only among truly similar institutions. The AAMC has recognized that payment limits derived from cross-classification schemes that are carefully constructed and conscientiously implemented to ensure comparability of institutions and costs are one legitimate approach to containing hospital payments. The following comments recognize those sections of the proposed legislation which contribute to more equitable and effective reimbursement provisions. The testimony also notes significant reservations about those aspects of S. 505 that need further study and consideration.

Hospital reimbursement provisions

A fundamental concern of the Association is the criteria employed to establish any hospital classification system used to calculate hospital payments. The Association is pleased that S. 505 recognizes the primitive "state of the art" of hospital costs comparisons and provides the Executive Branch with considerable flexibility in implementing the Congressional intent.

Health Facilities Cost Commission

In previous testimony on S. 1470, the Association strongly advocated the establishment of a "National Technical Advisory Board" to recommend and evaluate alternative classification systems of size and type, review program progress, monitor program implementation, examine problems encountered, and make recommendations regarding appropriate solutions for problems identified. The AAMC is pleased to note that the role of the proposed Cost Commission would encompass these activities.

The Association is also supportive of a Commission that includes representatives from both the public and private sector. However, it appears that the proposed limit of three hospital representatives would inappropriately exclude valuable and necessary viewpoints from certain types of hospitals with unique concerns. It would be particularly difficult, for example, to establish a rational classification group for teaching hospitals unless an individual were included who thoroughly understand the medical education process and its varying impact on hospitals which provide training and research capabilities for health professionals. Therefore, the Association recommends that five members of the fifteen person Commission be hospital representatives. In addition, the Association recommends that the provision for representation from "public health benefit programs" specifically permit inclusion of competent individuals from each of the following groups: large third party payors, state cost commissions which have implemented hospital rate review mechanisms, and knowledgeable managers of health benefits programs in private industry. Drawing on the extensive technical expertise available in all of these sectors is essential for assuring equitable and workable solutions to complex implementation problems that will arise.

Classification of teaching hospitals

In the past, the Association has expressed its opposition to a separate category for "primary affiliates of medical schools" that would be arbitrarily limited to one hospital per school. The AAMC is pleased that last year's Committee Report for H.R. 5285 recognized the need to include in the primary affiliates category more than one teaching hospital for some schools. The report stated:

"When classifying hospitals by type, hospitals which are primary affiliates of accredited medical schools would be a separate category, without regard to bed size. The Health Facilities Cost Commission should give priority to the development and evaluation of alternative definitions and classifications for the category primary affiliates of accredited medical schools. The Commission should ensure that the treatment of these medical center/tertiary care/teaching hospitals accurately reflects the hospital's role as a referral center for tertiary care patient services, as a

source for the development and introduction of new diagnostic and treatment technologies, and/or as the source of care for a high concentration of patients needing unusually extensive or intensive patient care services provided in routine service cost centers. In addition, these hospitals generally provide a broad range of graduate medical education programs and undergraduate medical clerkships. The committee recognizes that some medical schools, because of their organization and objectives, have more than one primary affiliate, and the primary affiliate classification should provide for the possibility of including more than one hospital in unusual situations. The primary affiliates category should not include affiliated hospitals which are not primary affiliates within the meaning of the concept described above."

If a special category for teaching hospitals is to be retained, the AAMC requests that a similar statement be included in this year's Committee Report.

While the modification in the teaching hospital category is a significant improvement, the AAMC remains concerned about the creation of a category for teaching hospitals because: (1) no one knows how routine operating costs in major teaching hospitals compare with routine operating costs in non-teaching hospitals; and (2) the principal source of atypical costs in major teaching hospitals results from the scope and intensity of service provided and the diagnostic mix of patients treated, not from the presence of an educational relationship with a medical school. In the absence of adequate data and operational experience to evaluate the proposed classification scheme, the Association believes that the combination of a flexible classification system and an adequate phase-in period are essential elements of the program's chances for success. Thus, the Association strongly recommends that the Secretary of the Department of Health, Education and Welfare be directed to examine the implications for reimbursement of alternative definitions of the term "teaching/tertiary care hospitals", and that this function be a primary responsibility of the Health Facilities Cost Commission.

Determining routine operating costs

In the past, the Association has not specifically advocated a classification approach to cost limitations. Rather, if a cross-classification approach is to be used, the Association has recommended the exclusion of specific components of routine operating costs which will help ensure that variations in the remaining costs are not due to the nature of the product or to characteristics of the production process. Therefore, the Association believes that the exclusion of capital costs; direct personnel and supply costs of hospital education and training programs; costs of interns, residents, and non-administrative physicians; energy costs; and malpractice insurance expense is a step in the proper direction.

The Association is particularly pleased that the Health Care Financing Administration (HCFA) has adopted this approach in proposing new routine service limitations. While the Association is concerned with several aspects of the HCFA proposal (e.g., the use of the service industry wage index to estimate appropriate wage changes for nursing personnel and the use of a percentile cut which forces 20% of hospitals to always exceed the limitation), there is substantial merit in using a simplified classification system with cost exclusions rather than an ever more complex classification system.

The list of excluded costs in S. 505 includes several significant items which make cost comparisons between hospitals difficult either because they are not uniformly present in all hospitals (e.g., stipends for residents), because they are uncontrollable by the institution (e.g., utility rates), or because there is substantial regional variation (e.g., malpractice premiums). However, because today's controllable cost may become tomorrow's uncontrollable cost, flexible legislation permitting appropriate additions to the list of excluded costs without new legislation is recommended. The Health Facilities Cost Commission is an appropriate body to recommend additions to the list of excluded costs.

Following a rather complicated calculation, S. 505 establishes the ceiling for routine service payments at 115 percent of each classification group's average. As we have stated previously, the present Medicare reporting system does not permit identification of costs to be excluded in computing routine services costs. Therefore, no one knows what the actual distribution of hospital costs by group will look like. The Association believes that a 115-percent ceiling should not be established by statute without knowledge of these distributions. It is recommended that the bill provide some flexibility in determining the ceiling and that the Committee Report clearly state Congressional intent as guidance for Executive Branch action.

The procedure for calculating the reimbursement limitation includes an adjustment for changes in general wage levels in the hospital's geographic area. However, because many medical centers must recruit personnel outside of their immediate areas, the AAMC recommends that S. 505 be amended to add that wage rates may

be used as the basis for an exception to a routine operating payment limitation where a hospital can demonstrate that it had to pay atypical wage rates to recruit personnel.

The Association strongly supports the case mix provision provided in S. 505. Tertiary care/referral hospitals serve the more severely ill patients and referral of such patients from other hospitals tends to increase in times of adverse economic conditions. Similarly, the AAMC is appreciative of the Subcommittee's exclusion of costs that are attributable to greater intensity of care because of shorter lengths-of-stay. Recognition of these facts in the legislation should help to ensure the economic integrity of tertiary/referral centers.

In the past few years as standards for hospital care have changed, hospitals have added special care units for coronary care, intensive care, burn care, kidney care, and other specialized services. Treatment of these units as routine services would decrease the comparability of costs across hospitals. Therefore, the AAMC requests that special care units, like ancillary services, be excluded from the definition of routine operating costs.

Exceptions process

Experience gained since the development and initial operation of Section 223 of the 1972 Medicare amendments has demonstrated the urgent need for a viable and timely exception and appeal process. Such an effective and equitable process has not functioned under the present Section 223 cost limitations. Therefore, the Association recommends that developed legislation include provisions for an exception and appeal process which provides (1) that information describing the specific methodology and data utilized to derive exceptions be made available to all institutions so that the initial application for an exception is judged complete; (2) that the identity of "comparable" hospitals located in each group be made available; (3) that the Secretary be required to regularly publish base line or typical costs for each group of hospitals in the classification system; and (4) that the basis on which exceptions are granted be publicly disclosed in each circumstance, widely disseminated, and easily accessible to all interested parties.

State rate control authority

Where the Secretary of HEW and a state enter into an appropriate contract, the bill permits a mandatory state reimbursement system to be used to determine payment limitations. In some states, such systems may contribute equitably and effectively to cost containment efforts; these efforts should not be discouraged. The Association is concerned, however, that without specific federal operating guidelines in the bill, a state could use Medicare/Medicaid participation in a state rate setting/budget review process to dramatically, arbitrarily, and capriciously reduce hospital payments below the legitimate financial needs of hospitals. If the state option were used in this manner, it could undermine the financial integrity of many hospitals. Therefore, the AAMC's position is that state rate systems are acceptable where the following conditions are met: (1) the system is based on the full financial requirements of hospitals; (2) the system is based on an adequately financed, politically independent agency headed by a small number of commissioners appointed for relatively long staggered terms of office and staffed by competent professionals; (3) the agency is structurally and functionally independent of any governmental or private payor of hospital services; (4) the agency's operations include clearly defined formal procedures, adopted after public hearings, for systematic review of rate or budget applications and with provisions for routine changes to be made with minimal procedure and expense; and (5) the agency provides due process, including the right to judicial appeal for the applicant as well as for others affected by the decisions, and specific protections against undue delays in action.

Ancillary and special care units' costs

In Section 2(c), the Health Facilities Cost Commission is directed to devise additional methods for reimbursing hospitals for all other (i.e., non-routine) costs. Any effort to expand the payment provisions to include some or all of the ancillary service departments and special care units is likely to present very difficult problems in terms of regulatory complexity. The deeper one gets into comparing specific revenue centers and/or ancillary service departments, the more important a hospital's distinctive characteristics become to an understanding of its costs. These individual differences are difficult to define quantitatively. In addition, an adverse result of such an approach would be to fractionalize the management of the hospital. A hospital is a very complex institution whose many facets need to be carefully coordinated to serve the needs of patients and to accomplish effective cost containment. A hospital control system which establishes many intra-institutional ceilings

threatens to undermine this coordination. Therefore, the AAMC would advise the Subcommittee to proceed very cautiously with this approach.

PRACTITIONER REIMBURSEMENT REFORMS

Defining "physicians' services"

Under present Medicare law, "the term "physicians' services" means professional services performed by physicians, including surgery, consultation, and home, office and institutional calls . . ." Section 6 proposes to extend the definition to state: "the term "physicians' services" means professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls . . . except that such term does not include any service that a physician may perform as an educator, an executive, or a researcher; or any professional patient care service unless such service (a) is personally performed by or personally directed by a physician for the benefit of such patient and (b) is of such a nature that its performance by a physician is appropriate."

As presently stated, the amendment could be interpreted to mean that a faculty physician performing or directing personal medical services in the presence of a student is not eligible for a fee for his professional medical services because the physician will be defined as an educator whose services are to be paid on a cost basis. The AAMC is opposed to this interpretation and, therefore, is opposed to the present wording of the amendment. Where a faculty physician is simultaneously performing or directing patient care and educational functions, the Association believes that the physician should be eligible either for professional service payment on a fee-for-service basis or for educator compensation on a cost basis. Therefore, the AAMC recommends amending S. 505 to explicitly permit "physicians' services" compensation for a physician who is simultaneously functioning as an educator and personally performing or directing identifiable patient care services.

Anesthesiology services

Anesthesiologists in the Association's Council of Academic Societies are concerned that the definition proposed in S. 505 for anesthesiology services could be so narrowly interpreted as to preclude payment for physicians' services traditionally performed by anesthesiologists. Therefore, the AAMC supports amending Section 6(a)(2) of S. 505 to read as follows: "In the case of anesthesiology services, where anesthesia is administered to facilitate surgery, obstetric delivery or special examinations, a procedure . . ."

Pathology services

The AAMC is concerned about the proposed pathology provisions of S. 505. The proposed provisions would tend to alter and restrict professional activities and services in clinical pathology. By emphasizing fee-for-service payment for surgical pathology services and hemato-pathology services, the bill would favor these two areas over other important areas of clinical pathology where distinct and medically important services are rendered.

Laboratory Medicine (Clinical Pathology) has become an important specialty of medicine within recent years, both in teaching centers and in the community at large. Clinical pathologists provide a variety of services vital to medical care including formal consultative functions in hematology, coagulation, microbiology, immunology, blood banking, and clinical chemistry (for example, bone marrow and peripheral blood examinations and reports in hematology). They have final medical and legal responsibility for all laboratory reports and verify their reliability. In this capacity, they also take responsibility for analytical validity and for the appropriateness of the methodological approach to the precise clinical needs, and they see to it that appropriate reference values are provided and are continuously reviewed and up-dated.

While the AAMC does not have a compensation alternative which would recognize the concerns of pathologists and of the government, it is concerned about payment mechanisms which could possibly discourage the contributions pathologists make to patient diagnosis and treatment and inhibit the development of the discipline.

Percentage fee compensation

Where the hospital's allowable costs include "the charges of physicians or other persons which are related to the income or receipts of a hospital or any subdivision thereof," S. 505 proposes that such charges would only be recognized as allowable costs to the extent that they do not exceed ". . . an amount equal to the salary which would reasonably have been paid for such services . . .". This provision is the focus of two concerns. First, some specialists have traditionally been paid on a basis

that is related to either hospital or departmental income or receipts. While not opposed to limiting the open-ended character of some of the compensation arrangements, the Association is concerned that the proposal may inhibit the development of some clinically necessary disciplines by placing them at a disadvantage with others.

Secondly, while the objective of limiting Medicare recognition of charges based on percentage arrangements is clear in principle, it is clouded with ambiguities in practical application. The bill includes no indication of the basis on which ". . . an amount equal to the salary which would have reasonably been paid . . ." is to be determined. Certainly the Association realizes and appreciates the desire of the Congress to permit those developing regulations to have some flexibility in implementing this amendment; however, the AAMC strongly urges this Subcommittee to clearly indicate in the legislative record of S. 505 that it is recognized and understood that the market for specialized physicians is often national in character and bears no necessary relationship to local community salaries.

Part A compensation arrangements

The apparent purpose of Section 6(c) is to eliminate Medicare and Medicaid recognition of renumeration arrangements between physicians and hospitals in which the physician's fee-based income rate in his professional medical service practice is used as a basis for computing his compensation for Part A reimbursable services. In place of such arrangements, the subsection proposes recognition of ". . . an amount equal to the salary which would have reasonably been paid for such services . . ." Because this provision includes the same practical ambiguities discussed under percentage fee compensation, the Association reiterates its request for a clear recognition of the national character of the medical marketplace.

Teaching physicians

A fundamental concern of the Association has been the establishment of equitable and reasonable payment provisions for physicians' services provided to Medicare and Medicaid beneficiaries in teaching hospitals. The AAMC is pleased that the legislative summary for Section 8 points out that Section 227 of Public Law 92-603 is intended to permit fee-for-service payments for medical care in teaching hospitals where a patient receives a private service standard of care. More importantly, by extending the implementation date for Section 227 until October 1, 1979, S. 505 recognizes the critical need to avoid disrupting the current constructive discussions between the DHEW and the medical education community which have been undertaken to develop workable, equitable, and realistic regulations for implementing Section 227.

Summary

Assuring Medicare beneficiaries needed health care services, encouraging efficiency in the provision of health care and paying the full and fair costs of health care providers should be the guiding principles of any reimbursement system. The compatibility of the goals can be maintained under a system which accounts for the many legitimate service and case-mix differences found between hospitals. When this is done, excessive costs arising from inefficiency or extravagance can be isolated. However, if care is not taken to identify the costs of inefficiency, legitimate reimbursement may be threatened and consequently the hospital's ability to provide needed health services will be reduced.

In this regard, one has to be impressed with the thought and effort that went into this bill. One is also impressed with the real complexity of implementing the proposal on a national scale. While the Association finds the proposal, with suggested amendments, worthy of support, the Association recommends that we move forward cautiously under the review and supervision of the recommended Health Facilities Cost Commission.

COST SAVING ALTERNATIVES

In a March 1st press release, staff of this Subcommittee suggested several actions which could be taken to reduce federal expenditures for the Medicare and Medicaid programs. While the AAMC is concerned about all twelve of these proposals, and would welcome the opportunity to discuss each of them with Subcommittee staff following additional study and analysis, comments in this testimony are limited to three alternatives of particular interest to Association members.

Limiting hospital outpatient costs

As previously stated, the member hospitals of the AAMC provide approximately nineteen percent of the emergency room visits and twenty-nine percent of the

outpatient visits provided by non-Federal, short-term hospitals. Past studies of the costs of providing these services have shown that hospital-provided ambulatory services are more expensive than office-provided services because: (1) a larger percentage of the patients present more serious and complex medical conditions, (2) of the provision of extensive emergency and ancillary service capability, (3) hospital-based ambulatory costs often include ancillary and special care services for which office-based physicians make a separate charge, (4) present Medicare cost allocation procedures often burden outpatient activities with a disproportionate share of the hospitals administrative and indirect costs and; (5) the involvement of residents in the care of ambulatory patients decreases the productivity of clinic operations. Concerned that government-imposed limitations on inpatient costs may stimulate efforts to shift costs between inpatient and outpatient cost centers, Subcommittee staff have proposed limiting payments for outpatient costs to twice the payments made for a service in a physician's office. Teaching hospital based outpatient departments have long been characterized as the principal financial "loss leader" of the academic health center. A number of reasons have been set forth as causes for this situation including: (1) private and public insurance payment programs often provide insufficient or non-existent benefit coverage for ambulatory services; and (2) patients who are attracted to hospital outpatient departments frequently have no insurance coverage or poor insurance coverage, and are unable to pay for services.

In the past few years, there has been substantial pressure and subsequent institutional commitment to provide a greater amount of educational experience in ambulatory settings to produce more primary care physicians. Generally, these commitments have been made without sufficient attention to longer-range financial considerations. The financing of all education programs in the ambulatory setting is a difficult problem and one which has not received the attention it deserves. Facing continuing large deficits in the operation of their ambulatory services, and diminishing ability to cover these losses from other revenue sources, teaching hospitals cannot significantly expand their ambulatory educational and service programs without adequate reimbursement for them. Providing adequate financing of ambulatory care services to encourage and permit improvement of "contact" specialty training programs, will help maintain and continue the growth in "contact" specialty positions and students which is already in progress. The March 1st staff proposal could further undermine the financial viability of hospital-based outpatient services. Thus, the proposal threatens the availability of both necessary patient services and essential educational resources. Given these serious consequences, the staff of the AAMC would be pleased to work with Subcommittee staff to assess the impacts of the proposal.

Standby ancillary limitation

One of the distinct virtues of S. 505 is its cautious application of cost controls where the technical state-of-the-art is so underdeveloped. This prudent and careful approach would be undermined if the proposal is immediately expanded to include ancillary service costs. These services include a broad range of diagnostic and treatment activities produced with varying combinations of professional and paraprofessional personnel and with complex, rapidly developing technology. Thus, less is known about these costs than about routine service costs. In this situation, the AAMC strongly recommends that the Subcommittee retain its original plan of using the Health Facilities Cost Commission to develop and evaluate alternatives for extending limitations on non-routine service costs.

Reimbursing teaching physicians using a unified fee

Under present Medicare regulations, the costs of house staff stipends and benefits are an allowable hospital cost. Except in the special circumstances of free-standing ambulatory care centers, therefore, residents may not bill patients for any medical services. Faculty and attending physicians may bill patients, under Medicare Part B, for personally performed or directed medical, surgical, and consultative services. In the March 1st staff proposal, it is suggested that Medicare could pay fees to the physician-resident team, regardless of whether the physician or resident performed the patient service, in lieu of cost reimbursement for residents.

The AAMC is seriously concerned about the incentives such a proposal creates. First, if the physician-resident team seeks to maximize fee income, the educational aspects of residency training will be undermined. An unwholesome emphasis on resident-provided services will replace the present emphasis on using involvement in services as a critical learning activity. In short, resident provided services may become an end in themselves rather than a means toward continued clinical growth and development. Secondly, this proposal is financially most advantageous in procedurally-oriented specialties where each individual activity generates a fee. At a time

when our nation is striving to stimulate the nonprocedural, primary care specialties, the adoption of the "unified" or "team" fee could undermine the financial support of primary care training while stimulating the procedural specialties and subspecialties.

For these reasons, the Association opposes the recommendation of a "unified" or "team" fee. The Association does recognize, however, that Section 222 of Public Law 92-603 provides authority for Medicare reimbursement experiments. The unified or team fee is, therefore, available to interested hospitals. To the extent that the legislated authority is presently being used to permit such practices, the AAMC would urge the Health Care Financing Administration to conduct careful, evaluative investigations of the impacts of this change in the pattern of funding graduate medical education.

Lastly, the Association would note that the medical education community and the Health Care Financing Administration are presently discussing alternatives for implementing the teaching physician payment provisions of Section 227, Public Law 92-603. Given the delicate and sensitive nature of these discussions, the Association would urge this Subcommittee to allow the regulatory process to proceed without the addition of constraining substantive legislation.

In conclusion, the Association expresses its appreciation to the Committee for this opportunity to testify on S. 505. The Association shares the Committee's objective of improving the Medicare and Medicaid programs, and the Association has offered this testimony on the legislation as a sincere effort to refine and improve the proposed amendments.

Senator TALMADGE. The next witness is Mr. John A. McMahon, president of the American Hospital Association.

Mr. McMahon, you have testified several times before us and we are delighted to have you back.

STATEMENT OF JOHN A. McMAHON, PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Mr. McMAHON. Thank you, Senator.

Mr. Chairman, I am Alex McMahon, president of the American Hospital Association and with me is Dr. Leo J. Gehrig, our distinguished vice president.

Senator TALMADGE. I am delighted to have you here. Where is Dan Barker today?

Mr. McMAHON. Dan Barker is off doing some preaching, Mr. Chairman, on the voluntary effort in another part of the country. I came back yesterday from Los Angeles and the same kind of preaching. We have our officers pretty well on the road going out to various places to take the gospel about the need for voluntary cost containment.

I will give him your regards, sir.

Senator TALMADGE. Please do. You may insert your statement in the record in full and summarize it if you please.

Mr. McMAHON. Thank you, Senator. I would like to have it placed in the record.

Senator TALMADGE. Without objection, it will be placed into the record.

Mr. McMAHON. I want to touch very briefly on four items: the story of hospital expenditure increases and why hospital costs go up; what we are doing in the voluntary effort; S. 505, S. 507 and some staff proposals, I will briefly comment on; and I have a few comments on the administration's bill.

In the testimony from pages 2 to 5, we have identified the reason for hospital expenditure increases—the increases in the cost of goods and services which we estimate and the Congressional Budget Office agrees, will probably go up somewhere around 9

percent in 1979; about a 1-percent increase in costs to take care of a larger and older population, people over 65 are increasing about 500,000 people per year and they are consuming more and more health and hospital services; and finally, increases resulting from improvements in services. Currently those increases add about 4 percent to hospital costs and we do not think people want us to do less.

That totals 14 percent. The only way we know to get down to 11.6 percent, Mr. Chairman, our goal for this year, is to find savings right across the board. The Secretary of Health, Education, and Welfare has erroneously suggested that we are going to take it out of improvements in services. We cannot possibly do so.

We do believe we can achieve the goal and I think the kind of effort you and your staff have undertaken to help us focus on efficiency can enable us to do so.

From pages 5 to 8, Mr. Chairman, we have talked about the voluntary effort. The key points are that the voluntary effort is a broadly based operation involving more than providers. It involves carriers and suppliers. It involves business and labor and consumers.

It recognizes that the problem of a reduction in the rate of increase in hospital costs, is going to take the cooperation of all parties.

It is based on State operations so we can take into account regional differences. We are trying to reduce the expenditures of hospitals and health care generally to the rate of increase in the gross national product and we think we can do it with improved management systems and improved utilization, just as we have pointed out.

We are pleased that we had success in 1978 and reduced the rate of increase as measured by our panel survey from 15.6 percent in 1977 to 12.8 percent in 1978. That means savings of $1.5 billion and as the years unfold, our savings from voluntary activity can match the claims of the administration.

I would like to jump over to page 8, Mr. Chairman, and call your attention to the 12 pages of testimony dealing with the Medicaid and Medicare Administrative and Reimbursement Reform Act of 1979, S. 505.

The bill contains many improvements over the present reimbursement system and we have appreciated the opportunity to work with members of the committee and with the staff in developing these improvements.

We have given particular attention to section 2, Mr. Chairman, and there are some modifications we have suggested in our testimony that would be a substantial improvement over the present reimbursement system in medicare.

We think the Health Facilities Cost Commission offers a needed flexibility and we have made one suggestion about a modification of the makeup of that Commission.

Other provisions are useful, too, and we have made some specific suggestions about them.

I would be glad to answer any questions you may have.

Senator TALMADGE. If you would yield at this point, our staff has reviewed the suggestion you made on the commission. We think your point is well taken and we appreciate your suggestion.

Mr. MCMAHON. Thank you, Mr. Chairman. We think it will add to the effectiveness and to the acceptability of the recommendations of the Commission.

Over on page 20, Mr. Chairman, from page 20 to 24, we dealt with the staff proposals for other cost saving alternatives. I must say we have some problems with some of those suggestions, particularly the stand-by limit for increases in ancillary costs because we think those would give us some of the same problems with the administration's bill.

On pages 24 and 25, Mr. Chairman, we have made some comments about S. 507, introduced by Senator Dole and yourself. We are pleased to see Senator Dole has joined the subcommittee.

Some of the provisions of S. 507 are also in S. 505 and we have addressed those in the course of the testimony on S. 505.

We paid particular attention to the application of the medicare, conditions of participation, to rural hospitals. We think that is moving on the right track. Rural hospitals and small hospitals do not want a separate set of conditions. They would prefer to see some flexibility in the application of conditions of participation instead of some of the rigid applications they have experienced in the past, and our suggestion here is that perhaps 100 beds would be a more reasonable limit than 50 beds.

Finally, Mr. Chairman, I would like to deal with the unworkable and the inequitable Hospital Cost Containment Act of 1979. I must say we appreciate your understanding of the problems that bill provides—the idea that any ceiling can become a floor, the lack of attention to encouraging efficiency, and some of the many other problems that we have pointed out in our testimony.

We just do not understand the administration's suggestion that hospitals need stand-by controls. Mr. Chairman, if stand-by controls are bad medicine for the economy as a whole, we do not understand why they are just what the doctor ordered for hospitals. The mechanism itself, the stand-by trigger and the controls that would go into place, ignore regional differences, they are complex, and it would take a huge bureaucracy to administer it.

The Secretary, in testifying before Senator Kennedy's committee the other day, said he thought it could be administered for $10 million and 100 people. That is $100,000 per individual and that would only seem to indicate to me what a bureaucratic undertaking that would be.

We are especially concerned about the grant of enormous power to the Secretary.

In our comments on the Hospital Cost Containment Act we point out the retroactive application of the bill. We also point out the inadequacy of the 1-percent allowance for improvement in intensity services and the absence of an allowance for improvement in services under controls.

We think the bill ignores the growth of our elderly population. I would note, Mr. Chairman, it looks as though people over 65 increased their admissions to the hospital in 1978 by 5 percent.

Someone may allege that is not necessary but that seems to me to be unfeeling toward the health needs of a vulnerable segment of our population.

We comment on the problems of revenue limits applied on a per admission basis, a suggestion for controls has been rejected before. I hope it will be rejected again because it is inequitable and would be costly and complex to administer.

We note the inadequate provision for exceptions and conclude by saying that Hospital Cost Containment Act of 1979 would reduce hospitals' ability to provide care and would cause a deterioration of the system. In fact, it would end the voluntary system as we know it.

In conclusion, Mr. Chairman, on page 31, we express our appreciation for your understanding and that of other members of the committee including Senator Dole, in S. 507. We appreciate all of the things that you have tried to do to encourage and incentivise the efficiency and to zero in on the problems that we have, problems that we are working on as I mentioned in describing the voluntary effort.

We have tried to comment constructively in the course of this testimony Mr. Chairman, and we stand ready to continue to work with you and your staff as the study of this legislation continues.

Thank you.

Senator TALMADGE. Thank you very much, Mr. McMahon.

You have worked with our staff for several years in this vineyard. I want you to know we appreciate your cooperation.

You were in the audience when I questioned Dr. Thompson. Is it a good ballpark estimate now that private beds in a hospital vary as much as $70 to $500 a day for the treatment of patients?

Mr. MCMAHON. Yes, sir. As a matter of fact, I was out at Children's Hospital here the other day. If I understand their preliminary figures for this year, it could even go as high as $600.

When you are providing the intensive care needed by the vulnerably ill and injured children, many of which have birth defects, that figure could very well be reached.

Senator TALMADGE. If you put a cap on hospital expenditures and limit the increase to 9.7 percent, a hospital where the cost is $70 a day could increase its cost by about $7.00, whereas a hospital with a $500 a day cost could increase by its costs by almost $50, could it not?

Mr. MCMAHON. Yes, absolutely, sir.

Senator TALMADGE. Does it seem reasonable to you to have a yardstick that would reward the fat and penalize the lean?

Mr. MCMAHON. The way you have phrased the question, Mr. Chairman, almost needs no answer. I agree, that is not the way to go. Of course, that is only one of the problems with this bill, that range itself. A hospital itself can change remarkably in its percentage increases over time as it adds new services needed in the community.

This simplistic single yardstick just will not work.

Senator TALMADGE. The Congressional Budget Office estimates an increase of 14.1 percent in hospital expenditures in fiscal year 1979. HEW estimates 9.7 percent increase for budget purposes.

What is AHA's estimate for fiscal year 1979 increase in expenditures?

Mr. McMAHON. Mr. Chairman, we come about to the same kind of estimate that the Congressional Budget Office does, in total—9 percent for inflation, 1 percent for additional people and particularly older people and about 4 percent for intensity and improvements.

The reason we are sticking with our goal of 11.6 percent and attempting through our voluntary effort program and other activities underway to bring that 14 percent down to 11.6 is that it has been our goal to reduce the rate of increase in hospital expenditures and health care expenditures generally down to the rate of increase in the gross national product.

It is going to take a Herculean effort, Mr. Chairman, to do it but we think that is what the Congress wants and we think that is what the people want and we just have to keep on working to reduce that rate of increase.

There is no question about the fact that in the normal course of events, it could be 14 percent. We are going to do our best to make our goal. Of course we set it when the rate of inflation in the economy as a whole was less than 7 percent, and it is now 9 percent, but we are going to continue our effort to reduce the rate of increase and we have every hope of success.

Senator TALMADGE. Yesterday the committee adopted a rule, 10 minutes for each Senator to question witnesses. If there is no objection, we will follow the same rule today.

We will follow the early bird rule and if anyone wants additional time for questioning, they will have that opportunity.

Senator Long?

Senator LONG. No; thank you.

Senator TALMADGE. Senator Dole?

Senator DOLE. I missed part of the testimony but I think I am able to scan it here briefly and understand your position. We certainly appreciate your willingness to work with the committee and the staff.

I think it is important that we continue to try to figure out some way in a voluntary way to get a handle on the costs. Everybody understands how important that is.

Specifically, what has been the experience of your industry with respect to the rise in the wages of nonsupervisory personnel and the wages of supervisory personnel and what impact would this pass through provision of the administration's bill have?

Mr. McMAHON. Very clearly, in order to provide variations in the ranges of salaries of different classes of people, there must be a relationship between those ranges.

Over time, as it is in the rest of the economy, though not step by step with the rest of the economy, we have seen differences in rates of increase. Very clearly, a change in the rate of increase and in the salary or wages of nonsupervisory personnel must be followed by comparable changes in the pay of supervisory personnel. Otherwise you bring about a squeeze, you bring about a loss of morale and you bring about a substantial number of problems in the administration of the hospital.

You cannot incenticize the managers if you are continually squeezing them, coming up from the bottom with pass through increases in non-supervisory wages that would be encouraged under the bill.

Senator Dole. I think Secretary Califano indicated again yesterday that the industry estimates that a 1.4 percent rate of growth in the most important element of the hospital's budget, maintenance and improvement of the facility and its services, do you agree with that estimate?

Mr. McMahon. Senator Dole, I paid my respects to that at the outset of the testimony. I am pleased to have the opportunity to repeat it. It is a complete misinterpretation of our position.

He has used some figures, as he has on other occasions, to distort the picture. What we have said, going back to the question Senator Talmadge asked, is we think without effort, the rate of increase in hospital costs based on past experience would be about 14 percent. We are going to do everything we can across the country to bring it down to 11.6 percent. That is a 2.4-percent reduction.

Clearly we are not going to take that out of improvement and intensity of services. We cannot possibly do it. A lot of the improvement that will come into place in 1979, for example, goes back to plans made in 1974 and 1975 and 1976. That is underway. We cannot stop or postpone or avoid that.

The way we are going to get the 2.4 percent is by increased efforts across the board, to see what we can do in improvement in management, improvement in systems, improvement in the utilization, the use of less expensive modalities of care, where that squares with proper care of the patient.

To say our 2.4 percent is going to come out of improvement in services, as the administration says, just is not so. We cannot possibly do it. I am glad to clarify the secretary's misstatement of our position.

Senator Dole. I think we all agree that whether or not we are going to control hospital costs depends a lot on cost containment efforts by physicians.

I am just wondering what kind of efforts hospitals have undertaken to encourage this behavior by physicians? Do you have any program in place or efforts being made by various hospitals to encourage physicians to use some of the cost containment efforts they have control of?

Mr. McMahon. Yes, Senator Dole. We have a number of things underway and we are adding to them all the time. We have encouraged through our quality assurance manual, just as the AMA has through its peer review manual, a focus on utilization review. We have made information available to the hospital, and this has been supported by the AMA down through the channels and publications of organized medicine. You will hear later on what the AMA is doing, but support of these programs and encouragement is going into each institution to encourage hospital trustees and administrative staffs and medical staffs to work together to improve utilization.

Dr. Sammons and I were in Los Angeles yesterday. We had a meeting with some of the hospital leaders and some of the medical leaders out there. When I said we were adding new things to it all

the time, one of the physicians on the cost containment committee of the Los Angeles County Medical Association talked about a new concept of his called "economic rounds." You are familiar with the grand rounds in the teaching process.

This was a new program to focus on the cost of care for an individual patient, questioning whether all of the things which were ordered needed to be ordered; whether the length of stay was appropriate and so on, focusing in on that kind of issue.

We are encouraging hospitals to pick up on that because if hospital people are talking to hospital people as physicians are talking to physicians, then they begin to talk to one another and can increase the involvement of the physicians on the utilization issue.

We noted in the testimony some improved utilization activities that are underway along with the other things that are going on with the administrative staffs—joint purchasing, sharing of services, and the focusing in on staffing patterns because clearly, the staffing issue was 60 percent of our cost going into salaries and fringes and it is a large potential area of savings.

Senator DOLE. I remember last week we had a general discussion of the legislation. Senator Moynihan was talking about the very successful cost containment efforts they have in the State of New York, indicating they were even doing a better job than the administration proposes and therefore he strongly supports the administration's efforts.

I wonder if you might comment on the impact of the mandatory control program on individual hospitals? Let's take the New York program for an example. Do you have any details on how many hospitals, if any, are operating in a deficit? What are the general conditions of their plans?

If they are as good as Senator Moynihan indicates, then we must have that information.

Mr. MCMAHON. Senator Dole, I would make three points. The first is the hospital costs in the State of New York are higher than the rest of the country, whether measured by per capita expenditures for hospital care, or by per diem, per stay or total costs. They are substantially above the average.

As Senator Talmadge asked me in an earlier question, obviously a 9.7 on top of a high base is substantially more than it would be on top of a lower base.

Second, the population in the State of New York is not growing. I made a point in my testimony to note the fact that one of the reasons for increasing costs is increasing population.

The third point is the direct answer to a question you raised, in the State of New York, 80 percent of the hospitals are operating at a deficit and while I have asked if those stringent controls in New York impaired patient services, caused people to be turned away, the answer to date is no, not in the short run.

With 80 percent operating at a deficit, Senator Dole, obviously impairment is just around the corner. They are living on their endowments. Dr. Thompson could tell you about that because he is suffering from the same kind of problems.

They are eating into depreciation as they operate at a deficit. One of these days the piper is going to have to be paid. They are

not going to be in a position to modernize, to improve and to stay abreast of developments and to expand.

Senator TALMADGE. Senator Long?

Senator LONG. One of the big items in increasing costs has been the cost of self-insurance or the cost of insurance against malpractice, is it not?

Mr. MCMAHON. Yes, sir. It has been a very rapidly increasing element.

Senator LONG. I have noticed that in states where a direct action is permitted against the insurer, it is possible to have much greater success than where you have to sue the doctor. In other words, when the jury understands that a direct action can be filed against the insurance company and there will be no direct cost to the doctor if you make the award against him, then there is an inclination of the jury to say that the insurance company is in the business of paying off anyway and these poor people need help so let's just award the people a big amount.

It occurs to me if the Federal Government just asserted its power to say you cannot file a direct action against the insurer, you have to sue the plaintiff and you cannot make reference to the fact of whether he is or is not insured, it seems to me that would go a long way toward holding the costs of the malpractice.

Do you have any reaction to that?

Mr. MCMAHON. I would certainly agree with you. I was not aware of that practice. We have had a package of suggested state actions to reduce the malpractice problem. I would like the opportunity to look into that because to the extent that is going on, we certainly should add that to the encouragement for State action.

As a practical matter, I would prefer to see State action going on to improve the situation. I think we would get farther.

Senator LONG. I just have in mind a doctor who was sued for malpractice. He is a friend. At one point in life he perhaps saved my little daughter's life and we thought well of him. He was sued for malpractice. Members of my family went into court and sat down by that doctor just to let people know they thought he was a good person.

The case was not successful against that doctor. It is not an unusual tactic for a defense lawyer, to get good people, relatives, friends, even his own family, who are well known in the community and think a lot of a doctor, to have them sit along side him when he is being sued.

The other side uses similar tactics and finds people to say how this poor person got the worse of it. The tactics are used on both sides.

It seems to me that permitting direct action against the insurer necessarily runs up the amount that is paid. In addition to that, I know as a lawyer many times we are in a position to sue somebody and find that he is not insured. When you take a look and see what he has to pay off with and he has nothing, there is no point in suing him.

It occurs to me with regard to younger practitioners, they really do not have to have all that insurance because they do not have that much that could be recovered against anyway.

Do you have any thought about that?

Mr. McMAHON. No, sir. I did not practice law in this area so I would have to look into that and I would like to submit some additional information.

The two things you mentioned are not the kinds of things that have been brought to our attention as problems in the malpractice area. As you have explained them, obviously they are latent problems.

[The following was subsequently supplied for the record:]

American Hospital Association,
Chicago, Ill., April 4, 1979.

Hon. RUSSELL LONG,
Chairman, Senate Committee on Finance,
Dirksen Senate Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: In the course of the hearing held March 14, 1979 by the health subcommittee of the Senate Committee on Finance, you raised some questions concerning the growing impact of hospital malpractice insurance premiums on the cost of providing hospital care, and I would like to expand on the preliminary comments I made at the time of the hearing.

As I pointed out then, the American Hospital Association has supported a number of reforms to the tort system at the state level and has urged hospitals to expand and improve their programs for risk management. We believe these efforts represent important steps toward moderating the current disproportionate amount of hospital revenues committed to the costs of malpractice insurance premiums or to hospital self-insurance programs.

During our discussion of this problem at the hearing you asked our opinion of the desirability of discouraging young physicians from obtaining professional liability insurance in order to render themselves "judgment proof". On reflection, I beleive there are sound public policy reasons for requiring professionals such as physicians to obtain coverage for the potential risks associated with the practice of their profession. Many hospitals do in fact require liability insurance as a precondition to the granting of staff privileges. The AHA has encouraged this policy.

Moreover, while some young physicians may have few assets in their early years of practice, their potential earning capacity is substantial, and legal practices such as judgment revival and the tolling of the statute of limitations for minority or for lack of knowledge of the negligent act can extend for years the time between an act of negligence and payment of a judgment based on such act.

As you know, there are other examples of public policy that are counter to the idea that the way to minimize litigation and avoid liability is to do without insurance. Many states have enacted minimum automobile insurance requirements as a condition of licensure in order to protect and restore those who are damaged by negligent acts.

We appreciate your interest and concern about the problem of malpractice insurance costs. We do not, however, believe that incentives for new physicians to practice without liability insurance coverage would result in a moderation of the costs of providing health care to patients.

Sincerely

J. ALEXANDER MCMAHON.

Senator LONG. I am also concerned about the defensive medicine aspects of it. A man told me a year or two ago that he took his child to the doctor for what appeared to be an ailment. The doctor said, in an earlier day, I would simply diagnose this just by looking at it. He said now days, I have to run this child through all kinds of tests because of concern with malpractice.

I wondered if there was some way by legislation we could help get back to the practice where if you diagnose something as what you think it is and the chances are about 95 percent or 99 percent that is what it is, if one could go ahead and treat the person the way they used to do.

Can you give us any suggestions along that line?

Mr. McMAHON. You have hit on one of the major problems in the malpractice area, the implications of defensive medicine.

We are using the PSRO, Professional Standards Review Organization, approach to review utilization that may be brought about in that kind of fashion to reduce some of the defensive medicine that goes on.

I think because of the complexities of it, it is the increased attention to that kind of approach that offers the greatest hope of success.

I do not know how else, again, with a proper concern for those who are truly injured, we can do it, except to keep the doctors and the hospitals' attention focused on the risk management issue, on the reduction of defensive medicine tactics where there are questions about it and on the way to develop the defense to a suit that is brought when they have not gone through all of the tests they could think of, but have approached it more as they approached it in the old days and then talk to the courts.

I think the courts are beginning to understand hospital cost problems. You can explain to the courts through proper and relevant testimony that if the kind of thing that was being suggested should have been done were done to everybody, we would have another escalation in costs that again would be passed on through third party mechanisms to the people as a whole.

Senator LONG. Thank you.

Senator TALMADGE. Senator Durenberger?

Senator DURENBERGER. Mr. McMahon, yesterday, listening to Secretary Califano, among his many charts he had a list of the nine mandatory States, the implication being that under mandatory regulation, you were getting better results of reducing costs.

I observed after that, Minnesota, which is not a mandatory State as such but which has an excellent voluntary program, took its 1977 average increase of something like 16 percent down to what I understand from the director of the State Planning Agency, last year to something in the neighborhood of 9.6.

My questions related to the room for voluntary effort and as the hospital trustee and a variety of other backgrounds, I understand a lot of these things are taking place only because of the threat of or the potential implications of mandatory cost controls.

My first question to you is could you suggest to us a set of basic principles that might exist in a mandatory system of cost control which would differ from the one that is being proposed here, which in effect would be there hanging over Minnesota's head as well as the head of other States who do not do a good job in the voluntary area?

Mr. MCMAHON. Senator Durenberger, let me first address myself to the implications, the erroneous implications of what the Secretary had to say.

He makes great moment of the fact that there are nine States with mandatory programs and cites their rates of increase. Most of those States, except Colorado as I noted earlier in response to another question, most of those States do not have population growth. They are in the northeast and their population is not growing. The one State that does have a population growth is the State of Colorado. It is among the highest of those nine States and the legislature in Colorado is already considering eliminating that

cost commission, that mandatory program, because it has not proven out effective.

Second, if you look at what happened in 1978—the Secretary uses figures for 1977, before the voluntary effort got underway—if you look at the figures for 1978 you would find there are voluntary States with just as good a record as the mandatory States.

Third, the mandatory States for the most part are States with high hospital expenditures at the present time.

When we look at 1978, we see a balance of activity across the country, mandatory and voluntary, all making a contribution to it.

In answer to the portion of your question about State control programs, we have long thought that if there is to be a mandatory control structure for hospitals, that a control structure based at the State level with flexibility to look at the budgetary needs and the financial requirements of individual institutions would be much better. Even then, there would have to be some mechanism put in place to take into account what is expected of an individual institution.

Clearly, the hospitals in growing areas of this country need more because of the additional people they have to take of. States where people stay on into retirement, where the growth of the elderly is a substantial cost, that also has to be taken into consideration.

Finally, we must recognize that one of the reasons for the concentration of mandatory States in the northeast is that the hospital system there has increased over time more rapidly in improvements and technology than in other areas. It certainly would not be fair to the States in the south and the States in the west to freeze them as the 9.7 simplistic formulistic approach would do, to freeze them and prevent the opportunity they might have, that they do have today, to approach the better systems which exist in the northeast.

A State system is preferrable to a simplistic formulistic approach as is in the administration's bill.

Dr. Gehrig. Senator, if I may add one comment and it relates just to one aspect of that question. The Secretary, in viewing the voluntary effort, has repeatedly made the comment that the action taken during 1978 which reduced the rate of increase by 2.6 percentage points, was in fact primarily the result of the proposed mandatory legislative programs.

I cannot give you the totality of the data for 1978. His challenge is made on the year 1977 data. We do have a fragment of data that we could share with the committee which covers the interval between March 1978 and November 1978.

Because New York had moved its rate of increase cap down so low, it was forced last year to increase it. As a result, the months I have identified show the rate of increase with regard to the mandated programs, went up by 0.5 percent. The remainder of the States in the voluntary effort—we are really looking for the best efforts of all States but States without mandated programs went down by 2.1 percent for this same interval.

I think we need everybody's effort but that allegation which has been made repetitively is not correct.

Senator DURENBERGER. Have you yet had an opportunity to share with us your thoughts on changes in the Federal reimbursement formula under medicare and a variety of other programs?

Mr. MCMAHON. As in section 2 of S. 505?

Senator DURENBERGER. Yes.

Mr. MCMAHON. Yes. I mentioned it briefly in the testimony. It is a better system than what we have, particularly in the light of some of the moves HEW is making to screw down in the application of the present system.

We made several suggestions that we think would improve section 2 but we lend our support to it with the modifications we have suggested.

Senator DURENBERGER. It would be my observation that since the Government is paying such a substantially high part of hospital costs now in various reimbursements that changing the system from a cost reimbursement to some more incentive kind of reimbursement system where you would as hospitals budget and be reimbursed in advance against the budget that stays within some guidelines would be a much more acceptable way to go.

Mr. MCMAHON. Senator, the incentives as well as the penalties in S. 505 move to some extent in that direction. Your question also puts me in mind of making once again the point that if we had a system for the States to develop rates that deal equitably with all parties, government as well as private, that we might be able to build into prospective budgeting incentives in that fashion, too.

I gather the committee is not yet ready to go that far but there are certain advantages to doing it that way. Until we get to that point, the prospectivity with the target rate here has some substantial advantages as do the incentives.

Senator DURENBERGER. Thank you.

Senator TALMADGE. Are there any further questions?

Senator Dole?

Senator DOLE. You are probably familiar with the Congressional Budget Office report of March 13, which claims that while the first year goal of the voluntary effort has been met, the 1979 goal will probably not be achieved because the program alone is not powerful enough to reduce the rate of increase in hospital expenditures.

I assume you do not agree with that. The second part of that question could be if there is not some pressure kept on by renewed efforts by the administration and by the Congress to pass a mandatory program, what will happen to the voluntary program?

Mr. MCMAHON. We got the March 13 issue late last night. I have not had a chance to do more than scan through it. I understand enough about it to recognize that they do not have the faith in volunteerism that we do. After all, the hospital and health care system was founded and nourished and has grown on voluntary activity.

We think that through the efforts of hospital leaders going out into all the parts of the country to explain the need for intensive voluntary effort, we can bring life and blood into an effort that goes beyond the impact of statistics.

As far as whether or not additional pressure is needed to encourage activity, I must say the administration's assumption on that score is wrong for two reasons. Clearly, President Carter does not

believe that stand-by controls will encourage voluntary wage and price restraint in the economy as a whole so I do not understand how all of a sudden you can switch and say it will do exactly that in the hospital area.

The second thing which gives me great concern is that we now have the attention of hospitals and physicians focused on what each can do. They roles vary greatly. Their attention is focused on what they can do voluntarily to reduce the rate of increase.

If we were to substitute a complex formulistic approach—and there are five formulas in this hospital cost containment proposal of 1979—hospitals and their physicians would be preoccupied with that formula rather than what they might do voluntarily.

It is our feeling it would be absolutely counter productive to our efforts to bring down voluntarily the rate of increase in hospital costs, a reduction that we were quite successful with in 1978 and a reduction that I gather even the Congressional Budget Office agrees we would make in 1979, if it had not been for the rapid increase in inflation and the rest of the economy.

Senator DOLE. I think they also suggest the reduction was not all due to the voluntary efforts, some was directly related to your effort and some was due to the so-called mandatory programs which Senator Durenberger made reference to.

Mr. MCMAHON. Senator Dole, we have never taken credit for the full rate of reduction for a couple of reasons. We know that in 1978, some of the rate of reduction was due to greater attention on rates of increase in capital expenditures. The Planning Act is beginning to have a deterrent effect without inflexibly reducing rates of improvement.

We know utilization is improving and development of ambulatory activity and rehabilitation and posthospitalization nursing care programs and home care programs have helped as well.

There were a lot of things which were in the atmosphere that had their impact. We agree with the overall thrust that a substantial portion of the rate of reduction in 1978 was due to voluntary activity. We know the same can happen in 1979, if we can keep the hospitals' attention away from a preoccupation with how to live with an unfair, inequitable and unworkable and unadministratable system.

Dr. GEHRIG. Senator Dole, as I went through the CBO report of March 13, it in fact projected approximately a fourteen percent inflationary pressure on hospital expenditures next year, which is very close to the figure we have also projected. It did say, as I read it, that the voluntary effort was working and was having impact. Going on to the state mandatory programs, while giving them credit for an input the report clearly pointed out that voluntary efforts were a major part of the action last year. Finally, because the goals of the voluntary effort to move to 11.6 were set sometime back when we were experiencing a much lesser level of inflation, I had a feeling when you began to read their fears, despite the fact they do not have faith that voluntary effort can do it, they were picturing so clearly the futility of attempting to put a flat cap on one industry when its inputs from the remainder of the economy are uncontrolled.

I think, as Alex mentions, hospitals are determined to meet their goal. I think this points out very graphically the problem we have ahead and I do not see anything in the administration's bill that changes that fact of high inflation across the economy.

Senator DOLE. Are you familiar with section 6 of our bill to change the method of reimbursement for hospital based physicians?

Mr. MCMAHON. Yes.

Senator DOLE. Would you like to comment on that? I am sure those affected will comment on that. Do you have any suggestions?

Mr. MCMAHON. I suppose the answer "Not particularly" would not be particularly appropriate.

Senator Dole, we do think the flexibility in the present bill is a little better than what we saw in previous editions. I frankly have not had the opportunity to take a close look at the possibilities of fee for service payments. I recognize there are problems of comparability, when you say reimbursement under a percentage arrangement could not be more than what reimbursement would be under a salary arrangement. There are problems of determining what salary would be. There are problems, particularly in the rural areas of your State and my State of North Carolina where in order to get the pathology service, you have problems.

This provision is a little more flexible. I would be glad to take another look at it and submit comments to you and for the record.

Senator DOLE. I think you made a point in your statement with respect to the need for hospitals to have some knowledge of the data used to compare hospitals in a group. I think that is a good point. I hope that is an area you can communicate with our staff and see if we can improve upon that provision.

Mr. MCMAHON. We will take a look at specific language, Senator Dole, to carry into effect what we might do.

Senator DOLE. Thank you.

Senator TALMADGE. Any further questions, Senator Long?

Senator LONG. No.

Senator TALMADGE. Thank you very much, Mr. McMahon. We appreciate your contribution.

[The prepared statement of Mr. McMahon follows:]

SUMMARY OF STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION

The genuine concern of the 6,400 health care institutions represented by the American Hospital Association about health care costs is evidenced by the nationwide Voluntary Effort (VE) to contain costs while maintaining availability and quality of services. This statement first offers brief comments on the nature of hospital cost increases and the VE program; discusses certain provisions of S. 505; comments on Finance Committee staff alternatives for possible cost savings; addresses a provision in S. 507 that is not included in S. 505; and concludes with the American Hospital Association's views on the Administration's Hospital Cost Containment Act of 1979, S. 570.

HOSPITAL EXPENDITURE INCREASES

Hospital expenditure increases do not result solely from inflation but are made up of increases in the cost of goods and services hospitals must buy; increases resulting from a larger and an older population; and increases resulting from improvements in medical technology and extension of services.

It is thus misleading to compare changes in hospital expenditures to the rate of inflation in the general economy.

THE VOLUNTARY EFFORT

This broadly based coalition of hospitals, physicians, health care suppliers and manufacturers, insurance carriers, local governments, and consumers in 1977 set a broad goal of reducing over a two-year period the rate of increase in total hospital expenditures by 4 percentage points. It is succeeding. For 1978, the reduction was almost 3 percentage points, and this means an estimated savings for the American people of $1.48 billion, including $621 million for Medicare and Medicaid. All 50 states have established VE programs and continued success is anticipated through a wide variety of actions such as improvements in management, energy conservation projects, self-insurance against malpractice, more widespread use of multihospital systems and shared services to obtain economies of scale, refinements in peer review, and greater involvement of medical professionals in health care cost containment.

S. 505, THE MEDICARE AND MEDICAID ADMINISTRATIVE AND REIMBURSEMENT REFORM ACT OF 1979

Hospital cost reimbursement reform involves many complex issues and must deal with widely varying local conditions and needs. The AHA offers the following specific comments based on our study and analysis of S. 505.

Sec. 2. Criteria for Determining Reasonable Costs of Hospital Services.—We recognize the thoughtful approach of the development of this classification methodology for reimbursement of hospital routine room service costs. Further, the reimbursement methodology provides incentives for efficiency and penalties for inefficiency. We believe this approach should be implemented flexibly so that needed modifications can be incorporated. For example, certain cost factors beyond the control of hospitals are excluded from the definition of "routine costs," but there should be provision for adding other factors as experience indicates.

We are concerned about the ratcheting effect of disregarding one-half of the routine costs above 115 percent of the group average. Thus, we recommend that the maximum payment limit be set at 120 percent as in earlier versions of the legislation, and further, that language be included to ensure that the ratchet effect is reviewed at least every two years.

In addition to bed size, type of facility, and urban or rural location, such factors as case mix, length of stay, regional pricing, and weather factors are important in attempting to classify "like" hospitals. It is therefore important to provide for exceptions and procedures to correct and improve the classification system. We also recommend that the Secretary be required to make available comparative data against which a hospital can justify atypical costs that result from intensity of care or unusual patient mix.

Hospitals with short lengths of stay are usually characterized by higher intensity of care and higher per diem costs; they should be allowed to elect a routine operating payment based on average per admission routine costs instead of being disadvantaged because of their higher patient turnover.

We agree with the bill's provisions that permit state budget review programs to determine Medicare and Medicaid reimbursement levels, as well as payments from other sources, and recommend this be extended to state-level voluntary programs along with legislatively mandated programs. There should also be a specific requirement that state programs deal equitably with hospitals and recognize their financial requirements.

We endorse establishment of a Health Facilities Costs Commission with five members from the field of hospital administration, five members who are third-party payers, and five other qualified public members. Changes made by the Secretary in reimbursement policy should be limited to those recommended by the Commission.

Sec. 3. Payments to Promote Closing and Conversion of Underutilized Facilities.—We endorse and commend this innovative approach to stimulate the closure or conversion of underutilized hospital facilities.

Sec. 4. Federal Participation in Hospital Capital Expenditures.—We support penalties against providers who proceed with capital expenditures in the absence of planning approval. Further, we believe certificate-of-need approvals in interstate SMSAs should not be treated differently from approvals in other areas.

Sec. 8. Teaching Physicians.—We strongly urge extension of the implementation date for Section 227 of Public Law 92-603 regarding payments to physicians in teaching hospitals, to allow additional time for HEW consultations on the regulations.

Sec. 9. Certain Surgical Procedures Performed on an Ambulatory Basis.—We support development of ambulatory surgical programs with proper adjustments of

hospital cost finding methods, including recognition that hospitals are the emergency standby resource for patients treated on an outpatient basis.

Sec. 13. Hospital Providers of Long-Term Care Services.—We strongly favor authorizing Medicare and Medicaid reimbursement for hospitals that use beds interchangeably for acute or long-term care, as the AHA has repeatedly urged. We also recommend that a similar reimbursement methodology be available for hospitals providing skilled nursing and intermediate care in a distinct part of their facilities.

Sec. 18. Repeal of Section 1867 of the Social Security Act.—We believe that the Health Benefits Advisory Council (HIBAC) should be continued with increased responsibilities or that the proposed Health Facilities Costs Commission be given more authority and responsibility for counselling the Secretary.

Sec. 25. Rate of Return on Net Equity for For-Profit Hospitals.—We support the proposed change in the allowable rate of return for investor-owned hospitals. We believe it is equally important that an operating margin for not-for-profit hospitals be recognized to meet capital requirements for renovation, repair, or replacement of facilities and equipment, as well as for investment in new technology.

Sec. 28. Confidentiality of PSRO Data.—We vigorously support the exemption of PSROs from the disclosure requirements of the Freedom of Information Act to protect the confidentiality of medical records in connection with these review activities.

Sec. 29. Repeal of Three-Day Hospitalization Requirement and 100-Visit Limit on Home Health Services.—The AHA supports development of home health services with proper controls to ensure quality care and favors liberalization of the home health benefit under Medicare.

Sec. 31. Development of Uniform Claims for Use Under Health Care Programs.—The AHA favors adoption of a standardized claim form for Medicare, Medicaid, and other third-party payers and in this connection encourages the Secretary to consider the results of tests now being conducted in a uniform billing project in which AHA is participating.

Sec. 32. Coordinated Audits Under the Social Security Act.—We support coordinated audits for programs under the Social Security Act. We recommend, however, that state Medicaid agencies not be permitted to perform coordinated audit functions inasmuch as this would present a direct conflict of interest.

Sec. 33. Encouragement for Health Care Philanthropy.—Philanthropic support for health care helps to maintain and improve services and facilities in all parts of the country and is especially important in the development of experiments and innovative approaches to delivery of care. Thus, it is plainly in the public interest, and we fully support this provision.

FINANCE COMMITTEE STAFF PROPOSALS FOR COST SAVINGS ALTERNATIVES

1. Reimbursement for Outpatient Hospital Care.—All outpatient visits are not the same since a wide scope of services is normally provided, and we do not favor imposing an arbitrary limit on Medicare reimbursement for outpatient services. Such a limitation would be counterproductive at a time when great emphasis is being placed on treatment of patients in ambulatory settings.

2. Disproportionate Medicare-Medicaid Payments for Hospital Care.—Studies by the AHA and others show nursing service differentials are warranted for certain groups, such as pediatric, maternity, and geriatric patients. Also, we know of no convincing evidence to support reduced Medicare reimbursement for malpractice insurance. We therefore oppose both of these suggested changes.

3. Prohibit Medicare and Medicaid Payment at Hospital Rates for Patients Medically Determined to Need Lesser Levels of Care.—The AHA favors incentives to assist hospitals to convert unused acute care bed capacity and to use acute beds interchangeably for long-term care. We do not, however, favor penalizing hospitals that provide long-term care in an area where long-term care beds are not available, nor applying penalties on the excess acute care beds in an area—a situation that may not be within the control of the hospital to be penalized.

4. Stand-by Limitation for Medicare and Medicaid on Allowable Increases in Ancillary Hospital Costs.—We strongly oppose arbitrary caps on hospital payments. Comments of the Committee staff recognize the shortcomings in current knowledge and methods for determination of ancillary hospital costs. We believe it would be more appropriate to have the Health Facilities Costs Commission study this issue, as provided in the bill.

6. Competitive Bidding and Negotiated Rates Under Medicaid.—The language of this proposal is not clear, but it appears to be directed at procurement of certain laboratory services, eyeglasses, hearing aids, wheelchairs, and other medical devices.

We would oppose including hospital services in the scope of the provision for primary reasons related to freedom of choice, accessibility, and quality of care.

9. Deletion of Statutory Requirement for Payment of "Reasonable Costs" Under Medicaid.—This proposal would permit states to pay less than reasonable costs for services to Medicaid beneficiaries and would place hospitals in financial jeopardy unless these unreimbursed costs are transferred to other payers. We strongly oppose the suggestion.

10. Deletion of Statutory Requirement for "Reasonable-Cost Related" Reimbursement to Skilled Nursing and Intermediate Care Facilities.—We are opposed to this for the reasons stated under 9. above.

11. Apply "Prudent Buyer" Limit to Purchases by Hospitals of Routine Supplies.—We favor the economical purchase of supplies and urge that positive incentives for shared services and joint purchasing be established under Medicare and Medicaid.

S. 507, THE MEDICARE AND MEDICAID MISCELLANEOUS AND TECHNICAL AMENDMENTS OF 1979

Sec. 6. Flexibility in Application of Standards to Rural Hospitals.—We believe flexibility in the application of Medicare standards is essential to recognize that staffing requirements and policies and procedures suitable for large urban hospitals are often inappropriate for small, rural facilities. We also favor extension of the Secretary's authority to waive the 24-hour nursing service requirement for small, rural hospitals that are making good faith efforts to comply. We strongly support this and recommend it be applied to hospitals with 100 or fewer beds rather than limited to hospitals having 50 or fewer beds, which is in line with the definition of "small, rural hospital" in the law that originally authorized such waivers.

THE ADMINISTRATION'S HOSPITAL COST CONTAINMENT ACT OF 1979, S. 570

Deficiencies the AHA has identified in our initial review of this bill which was introduced just a week ago include the following:

The bill's reference to a "voluntary" program is misleading. The program is not voluntary, and would impose either a mandatory limit on increases in hospital expenditures or a mandatory ceiling on hospital inpatient revenues.

Standby wage/price controls have been rejected by the Administration and by most economists as inflationary. They would be just as harmful in the hospital industry as in other parts of the economy.

No single formula applied nationally can adequately recognize the widely varying conditions and needs of hospitals throughout the country and the communities they serve.

Implementation of such a regulatory program would be costly and would impose burdensome record keeping and reporting requirements on hospitals.

Sec. 2. Establishment of Voluntary Limits.—The Secretary would establish in January of each year an estimated limit on increases in hospital expenditures to be applied to hospital fiscal years ending during the year. Thus, hospital managers would not know in advance of their fiscal years, when they are developing their budgets and making management decisions, the precise limit to be imposed on them.

The bill's allowance for needed improvements in services and advances in technology is inadequate and constitutes an arbitrary denial of improved care to large segments of the American people. Also, the section does not deal with the impact of the significant increase in the elderly population which uses three times more hospital service than younger age groups.

The so-called "wage pass-through" excludes fringe benefits and shift differentials and overtime that are very important in the 24-hour operation of a hospital.

Sec. 3. Applicability of Mandatory Limits.—This section would impose automatically a mandatory revenue cap on hospitals based on estimated data that would be effective retroactively; if triggered in 1980, it would, in effect, be in force on hospitals today. Also, there is no procedure for considering justifiable or trivial variations.

Sec. 4. Exemption of Hospitals in Certain States.—This provision would grant wide, nonspecific authority to the Secretary in regard to state and individual hospital exemptions and does not require that hospitals be treated equitably along with payers, hospital employees, and patients.

Sec. 6. Application of Mandatory Limit.—Application of a mandatory limit on inpatient revenues of hospitals on a per admission basis by class of purchaser would be complex and costly to administer. It would not assure that each purchaser would pay appropriately, or provide a means to compensate for inadequate payments by

any payer, and would artificially segregate sources of revenue without regard to changes in patient mix and benefit structures.

Sec. 7. Calculation of Mandatory Limits.—In addition to the deficiencies noted with respect to determining a limit on hospital expenditures, the extremely complex formula for determining a revenue increase limit for hospitals would deny improvements in health care since no allowance is provided for cost increases arising from needed improvements or advances in medical care delivery. Also in this section:

The proposed penalty or bonus provision is vague, but it is clear that the potential for a penalty is greater than possible rewards, and throughout the section there is excessive delegation of authority to the Secretary;

The description of possible exceptions or adjustments is so incomplete as to preclude evaluation of the provision; and

The adjustments the Secretary would be authorized to make in calculating a hospital's revenue cap with respect to its performance are entirely punitive and could involve use of data as much as three years old.

Sec. 10. Improper Changes in Admission Practices.—This provision assumes the only reasons for changes in a hospital's admission practices relate to reimbursement considerations, when in fact such changes can occur for reasons not related to the source or amount of payment. Further, the provision is entirely lacking in any due process safeguards.

To summarize the American Hospital Association's position on S.570, we believe that the bill is unnecessary, conceptually flawed, and would lead to serious disruption in the delivery of health care to patients. It includes arbitrary and unreasonable provisions and grants excessive authority to the Secretary of HEW. The AHA is totally opposed to S. 570.

In conclusion, Mr. Chairman, your bill S. 505 contains many constructive and important reforms in administration and reimbursement for services under Medicare and Medicaid. We will be pleased to continue working with you and your staff on further refinements that we believe are necessary for the improvement of the existing payment systems of these programs.

Thank you for the opportunity to be heard on these proposals.

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION ON THE MEDICARE AND MEDICAID ADMINISTRATIVE AND REIMBURSEMENT REFORM ACT OF 1979, S. 505, AND OTHER HEALTH CARE COST CONTAINMENT PROPOSALS

Mr. Chairman, I am John Alexander McMahon, President of the American Hospital Association. With me is Leo J. Gehrig, M.D., Senior Vice President of the Association. Our Association represents some 6,400 health care institutions, including most of the nation's hospitals, long-term care institutions, mental health facilities, hospital schools of nursing, and over 27,000 personal members. We appreciate this opportunity to testify on the proposed Medicare and Medicaid Administrative and Reimbursement Reform Act of 1979 (S. 505), as well as other health care cost containment proposals pending before the Committee.

I would like first to offer brief comments on hospital expenditure increases and the Voluntary Effort (VE) to contain health care costs. Next, I will discuss specific sections of your bill, S. 505, along with comments on certain alternatives for possible cost savings outlined by staff of the Committee on Finance. Then I will comment on a provision of the Medicare and Medicaid Miscellaneous and Technical Amendments of 1979, S. 507, introduced by Senator Dole, which is not included in S. 505. Finally, I will present our views on the Administration's bill, S. 570, The Hospital Cost Containment Act of 1979.

As you are aware, Mr. Chairman, the hospitals and health care institutions represented by our Association have a genuine concern about health care costs. They are committed to a reduction in the rate of increase of health care expenditures within their control in order to bring that rate of increase in line with the increase in the GNP. The American Hospital Association is one of the primary sponsors of the Voluntary Effort, a nationwide program to contain health care costs, while maintaining quality. We are deeply committed to attainment of the goals established by the VE program, and we are succeeding.

The VE goals—indeed, any cost containment goals—should have the following characteristics. They must be:

Attainable through concerted and intense effort. We believe that an appropriate goal should not be easy to achieve; on the other hand, if it is unattainable, it is not meaningful;

Consistent with policy objectives not only for achieving inflation and budget control, but also for maintaining the availability of quality health services; and

Flexible in application in different regions of the country and for individual hospitals.

HOSPITAL EXPENDITURE INCREASES

In determining an appropriate goal, we must recognize that hospital expenditure increases are complex. Although increases in such expenditures are often viewed as resulting solely from inflation, they are made up of three basic factors:

Increases in the costs of goods and services that hospitals must purchase;

Increases resulting from both a larger and an older population; and

Increases resulting from improvements in medical technologies and extension of services.

These factors, taken together, account for increases in hospital expenditures and make it misleading and incorrect to compare changes in hospital expenditures to the rate of inflation in the general economy.

Realistic consideration of the impact of each of these factors is basic to an understanding of hospital expenditure increases and to the development of effective and equitable strategies to foster cost containment while maintaining the quality and accessibility of hospital care. Thus, as a part of our efforts to analyze hospital expenditures, we have made estimates of increases in each of these factors for 1979.

Increases in costs of goods and services

In 1979, hospitals will have to pay at least 9.1 percent more for the same goods and services—known as the "hospital market basket"—that they purchased in 1978, if the President's economy-wide anti-inflation program is successful. About half of this increase will be due to wages and salaries. In the hospital industry, about 20 percent of all wages and salaries are not subject to the wage guidelines of the President's anti-inflation program, inasmuch as they fall under the minimum wage exemption. An additional 20 percent of wages may be exempt under the tandem relationship guideline. Other mandated personnel expenses that do not fall under the wage guidelines, such as Social Security taxes, will increase approximately 12 percent in the coming year.

Approximately 25 percent of hospital nonwage expenditures are made for such items as energy, food, and interest rates that are exempt from the President's wage/price guidelines. Increases in the prices of these items will cause increases in the prices hospitals pay that exceed national price increase averages. Further, hospital operations are now adjusting to the rapid inflation in costs of goods and services which occurred during the second half of 1978. In the aggregate, increases in the wage and nonwage components of hospital costs that are exempt from the wage/price guidelines mean that more than 30 percent of hospital costs will rise faster than the target rate proposed in the President's guidelines.

Increases resulting from both a larger and an older population

Changes in the population will also contribute to increased hospital expenditures in 1979. The U.S. population is expected to grow by about 1,800,000 persons, or by more than 0.8 percent. Additionally, there will be an increase of about 500,000 persons in the over-65 group—an increase in the elderly of more than 2.1 percent. Further, the elderly population itself is aging—persons 75 years old and older will, in 1979, become the fastest growing population segment in the country.

Persons 65 and over, who represent 11 percent of the total population, constitute 26 percent of total hospital admissions and utilize 38 percent of total inpatient days. Elderly persons make greater use of hospitals for a variety of reasons, including a higher incidence of chronic conditions and the existence of multiple medical problems requiring longer and more frequent hospital stays. Per capita expenditures for the aged are about 3.5 times greater than for the younger population. The projected increase in persons 65 and older will add approximately three-tenths of 1 percent to the overall increase in hospital expenditures during 1979. Thus, predictable changes in the size and age of the population are likely to increase hospital expenses about 1.1 percent.

Increases resulting from technological improvements and extension of services

Hospitals will experience the impact of more complex technology and other service improvements during 1979. Such advances are the products of the continuing national investment in biomedical science and technology. The increasing efficacy and availability of medical care is reflected in increasing utilization of health services—particularly among the elderly. Our capabilities to diagnose and treat illness effectively are expanding. Recently, increases in services due to such enhanced capabilities have added about 4 percentage points to the annual increase in hospital expenditures. During 1979, it is expected that advances in technology and

increases in utilization will contribute about 3.8 percent to the overall increase in hospital expenditures. Much of this increase will be the result of commitments and activities started years ago that cannot be eliminated in the short run.

In summary, hospitals will face cost increases of about 14 percent in 1979, comprised of the following factors:

A 9.1-percent increase in the costs of necessary goods and services;

A 1.1-percent increase resulting from the growth of population, and a relatively large increase in the number of elderly persons; and

A 3.8-percent increase in services resulting from technological improvements in medical care and other factors.

Under these circumstances, the achievement of the 1979 VE goal, an 11.6 percent rate of increase in community hospital expenditures, will be very difficult. However, through improved management, planning, and productivity, we are committed to the attainment of this goal.

THE VOLUNTARY EFFORT

The Voluntary Effort (VE) to contain health care costs is a broadly based coalition of organizations which was created in 1977. The overall policy and governing body of the VE is its National Steering Committee (NSC), made up of representatives of hospitals, physicians, health care suppliers and manufacturers, insurance carriers, local government, business, labor, and consumers. The goals and objectives set by the NSC are implemented by state VE committees, which generally mirror the NSC and are established in all 50 states. Technical assistance to hospitals and physicians is provided by the NSC member organizations and the state committees.

The broad goal of the VE, set in December 1977, is to significantly narrow the gap between the rate of increase in total health care expenditures and the rate of increase in the overall (nominal) GNP. The most visible and immediate operational component of this goal is the objective of reducing, over a two-year period, the rate of increase in total hospital expenditures by 4 percentage points—from a 15.6 percent rate of increase for calendar year 1977 over the 1976 level to 11.6 percent for calendar year 1979 over the 1978 level.

I am happy to report to you that we have just last week received from AHA's National Hospital Panel Survey the December 1978 data, and therefore are able to present the results of the VE's first year: the rate of increase in hospital expenditures in calendar year 1978 was nearly three percentage points lower than that for 1977. In 1978, the rate of increase was 12.8 percent, as contrasted to 15.6 percent for 1977. The VE, therefore, has not only achieved its basic goal of a two-percentage-point reduction in 1978, but has also exceeded that goal by almost 50 percent. This has resulted in an estimated savings for the American people of $1.48 billion (including $621 million for Medicare and Medicaid).

The VE also has established a number of other operational objectives, addressing multiple health care issues. Specifically, these are:

No net national increase in hospital beds during 1978 and 1979, except for new beds approved by the planning process prior to December 31, 1977.

Reduction of new hospital capital investments in 1978 and 1979 to 80 percent of the price adjusted average of the total capital investment from 1975 through 1978.

Improvements in productivity.

Tightened utilization review procedures within hospitals.

Acceleration of current trends to improve the delivery of care through multihospital systems, shared services, alternative delivery systems, and the like.

A reduction in the rate of increase in physician fees to bring this rate down to or below the overall CPI.

As noted above, VE programs have been established in all 50 states to systematically address and resolve the multifaceted problem of rising hospital and health care costs. Intensified cost containment activities at state and community levels are underway in 1979. In spite of a substantial increase in the rate of inflation in the general economy since the VE began, hospitals were successful in achieving and surpassing the 1978 VE goal and are committed to achieving the 1979 goal—a maximum of 11.6 percent increase in total hospital expenditures.

Let us take a closer look at some changes that have taken place in the hospital component of the health care industry and analyze how they are making permanent inroads in curtailing cost increases. Such changes must be viewed collectively since there is no single model for cost containment programs, and they must be considered in terms of long-range application in a system that is changing continually as the result of numerous forces, technological, economic, and conceptual.

Improved management.—Hospital management has in recent years become much more sophisticated and more effective in coming to grips with rising costs. A key

mechanism within the hospital has been the establishment of a cost containment committee in most institutions, representing management, medical staff, board members, and other professionals. These cost containment committees have devised a wide range of approaches to the problem of rising costs and have been a major factor in the overall deceleration of costs in the industry. Examples of cost containment activities include energy conservation programs, self-insurance against malpractice risks, more sophisticated budgeting, and a greater use of management engineering and productivity improvement programs.

Improved systems.—There has been a substantial change over the past ten years in the direction of multihospital systems. Our latest estimates show that more than 2,000 hospitals in the country are affiliated with or are an integral part of a multihospital system. The cost containment benefits of these arrangements are both clear and substantial. A centralized management system has demonstrated that it can take advantage of economies of scale and bring a new sophistication to managing the health care institution.

Shared services also have expanded substantially in the past decade, and our latest survey shows that more than 80 percent of all hospitals in the nation participate in one or more shared service activities. These include both administrative and clinical sharing, such as purchasing, billing, education, insurance arrangements, and laboratory services. Beyond shared services and multihospital systems, many hospitals have developed hospital-related alternatives to acute inpatient care, such as outpatient surgery programs, preadmission testing, linkages to intermediate and long-term care facilities, and home health services.

Utilization of facilities and services.—There is clear evidence that the practicing physician is making a major contribution to cost containment efforts within the hospital through a variety of approaches. Declining lengths of stay in hospitals, reduced admissions, refinements in peer review, the greater participation of medical staff members in institutional decision-making, and the development of physician education programs to heighten awareness of the costs of routine tests and various modalities of care, without sacrifice of quality, all attest to a broader approach to cost containment in hospitals by the medical profession.

We believe the activities described above demonstrate that the progress by the hospital field in recent years reflects permanent changes in the health care system and ongoing improvements in the management of both the institution and patient care.

MEDICARE AND MEDICAID ADMINISTRATIVE AND REIMBURSEMENT REFORM ACT OF 1979

In light of the foregoing, I would like now to turn to specific aspects of S. 505. This bill would modify a number of sections of the Medicare and Medicaid programs which are important to the public, providers, and government in the provision of hospital and health care services. These proposed modifications affect the administrative, benefit, and, most significantly, reimbursement aspects of these programs. All of these aspects are crucial to our shared concerns about methods to hold down health care expenditures while improving access to quality medical services.

Excessive expenditures for health care benefit no one. We are especially concerned about expenditures that result in underutilized services or that encourage inappropriate demand. Our members have consistently supported innovations in the health care system which are designed to sharply reduce or eliminate such expenditures.

The complexity of health care economics and health care delivery requires such innovation. This complexity is the result of local and areawide variances in such factors as: demographic characteristics; levels and patterns of utilization; prices of material and labor inputs; service intensity and technological development; capacity changes; medical practice modalities; and facility renovation and replacement in compliance with licensure and life safety codes.

In addition, the effects of general economic inflation and the expansion of national priorities in health must be recognized. All of these variables underlie the differences in health care expenditures among communities and among institutions.

Clearly, no single national program could provide the necessary flexibility which must accompany control of total expenditures for health care. We must seek solutions which encourage responsibility at the local level to develop effective and innovative programs which will satisfy community needs while holding down the costs of medical care.

The American Hospital Association supports many activities which are designed to meet these criteria. We have supported experiments and programs in reimbursement reform, involving both public and private payers. We have encouraged such activities as health planning, utilization review, the development of HMOs, multiho-

spital and shared service organizations, and consumer education as methods of controlling health expenditures.

Since we last testified on your proposal, we have devoted further effort to the assessment of the effects of the reimbursement aspects of these programs on the nation's hospitals and their ability to deliver adequate health services to the beneficiaries of government programs. We would like to share with you some of our observations and concerns which our research has uncovered. We would also like to emphasize at the outset our willingness to provide our resources to the Committee for future discussions.

Section 2. Criteria for determining reasonable cost of hospital services

When a classification and comparison system is used for determining payments or "target rates," it must be sufficiently sophisticated to permit differentiation of efficient and inefficient hospitals—that is, the appropriate mix of variables that determine hospital expenditures must be used in the system for grouping "like" hospitals. Our experience with the existing and proposed classification and comparison system under Section 223 of Public Law 92-603 underscores our serious concerns about these problems. We believe that the provisions of Section 2 could result in serious inequities unless this approach is implemented with sufficient flexibility to make necessary modifications.

We agree with the policy of this section that in defining routine operating costs, several cost factors should be excluded because they vary widely among institutions and are unrelated to their efficiency. We also recognize that in the future other cost factors meeting the same criteria will be identified. Thus, we recommend that sufficient flexibility be provided in the methodology so that other such cost factors may be excluded in the future. In this way, the provisions which you have wisely included in your bill to reward efficiency and penalize inefficiency will be even more sharply focused.

As we have indicated in the past, we are concerned about the potential impact of the averaging procedure in determining payment limits and its "ratchet" effect. This would be the result of disregarding in the averaging procedure one-half of the routine costs for hospitals classified above 115 percent of the average. The outcome of such an averaging procedure would be that in successive years the limit on average per diem costs would be reduced and additional hospitals not previously found to have high costs would be so identified and penalized. Further, we recommend that legislative language be included to ensure that the ratchet effect of the averaging procedure be reviewed at least every two years so that the system may be evaluated and modified accordingly. We recommend that the maximum payment limit be set at 120 percent of the average, as provided in earlier versions of this legislation.

The proposed system of classification is based on bed size, type of facility, and urban or rural location. While these variables account for certain differences in hospital routine costs, others such as case mix, length of stay, certain regional pricing factors, and weather are also important to classify and compare "like" hospitals. We recognize the inherent problems of developing and utilizing such data in any classification system. Further, the state of the art of determining and comparing these extremely important variables, as they relate to cost, requires further development. It is essential that evaluative procedures for analysis of the effectiveness of the payment method be carried out on a continuing basis and that payment decisions not be based on erroneous or nonexistent data. Thus, it is important to ensure that the basic classification and exceptions processes cover all appropriate factors and that the entire system includes procedures for correction and improvement.

While this section provides for an exception for hospitals experiencing increased intensity of care or unusual patient case mix, one of the problems faced by such hospitals is that they do not have the necessary comparative data to justify their costs. We have observed that hospitals seeking exceptions from the limitations imposed under Section 223 of Public Law 92-603 for this same purpose experience this difficulty. They must attempt to justify atypical costs without knowledge of the amount or nature of such costs for other hospitals in their peer grouping. We recommend a provision in the bill requiring the HEW Secretary to make such comparative data available to all hospitals within a classification group.

Furthermore, the assessment of the intensity and complexity of care provided by the institutions should include in addition to patient mix, such variables as length of stay. Hospitals with high patient turnover and short lengths of stay are usually characterized by higher intensity and per diem routine costs, and we strongly recommend that these factors be included in the classification system or, until that

is possible, hospitals with short lengths of stay should be allowed to elect a routine operating payment based on a comparison of average per admission routine costs.

Mr. Chairman, we support the provision of your bill which permits state budget review programs to determine payment levels for Medicare and Medicaid as well as payment levels for other sources of hospital revenue as an option to the bill's federally-administered controls. However, this section would permit delegation only to state programs which are legislatively mandated, and we urge that you amend this provision to recognize state-level voluntary programs which meet other established criteria.

Also of concern to us is the requirement that Medicare and Medicaid payments in states with delegated budget review programs not exceed payment permitted under the federal programs. We believe also that new state-delegated programs should have an adequate opportunity for development and implementation. Experience in some states with established programs demonstrates that progress has been incremental, and in the early years has actually resulted in expenditure increases for certain classes of payers in order to establish an equitable basis for payment levels. We recommend flexibility under the test for federal delegation related to the aggregate level of Medicare and Medicaid payments. Moreover, we believe that additional specifications for the delgation of such programs to states should be included. Such specifications should ensure that the state programs deal fairly in recognizing the financial requirements of hospitals in delivering needed services.

HEALTH FACILITIES COSTS COMMISSION

We endorse the establishment of a Health Facilities Costs Commission. The Commission could make a valuable contribution to improved understanding and resolution of reimbursement issues. The proposed responsibilities of the Commission to study and submit recommendations on methods of reimbursing hospitals and other entities, in a manner which recognizes costs of providing care and includes incentives for efficiency, are appropriate and desirable.

We believe that such a Commission would be most effective if its membership were comprised of: (1) five members from the field of hospital administration; (2) five members who are third-party payers; and (3) five other members, not in categories (1) and (2) who are technically qualified in the areas of the Commission's responsibilities. This composition would ensure that, in carrying out its important tasks, the Commission would have the benefit of a broad and informed range of views and experiences.

The bill indicates that the Secretary is to take account of the proposals and advice of the Commission in modifying methods of reimbursement under Titles V, XVIII, and XIX. We suggest that this provision should require that changes made by the Secretary in reimbursement policy be limited to those recommended by the Commission. When the Secretary did not choose to follow the Commission's recommendation, he would provide to the Commission and to the Congress a statement of his reasons for not doing so.

Section 3. Payments to promote closing and conversion of underutilized facilities

We commend the innovative approach of this section which builds on the impetus of hospitals themselves to voluntarily convert excess capacity to more efficient usage, to close underutilized facilities, and to share clinical and support services. We support the use of special payment provisions as incentives to stimulate this process.

Section 4. Federal participation in hospital capital expenditures

This section of the bill amends Sections 1122 and 1861 of the Social Security Act relating to the health planning process. We support the provision in this section that would strengthen that process by expanding the payment penalties applied to providers who proceed with capital expenditures in the absence of planning approval.

We are concerned about the provision requiring that proposed capital expenditures in a standard metropolitan statistical area (SMSA) must be approved by all pertinent state agencies. This would mean, for example, that all proposed capital expenditures in any part of the Washington, D.C. metropolitan area be approved by three state agencies—that is, the agencies in the District of Columbia, Maryland, and Virginia.

Such an approach appears excessive and likely to result in extended delay and protracted negotiations. It would tend to discriminate against activities in SMSAs that happen to be designated on an interstate basis. We suggest, rather, that proposals in SMSAs be reviewed by all pertinent local and state health planning agencies and that the results of their reviews be made public, while responsibility

for decision remain with the state agency of the pertinent jurisdiction. The recommended policy is consistent with the practice followed under Public Law 93-641.

We support the amendment to Section 1122(g) which clarifies that notice, approval, and payment penalty provisions contained in that section (with respect to approval of health care facility capital expenditures) do not apply to simple changes of ownership (either through purchase or under lease or comparable arrangement) of existing and operational facilities which create no new beds or services.

Section 8. Teaching physicians

We strongly support the extention from October 1, 1978 to October 1, 1979, of the implementation date for final regulations under Section 227 of Public Law 92-603. This extension is needed to afford the Secretary of HEW additional time to consult with members of the medical education community and to publish necessary regulations.

Section 9. Certain surgical procedures performed on an ambulatory basis

The American Hospital Association supports the development of lower cost alternatives to inpatient hospital services, including ambulatory surgical programs. Many hospitals today are reducing costs through the use of outpatient surgery.

We are concerned, however, that outpatient surgery in the hospital setting not be rendered noncompetitive because of cost-finding methods required by Medicare and Medicaid. The cost-finding process employed for these programs requires, for example, that the hospital's overhead be allocated to the outpatient units on a 24-hour basis, even though these outpatient facilities may only operate for 8 to 10 hours per day. As a result, hospital-based ambulatory surgery programs may appear more expensive. This distortion could be corrected by modifying current cost-finding requirements in the Medicare and Medicaid programs.

Another aspect of the hospitals' participation in ambulatory surgery in any setting is exceedingly important. This is the standby availability of the hospital—as both an emergency and an inpatient resource—for patients treated on an ambulatory basis, if required. While this aspect cannot be directly incorporated in this equation, it is important to consider such standby capability. Cost allocation requirements under these governmental programs should not unfairly discriminate against hospital ambulatory surgery programs.

Section 13. Hospital providers of long-term-care services

Section 13 of the bill would authorize Medicare-Medicaid reimbursement for hospitals alternating the use of beds from acute to long-term care, depending upon patient and community need. This section would permit the Secretary of HEW to extend nationwide a program which presently applies experimentally to four states: Iowa, South Dakota, Texas, and Utah.

Called the swing-bed approach, this program was originally viewed as a means of offering long-term care in rural areas, by switching acute-care beds in hospitals for extended-care use by patients in their own communities. However, the program has evolved into an effort of full-facility utilization, designed to meet patients' needs for close-to-home, long-term care, on a cost-effective basis.

Both the success of the experimental program and its potential for full-scale application lead us to recommend that the swing-bed concept be authorized nationwide without restriction on geographic area or hospital-bed size. Planning approval, as presently required by the bill, is sufficient assurance of the appropriate use of this cost-beneficial concept.

While supporting Medicare-Medicaid reimbursement for swing-bed usage, we recognize the significant role of hospitals with distinct-part, extended-care units in providing long-term care to Medicare and Medicaid beneficiaries. In order to provide equitable treatment to such distinct-part facilities, we recommend that a clause be added to Section 13 to provide that, under certain circumstances, the methodology in Section 1861(cc)(5) may be followed in determining reimbursement for hospitals with distinct-part units for skilled nursing care provided to Medicare and Medicaid beneficiaries and for intermediate care provided to Medicaid beneficiaries in these units.

Section 18. Repeal of Section 1867

Section 18 would terminate the Health Insurance Benefits Advisory Council (HIBAC). We believe that the use of expert, nongovernmental advisors through HIBAC has contributed significantly in the development and implementation of federal programs. It is important that the major health care programs of Medicare and Medicaid be provided the advice and assistance of such an advisory group, particularly during a period of significant legislative and program changes.

HIBAC served an important and useful role in the earlier development and implementation of Medicare. As a result of the changes in the responsibility of this advisory council in 1972, the evolution of the programs, and the extent to which HIBAC's advice has been sought and utilized in recent years, the role of the council has decreased. Nevertheless, such an advisory council should be continued not only for its potential contributions to this improvement of Medicare and Medicaid, but also for the development and implementation of any major revisions in Social Security health-related legislation. Therefore, we strongly recommend that either HIBAC be continued with increased advisory responsibility or, if it is discontinued, that the new Health Facilities Costs Commission be given more adequate authority and responsibility for counselling the Secretary about these programs, as we have described in our comments on Section 2.

Section 25. Rate of return on net equity for for-profit hospitals

It is the AHA's position that investor-owned institutions should receive a reasonable return on their owners' equity, and we support the proposed change in Section 25 in the rate of return.

We believe it is equally important to recognize an operating margin for not-for-profit hospitals within the Medicare reimbursement system. An operating margin provides necessary funds for working capital requirements and capital needs for major renovations and repairs, the replacement of plant and equipment, and investment in new technology. Recognition of these needs would have positive effects on the cost of operating health care institutions. For example, it would reduce costs incurred in short-term borrowing; permit the improvement of operational inefficiencies resulting from out dated plant and equipment; and encourage the development of lower-cost service alternatives and shared services. Further, the recognition of an appropriate operating margin for not-for-profit hospitals would make them more competitive in debt capital markets.

Section 28. Confidentiality of PSRO data

We vigorously support the principles embodied in this section, calling for exemption of the PSRO data from the Freedom of Information Act. In order for PSRO's to serve their intended function, it is imperative that the individuals and organizations participating in the review process have faith in the confidentiality of that process.

The evolving atmosphere of trust and cooperation among the providers of health care and PSROs could be undermined entirely should information which identifies a specific patient, physician, provider, supplier, or reviewer become publicly available. Such a development would make it very difficult to recruit persons from the local health care community to cooperate with the review system. Furthermore, exposing PSRO data to FOLA release would completely change the nature of the PSRO program. Rather than being a constructive, cooperative system of peer review, it would add yet another layer of governmental regulation, which many providers would view as intrusive and punitive. The public benefits of improved quality health care and a more cost-effective Medicare program which flow from an effective peer review system would be lost. This bill acknowledges that the legislated purpose of the PSRO program is best served by preserving personal, professional, and institutional privacy, and we heartily endorse this precept.

Section 29. Repeal of 3-day hospitalization requirement and 100-visit limitation for home health services

The American Hospital Association's membership supports and participates actively in the development of home health care services. We are pleased to see that S. 505 provides for the elimination of specific restrictions on home health services and hope that such services will be further extended, with appropriate controls, as a cost-effective modality of care for patients.

Section 31. Development of uniform claims for use under health care programs

We support the adoption of a standardized claims form for Medicare and Medicaid, as well as for other third-party payers. We would encourage the Secretary, in designing the form, to utilize the results of tests currently being conducted in conjunction with the Uniform Billing Project sponsored by AHA, with representatives of all third-party payers, including Medicare and Medicaid.

Section 32. Coordinated audits under the Social Security Act

The use of coordinated audits as a means to avoid the costly duplication of auditing procedures for the determination of reimbursement under federal health benefit programs is supported by AHA. We are concerned, however, about the lack of specificity in this section concerning the scope of the Secretary's delegating authority. Auditing is an important, highly refined, and complex function which

requires extensive experience and understanding of the basic system in order to achieve satisfactory performance.

Under this provision, it would be possible for a state Medicaid agency to be awarded the auditing responsibility. However, a state Medicaid agency as auditor with the authority to determine which costs are allowable could have a conflict of interest. This situation should be avoided by prohibiting such an agency from performing the coordinated audit functions.

Section 33. Encouragement for health care philanthropy

Private contributions assist our members in meeting the obligations they have assumed for delivery of quality health care to the people of their communities. Philanthropy reflects and fosters a highly desirable participatory attitude by individuals and organizations toward the needs of their community.

While other sources, including the government, now provide the funds for the activities of not-for-profit health care institutions, which represent the greatest portion of our health care resources, hospitals continue to rely on charitable contributions for a variety of purposes. Some of these include helping to meet the costs of outdated facilities and equipment; conducting health research and education programs; maintaining and improving community health care; and the implementation of experimental and innovative approaches to the delivery of care.

These worthy activities are clearly in the public interest, and philanthropic support for them diminishes a burden on government. They also help reduce the cost of services to all patients. Therefore, we support this section of your bill as an endorsement of the philosophy of individual and community self-sufficiency.

FINANCE COMMITTEE STAFF PROPOSALS FOR OTHER COST SAVINGS ALTERNATIVES

1. Reimbursement for outpatient hospital care

We oppose the imposition of arbitrary limits on Medicare hospital outpatient cost reimbursement. The limit suggested would be double the prevailing charges the program would have paid had the services been provided in a physician's private office.

This proposal appears to assume that all outpatient visits are the same. In fact, a wide scope of services can be, and often is, provided in a hospital in the diagnostic study and treatment of patients. The availability and use of such a scope of service makes possible dealing with more complex medical diseases and conditions, and it also adds to costs.

As the Committee is aware, hospital outpatient departments and emergency rooms in many underserved areas have been a point of patient access on a 24-hour basis, have been vital in the training of physicians and other health personnel, and are a community resource quite different from physicians' private offices.

At a time when emphasis is being placed on the treatment of illness on an ambulatory basis, including the treatment of many conditions which formerly were treated in inpatient facilities, such an arbitrary limitation would be counterproductive.

2. Disproportionate Medicare-Medicaid payments for hospital care

The AHA takes issue with the statement that there is no objective, convincing evidence that nursing service differentials are warranted. On the contrary, studies by the AHA and others demonstrate that there are clear differences in the required intensity of nursing care for pediatric, maternity, and geriatric patients. Aged persons, for example, frequently require extra assistance in bathing, eating, and other personal care activities. In fact, our surveys show that the 8½percent differential now paid is inadequate to compensate for these differences. We believe, as a U.S. District Court indicated during litigation on this subject in August 1975, that it is incumbent on those who would eliminate this differential to furnish convincing evidence to the contrary.

The proposal to change Medicare and Medicaid reimbursement for malpractice insurance expenses raises two issues. First, we are not knowledgeable about clear-cut evidence that federal beneficiaries are responsible for less than their proportionate share of dollar awards resulting from malpractice claims. One of the real problems in this insurance issue has been the long tail of claims—claims which are unpredictable, either in number or amount. Secondly, this suggests that governmental reimbursement should be on the basis of direct costing rather than the present, primarily average, cost basis. We believe that if direct cost reimbursement is to be implemented, such action should be taken across the board in both federal programs. However, we would oppose this isolated change in malpractice insurance reimbursement at this time.

3. Prohibit Medicare-Medicaid payment at hospital rates for patients medically determined to need lesser levels of care

The AHA has supported, as a means of reducing the cost of medical care, proposals which would provide incentives and assistance to hospitals which convert all or part of their unused capacity to long-term care usage. We also support reimbursement changes which facilitate the alternative use of acute care beds for long-term care. However, we oppose any penalty on a hospital for providing care to patients requiring long-term care in an area where long-term care beds are not available for their care.

The staff suggestion further indicates that a penalty should be applied if there are excess actue care beds in the area. It must be recognized that the existence of excess hospital beds may not be within the control of a hospital which would be penalized, and necessary adjustments could require not only financial assistance but also sufficient time for implementation, as well as planning agency cooperation.

4. "Stand-by" limitation for Medicare-Medicaid on allowable increases in ancillary hospital costs

The AHA strongly opposes this provision. First, we oppose arbitrary, flat limits on cost increases since such limits do not adequately account for local and areawide differences in the matrix of factors which underlie variances in hospital expenditures, including the costs of goods and services, patient mix, intensity of services, and levels and patterns of utilization. For example, in 1978 price increases as measured by the CPI varied from 6 percent in New York City, 8 percent in Los Angeles, 10 percent in Chicago, to 13 percent in Colorado. Hospitals have very different pressures on their costs in various parts of the country.

Second, a mechanism to set limits on ancillary costs based only on adjustments of wage and nonwage components according to geographic and national market basket indices could be arbitrary, imprecise, and complex and could be very difficult and costly to administer. The data and methodology to administer such limits are not available at the present time. The Committee staff comments recognize the inadequacies of current knowledge and methods, and the proposed bill establishes a Health Facilities Costs Commission to study these issues and to develop more adequate approaches. It would be detrimental to the maintenance of quality health care to freeze existing arrangements under arbitrary cost indices while the necessary studies and developmental work are conducted.

6. Competitive bidding and negotiated rates under Medicaid

This proposal appears to be concerned with arrangements to procure laboratory services and medical devices such as eyeglasses, hearing aids, and wheelchairs. The language is not clear, however, with respect to its potential scope. We would be opposed to the inclusion of hospital services as part of this item for a number of reasons, including freedom of choice, accessibility, and quality of care.

9. Delete statutory requirement specifying State payment of "reasonable costs" to hospitals under Medicaid

The AHA is totally opposed to this proposal which would potentially place participating hospitals in further financial jeopardy at a time when hospitals are required to participate in Title XIX under the Hill-Burton community service requirements. The clear ramification of the deletion of the "reasonable cost" requirement is that states experiencing fiscal constraints or deficit spending limitations could arbitrarily restrict or deny payments to hospitals without regard to the actual costs of services provided to beneficiaries under the state-approved benefit structure. If there is further inadequate reimbursement under Medicaid, the additional shortfall would have to be borne by nongovernmental third-party payers or patients who pay their own bills directly.

10. Delete statutory requirement specifying State payment of "reasonable-cost-related" reimbursement to skilled nursing and intermediate care facilities

We are opposed to this proposal for the reasons indicated in No. 9 above.

11. Apply "prudent buyer" limit to purchases by hospitals of routine supplies

The AHA supports efforts for the most economical purchase of supplies which meet appropriate standards and are needed for the care of patients. Further, we would encourage the development within the Medicare and Medicaid programs of positive incentives for the establishment of shared services and joint purchasing programs which help to achieve economies of scale.

On the other hand, this suggested procedure would involve substantial administrative complexity. The hospital manager would be unable to operate within such a

requirement unless appropriate limits were announced on a timely basis and were frequently adjusted for each community.

S. 507, MEDICARE-MEDICAID MISCELLANEOUS AND TECHNICAL AMENDMENTS OF 1979

S.507—introduced by Sen. Dole and yourself, Mr. Chairman—contains a number of Medicare-Medicaid provisions, approved last session by the House or the Senate, or, in some cases, by both chambers. Although many of these provisions are contained in S.505, they are grouped into a separate bill, which we hope will expedite consideration of them. Having commented in our statement on S. 505 on some provisions common to both bills, we would like to address a provision which appears only in S. 507.

Section 6. Flexibility in application of standards to rural hospitals

This section provides authorization for the Secretary of HEW to use flexibility in applying Medicare conditions of participation to small, rural hospitals, as long as hospitals are making good faith efforts to comply with such conditions and to the extent that their patients' health and safety would not be jeopardized. This provision was passed by the House last session as part of H.R. 13097.

While seeking to provide high quality health care within the scope of services offered by their institutions, the administrators of the many rural hospitals in the nation with 100 or fewer beds reject the idea of separate Medicare standards for their facilities. On the other hand, it is essential that government regulators be flexible in the application of one set of standards.

Flexibility in the administrative application of Medicare fire and safety and personnel standards would recognize that certain policies, procedures, and staffing requirements which may be appropriate to large, urban hospitals are often inappropriate for small, rural facilities. Rigid interpretation of the numerous and complex regulations frequently results in burdensome paper and committee work, questionable capital expenditures, and unproductive recruitment activities. Such efforts increase costs without improving the level of patient care.

Also included in Section 6 is extension of the Secretary's authority—which expired December 31, 1978—to waive temporarily the 24-hour requirement for nursing services for small, rural hospitals, provided the hospital was making good faith efforts to comply with the requirement and provided no undue health hazard existed. This authority, enacted by Congress as an amendment to the Social Security Act (P.L.91-690) in 1971 has been important in assuring access to needed hospital care for Medicare beneficiaries. Although initially some 600 hospitals were granted waivers under the authority, recent HEW data show that only about 36 hospitals were granted waivers at the end of 1978, a demonstration of hospitals' sincere efforts to comply.

We believe that the waiver authority should be extended, in order to continue to permit the Secretary to recognize and deal constructively with the special problem of recruiting and retaining health professionals in rural and often isolated areas.

We strongly support the concept of flexible application in Section 6. We recommend that it apply to hospitals with 100 or fewer beds, rather than be limited to hospitals with 50 or fewer beds. Our recommendation is in line with the definition of "small, rural hospital" accepted by Congress in Public Law 91-690, in which the 24-hour nursing waiver was provided. It is also in line with the definition accepted in the health care field, which recognizes that hospitals with 51 to 100 beds experience similar administrative, budgeting, funding, and personnel problems as do those with fewer beds.

PROPOSED HOSPITAL COST CONTAINMENT ACT OF 1979

Finally, I would like to turn to the Administration's cost containment bill, S. 570, which we are presently analyzing in greater depth. I would like to point out some of the deficiencies that we have identified on initial review of this very complicated bill.

The proposed bill calls for the Secretary of HEW to establish so-called "voluntary" limits on hospital expenses. These limits are fundamentally different from the goals of the VE which I have described above. There is absolutely nothing voluntary about this proposal—a hospital is either under a mandatory expenditure increase limit or a mandatory inpatient revenue cap. I trust that no one will be deceived by the misuse of the word "voluntary."

The Administration has consistently opposed standby wage and price controls for the national economy. Its opposition has been based on the concern that standby controls are inflationary, a view with which most economists agree. Standby controls encourage protective actions by those threatened with controls in anticipation

of future constraints. Standby controls would be just as harmful in the hospital industry as in other parts of the economy.

Hospitals face a wide variety of different conditions and needs in the local communities they serve throughout the nation. There are important differences, for example, in the size and scope of their services, the composition of the populations they serve, the problems of the patients they treat, the characteristics of the medical practice they offer, the levels and patterns of utilization in their localities, and the costs of goods and services in their communities. There is no formula that can deal adequately with these differences. Attempts to impose a formula must inevitably result in complex and inequitable adjustments and exceptions. The Administration's bill presents many such inadequacies, and promises further complexities in the regulations to be issued by the Secretary if he is given the very broad discretionary authorities included in this legislation.

Efforts to implement such a regulatory program would involve a costly and cumbersome bureaucratic machine. A large cadre of administrators and regulators would be necessary to collect, process, and analyze the vast quantity of data that would be required and to consider and make decisions on an infinite variety of special conditions and exceptions. In addition, substantial administrative costs would be imposed on hospitals as they would be required to respond to a new battery of regulatory requirements.

I would now like to comment on the bill on a section-by-section basis:

Section 2

Section 2 of S.570 would direct the Secretary of Health, Education, and Welfare to establish annual limits on increases in hospital expenses. The Secretary would estimate in January of each year the national percentage increases in the costs of goods and services (other than for nonsupervisory wages). At the beginning of the following year, the Secretary would make the actual calculation of the so-called "voluntary" limits to apply to increases in hospital expenses in the previous year. Hospitals would not know in advance of their budget year of the voluntary limit set by the Secretary. It would be virtually impossible to effectively manage a hospital under these circumstances—a sort of "Russian roulette" would most nearly describe the situation in which most hospital managers would find themselves.

This section of the bill would provide only a one percent annual allowance for needed improvements in hospital services and medical technology on a continuing basis. This fixed and essentially arbitrary allowance would result in the denial of needed and efficacious medical care to large segments of the American public. We do not believe that the Congress or the public will support a policy that prevents the health delivery system from extending the results of research and technological innovation to the treatment of illness and injury across the country.

This section does not deal adequately with the impact of our growing and aging population on the use of institutional health services. It totally disregards the significant growth in the over-65 age group of our nation. Extensive data on hospital utilization by the elderly, as compared to the population as a whole, demonstrates that this group has a rate of hospitalization more than three times greater. Moreover, the failure of the bill to recognize the impact in local population shifts compounds these problems and dramatizes the unreasonable and inequitable assumptions underlying this proposal.

Another illustration of the unrealistic nature of this section is its promise that wage increases of nonsupervisory hospital workers (about 40 percent of hospital payroll expenses) would, in effect, be passed through any voluntary or mandatory limits set by HEW. In fact, the definition of such wages in the bill excludes wage costs for shift differentials and overtime, both of which are very significant for the 24-hour operation of hospitals, as well as fringe benefits that have a direct relationship with real wage increases. Thus, while the bill appears to accommodate fully wage increases for such employees, hospitals would be unable to fulfill this misleading promise. This practical problem is further extended by the inevitable ripple effect on the hospital's wage structure resulting from upward adjustments of the lower wage levels. Finally, how can one demand that hospital managers control total expenditures while exempting a major area of those expenditures?

Section 3

In this section, the Secretary of HEW would be authorized to use estimated data to determine whether hospitals nationally, by state, or individually met a fixed "voluntary" limit. If hospitals were determined to have failed to meet this limit, a mandatory revenue cap program would be automatically triggered. There is no procedure for evaluating justifiable or trivial variations from the limit. The arbitrary and automatic features of this provision would trigger a broad and complex

federal regulatory program. The controls would become effective retroactively; that is, the so-called 1980 program would apply to hospital fiscal years beginning after January 1, 1979. Thus, the program, which has been described as standby in nature, if triggered in 1980, would, in fact, be in force today. These provisions further demonstrate the unreasonableness of this proposal.

Section 4

This section would permit the Secretary to exempt from the application of mandatory controls all hospitals in a state if the Secretary found that the state had in effect a mandatory hospital cost containment program that meets certain conditions. The AHA has been supportive of the development of reasonable and equitable programs at the state level to determine in an objective manner the financial requirements of hospitals necessary for the provision of needed health care services. Section 4 provides an excessive delegation of non-specific authority to the Secretary of HEW. Further, within the limited criteria for delegation included in this section, state cost containment programs would be required to deal equitably with all payers, hospital employees, and patients, but there is no requirement that hospitals be treated equitably.

Section 6

This section would apply a percentage cap on the per admission revenues of hospitals on a class of purchaser basis for any year in which mandatory controls are triggered. Reliance on a per admission revenue cap applied on a class of purchaser basis would be costly and inequitable, and would undermine hospital solvency. First, the data and administrative burden imposed by such a control structure would be excessive and costly—on hospitals, intermediaries, and the federal government. Second, a per admission control program on a class of purchaser basis ignores the existing variations in levels of payments by third party payers, and denies hospitals the opportunity to establish pricing policies that reflect these payment realities. For example, there is no recognition of the cost impact of providing uncompensated care for those persons unable to pay or the need to generate revenues sufficient to cover the often inadequate payments under Medicaid. In fact, while this methodology provides a cap on revenues from each payer, it does not assure that each purchaser will pay appropriately or provide a means to compensate for the inadequate payment of any payer. Finally, a per admission control program on a class of purchaser basis artificially segregates sources of revenues without regard to changes in the patient mix or benefit structure.

Section 7

This section provides detailed instructions for calculating the allowable, percentage increase in per admission revenues on a class of purchaser basis for each hospital covered under the revenue cap program. In addition to the deficiencies identified earlier with respect to the calculation of the "voluntary" limits, this section includes further inequitable and arbitrary features.

The extremely complex formula for determining the revenue increase limit for hospitals under the mandatory program does not explicitly allow for cost increases related to needed improvements and advancements in medical care delivery. While the "voluntary" expenditure limit inadequately recognized the cost impact of improvements in health care, the mandatory per admission cap totally ignores this factor. This policy thus would support a virtual freeze on such advancements.

There are three other broad areas of concern which we have identified in this section of the bill:

The proposed penalty (or bonus) provision is so general and vague as to make it impossible to evaluate its appropriateness or impact. What is clear is that the potential for penalty is substantially greater than possible rewards. Here again there is excessive delegation of authority to the Secretary;

The brief and vague description of possible exceptions or adjustments to be made at the Secretary's discretion is so incomplete as to preclude any evaluation of its adequacy; and

Adjustments to be made by the Secretary in the calculation of the allowable per admission revenue cap with respect to a hospital's performance are entirely punitive. Further, hospital expenditure performance for periods as far back as three years may be used in the calculation of these penalties.

Section 10

This section would permit the Secretary to exclude a hospital from the Medicare, Medicaid, or Maternal and Child Health programs if the hospital changed its admission practices in order to reduce its proportion of low-income patients. This

provision assumes that the reasons for changes in admission patterns are solely related to reimbursement considerations, when in fact changes in admission patterns can occur for reasons unrelated to the source or amount of payment. There are no criteria to define an unacceptable change in admission experience, and, finally, there is no provision for due process in the consideration of complaints.

We are continuing our analysis of this legislation, Mr. Chairman. But it is evident to us that this bill is unnecessary, conceptually flawed, and would lead to serious disruption in the delivery of hospital care to patients. As we have previously indicated, the proposed bill includes many arbitrary and unreasonable provisions, such as the granting of excessive discretionary authorities to the Secretary. Despite years of effort, HEW has been unable to present promised methods to deal with many key issues, yet the proposed bill addresses critical complexities with a simple solution: let the Secretary decide later what to do on his own.

Therefore, we strongly oppose S. 570. Hospitals are sincerely committed to containing health cost increases and are actively participating in the only organized industry-wide voluntary program to fight inflation. It is our strong conviction that such voluntary actions are the most effective ways of dealing with the containment of health care costs while maintaining quality. The Voluntary Effort is succeeding and should be allowed to develop without further governmental intervention which would undermine its continued success.

CONCLUSION

In summary, Mr. Chairman, you recognize that reform and change in the system of paying for hospital care to patients is an exceedingly complex undertaking. Your bill, S. 505, reflects that complexity, and we appreciate the long and careful attention you and your staff have given to the development of S. 505 to this point.

We have in this statement continued to comment constructively on your proposals to incentivize a payment system for hospitals and to recognize the important variations that exist among institutions. While the bill itself in a number of areas recognizes the state-of-the-art limitations in classification systems for hospitals, in data collection and analysis, and in cost comparision methodologies, it is in sharp contrast to the arbitrary, inequitable, mandatory per admission revenue caps recommended by the Administration. Your bill includes many constructive and important reforms in administration and reimbursement for services under Medicare and Medicaid. We will be pleased to continue working with you and your staff in further refinements that we believe are necessary for the improvement of the existing payment systems used by these programs.

Mr. Chairman, this concludes our comments on the various health care cost containment proposals that are presently under consideration. Thank you for this opportunity to be heard. We will be pleased to answer any questions you or members of the Committee may have.

Senator TALMADGE. The next witness is Mr. Lawrence C. Morris, senior vice president of Blue Cross Association and Blue Shield Association.

Mr. Morris, you may insert your full statement into the record and summarize it for not more than 10 minutes, please.

Mr. MORRIS. Thank you, sir. I would ask our written statement be put into the record.

Senator TALMADGE. Without objection, it will be inserted into the record.

STATEMENT OF LAWRENCE C. MORRIS, SENIOR VICE PRESIDENT, BLUE CROSS ASSOCIATION AND BLUE SHIELD ASSOCIATION

Mr. MORRIS. Mr. Chairman, members of the committee, I am Lawrence C. Morris, a senior vice president of the Blue Cross and Blue Shield Associations. On my left is Neil Hollander, a vice president of the associations. We thank you for the opportunity to comment on S. 505 and S. 570.

Collectively, the 69 Blue Cross and 70 Blue Shield plans in this country serve almost half the population. Obviously, the cost of

health care is a principal concern of those plans and appropriate measures by Government against costs will have their support.

We believe health care costs are more than a simple pocketbook issue. We have to address these problems while maintaining access to quality care, a priority shared equally by the public and by the private sectors.

Effective reforms in the administrative and reimbursement features of medicare and medicaid could have positive effects on the total health care system. We would certainly welcome that.

Our commitment to cost containment has been previously reported to this committee and we believe our efforts have shown results.

We were among the first to develop and implement such basic tools of cost containment as health planning, utilization review, innovative payment systems, and alternative delivery systems.

We are working with some of the major professional organizations to examine critically the medical necessity of traditional procedures and processes. The Blue Cross and Blue Shield plans have established specific cost containment programs as conditions of membership in the national associations.

These and all of our other efforts have been undertaken with a goal of affecting total health care cost. This last point is important because costs simply transferred from us or from the Government to the individual do not present in any fair sense of the word "cost containment."

Two years ago, in spite of our efforts and those of others, we saw hospital costs rising at an unacceptable rate. We supported action by government to restrain those costs. Since then, we have joined with major hospital, physician, business, and labor and carrier organizations to help bring health care costs under voluntary control.

We have been highly encouraged by the voluntary effort. We think the voluntary effort and efforts within the medicare and medicaid programs can be mutually supportive.

The voluntary effort set ambitious short-term goals. It sought a 2-percentage-point reduction in hospital expenditures for both 1978 and 1979. It sought a 1-percent reduction in physician charges in 1979 and again in 1980. It sought a stabilization of the national supply of hospital beds, a deceleration of capital expenditures and a reduction in the growth of full-time equivalent hospital employees per bed.

In a little more than a year, the results are impressive. In 1978, hospital expenditures fell to a 12.8 percent rate of increase from 15.6 percent the year before. Physician charges fell to 8.4 percent from 9.3 percent. Other measures are not yet available but we are optimistic.

We do not believe this decleration has been totally due to the voluntary effort. We think a major part of it has been. We believe the effect of private, voluntary efforts should be as important to the Government as it is to the private sector. The voluntary effort is an important resource in our mutual activities to contain health care costs.

We are not suggesting that Congress should simply stand aside and wait for voluntary initiatives to suceed or fail. Government has

two roles to play. One is as a very large purchaser of care and another is as a regulator.

In view of the voluntary program accomplishments in the last 18 months, we do not believe the administration's proposed regulatory approach in S. 570 is appropriate at this point. It is more likely to frustrate than enhance the voluntary effort.

For example, the automatic trigger proposed by the act could seriously weaken the voluntary effort challenge to all hospitals. Further, the suggestions before you in this proposed legislation do not meet the tests of clearness of purpose, simplicity of implementation and reasonable certainty of result.

Instead, as an extension of its regulatory role, the Federal Government should create a commission as contemplated by the Hospital Cost Containment Act but with greater judgmental and evaluative responsibilities. The commission should be independent and should monitor health care costs in the context of management performance and social priority. It should specify and help maintain adequate data.

It should evaluate the controllable and uncontrollable factors which affect health costs and translate the evaluations into policy recommendations or where appropriate, proposed legislation. It should address the very complex question of forming appropriate hospital group for monitoring and whether additional controls on capital may be necessary. Should the voluntary effort fail, the commission could recommend necessary legislation.

As regards the Government's role, our written testimony contains our thoughts on S. 505 as well as responses to alternatives the committee asked us to address. While time clearly does not permit me to go through our comments in detail, I would like to highlight a few points.

The potential cost containment effectiveness of the bill, we believe, will rest largely on its second section, "Criteria for determining reasonable cost of hospital services."

We support the use of incentive payments to support hospital efficiency and the use of prospective target levels for peer groups in determining medicare and medicaid reimbursement.

We do urge that sufficient flexibility be built into any final measure so that cost containment programs now underway and based on local conditions are not undermined.

The Health Facilities Cost Commission is an appropriate body to deal with the difficult question of classification.

We support the concept of this second commission to concern itself with the best application of Government's purchasing role. We would want to see its responsibilities broadened.

We believe it should be given the resources necessary to monitor such things as impact on the quality of care, adverse impact on certain hospitals which do not fit well into peer grouping; inappropriate shifting of costs to such areas as ancillary services or outpatient care; shifting of costs between payers or to individual patients and the impact on hospital costs of additional recordkeeping requirements.

We also support provisions for transitional allowances for hospitals closing or converting unneeded services or facilities. We make suggestions that we believe will strengthen these provisions.

We support the goal of section 5 to encourage more physicians to accept assignments under the medicare program. Blue Shield plans have used the participating physician concept for years and we would be happy to consult with your staff on how to make it work effectively.

We also urge that careful monitoring and evaluation be made of any changes in reimbursement for hospital associated physicians to be sure that their impact is consistent with the intent of the law.

We support the provisions of section 13 to encourage acute care hospitals to provide skilled extended nursing care where feasible and we are pleased to see the provision for evaluating the impact on utilization. We encourage a broadening of this section to allow for more thorough program evaluation.

The committee has also invited our opinions on a number of alternative proposals. One of them involves the proposed alternative to disproportionate sharing by medicare and medicaid in hospital costs. We urge careful study.

Basically, we support payment of the full economic cost of services rendered to beneficiaries or subscribers of various third party payers. This is a complex issue and its resolution warrants an overall evaluation of the total medicare/medicaid reimbursement structure.

Another of the alternatives being considered has to do with standby limitations on reimbursement for ancillary services to become effective should the goals of the voluntary effort not be met.

I have already described the initial success of the voluntary effort program. We believe it has every chance of working and that the Government should do everything it can to encourage it. Standby controls in our judgment are more likely to stifle than strengthen the voluntary effort.

We support the repeal of the three day hospitalization requirement in section 29. It should provide access to more appropriate care for medicare beneficiaries and promote the use of lower cost care.

The uniform billing concept included in section 31 can both improve administration and reduce costs. We believe it should be implemented after full evaluation of the tests under way.

I have tried to outline the response of the Blue Cross and Blue Shield Associations to S. 505 and S. 570 in a few minutes.

We would like to assure you of our cooperation in helping to design and implement improvements to these two bills.

I thank you.

Senator TALMADGE. Thank you very much, Mr. Morris. We appreciate your testimony and your cooperation.

I want to congradulate Blue Cross and Blue Shield on the their action taken concerning reimbursement for routine tests.

In order that I might get a better understanding of your action, I would like to review that very briefly with you.

Suppose I break my toe and I go to the hospital. The hospital is concerned that I might sue them for malpractice. What routine tests am I likely to get either by order of the hospital or order of my physician that I do not need? All I have is a fractured toe, a pretty simple problem.

Mr. MORRIS. Mr. Chairman, I think what has developed over a period of years has been an expansion of the routine batteries in many hospitals, beyond the real medical needs, partly because a number of hospitals have been concerned about exactly what you cite, the malpractice threat.

One of the problems in malpractice has been that the burden of proof has usually been on the defendant to prove why he did not do something. One of the effects of this particular program—which is not implemented solely by us but is also implemented by some of the most credible professional organizations in the country—has been to try to establish that there are things which ought not to be done, where ordinarily there should be no real need: For example, with the broken toe, to give the routine chest X-ray or the routine test for a venereal disease and some of the other tests that are customarily given.

This is not to say that some hospitals have not done cost-effectiveness studies on their routine batteries and in fact done a pretty good job of establishing batteries which can be done on all patients early in the admission to be sure that the information is up on the floor when it is needed, economically and efficiently.

We expect fully to make accommodation for those kinds of arrangements.

That program developed from a survey we did ourselves of about 200 hospitals chosen randomly which showed enormous variation in the routine batteries. Some of them simply are not very conservative and did not appear to us to be medically necessary which question we referred to the College of Physicians who agreed with us.

Senator TALMADGE. What tests are likely to be given me when I go into a hospital with that broken toe?

Mr. MORRIS. Mr. Chairman, it would depend so much upon the hospital.

Senator TALMADGE. In other words, they might give me a half a dozen tests that have no relation to my broken toe; is that right?

Mr. MORRIS. It could certainly happen.

Senator TALMADGE. Have you stopped any or all tests of the hospital without an order from the physician?

Mr. MORRIS. We have stopped no tests that a physician has said he needs.

Senator TALMADGE. You have stopped no tests ordered by the physician. You have stopped hospital tests; is that correct?

Mr. MORRIS. We have said that before we expect to pay for the tests. We expect a physician to say, "I want the test, I have ordered it."

Senator TALMADGE. If the physician thinks I need an X-ray for my broken toe, is that payable?

Mr. MORRIS. Certainly.

Senator TALMADGE. Does it have any relationship whatever to my broken toe?

Mr. MORRIS. It might. If, for example, you were a candidate for surgery on the foot and the physician felt that before giving you anesthesia he would like to see your chest; yes.

Senator TALMADGE. I presume medical science in its great skill has developed many tests? How many tests would I get if I went to Johns Hopkins?

Mr. MORRIS. I think in the procedure nomenclature, there are something on the order of 3,000 pathology tests.

Senator TALMADGE. What would the 3,000 tests cost if my physician thought I needed every one of them?

Mr. MORRIS. It would be awful to contemplate, Senator. I have not done the arithematic but it would be a lot of money.

Senator TALMADGE. Running into thousands and thousands of dollars.

Mr. MORRIS. I am sure it would.

Senator TALMADGE. One review we have on physicians tests is through PSRO's. Suppose a physician wants to put a CAT scanner on my brain because I have a broken toe. Is PSRO review the only way to hold him responsible? I know you pay by contract on a fee for service and in some instances cost plus.

You do have contractual arrangements and the fees are reasonably standard; are they not?

Mr. MORRIS. We have a variety of ways to pay. They include fee for service and cost of the hospital and charges.

Senator TALMADGE. Suppose I am a medicaid patient. How many of these tests could my physician order for me if he wanted to, all 3,000?

Mr. MORRIS. He would have to show medical necessity.

Senator TALMADGE. Suppose he did not, who is going to stop him, PSRO or who else?

Mr. MORRIS. There is a mechanism within the hospital. Many hospitals have cost containment committees. The American Hospital Association——

Senator TALMADGE. I am talking about the physician and not the hospital. Are there no constraints on what a physician thinks is necessary.

Mr. MORRIS. That kind of thing should be picked up in the utilization review processes of the carrier.

Senator TALMADGE. Of the hospital or the PSRO?

Mr. MORRIS. Of the carrier.

Senator TALMADGE. Who?

Mr. MORRIS. The insurance company, the carrier.

Senator TALMADGE. I am talking about a medicaid patient now. The Government pays for that.

Mr. MORRIS. It would depend upon the adequacy of the utilization review program that the medicaid agency were using.

Senator TALMADGE. You are talking about two reviews? Is there a review separate from PSRO?

Mr. MORRIS. Yes; for outpatient tests, there would be a wholly different mechanism.

Senator TALMADGE. Who makes that review?

Mr. MORRIS. The medicaid agency would make it.

Senator TALMADGE. In other words, the State would make it with respect to medicaid. They have standards by which they pay and do not pay.

Mr. MORRIS. It could be the State. It is not necessarily the State. It depends upon which State we are discussing.

Senator TALMADGE. How much do you estimate that your action will save?

It has no relation to medicare or medicaid; is that correct?

Mr. MORRIS. I think it will have a relationship.

Senator TALMADGE. We are now talking about what you pay for. You are not acting for the Government; is that correct?

Mr. MORRIS. That is correct. In order to really answer that question accurately, we would have to do a very exhaustive study of what the admission batteries are across the country. We have not done it.

Senator TALMADGE. Do you have an idea of how much it would save?

Mr. MORRIS. No; we have estimated it.

Senator TALMADGE. What is your estimate?

Mr. MORRIS. The cost of admission batteries is on the order of $2 billion a year. We do not know how much of that can be saved because much of it is necessary. But the savings might be on the order of 20 percent of that, at a guess.

What we are really quite interested in doing and we expect this program will have that effect—or reinforce that effect—is bringing about a reexamination of some of these decisions. If they are reexamined and found to be useful, we have no objection to their being continued. We want to address the things that have built up out of habit or out of precedent without real address to the question, if we really need them anymore. If it does that and that alone, it may be quite useful.

Mr. HOLLANDER. Senator, might I expand on Mr. Morris response to your toe? That concerns us and the inappropriate services which might surround it.

Blue Cross plans have medical necessity requirements in their contracts with hospitals. We have independent utilization review programs oftentimes using the hospital's utilization review committee or contracting with PSRO's or our own medical directors reviewing claims.

If you received an inapprorpiate service, it would be the responsibility of those agents to insure that we did not pay for medically unnecessary services for you.

Senator TALMADGE. In your statement, Mr. Morris, you express concern over the lack of a provision in S. 505 that would discourage shifting of cost disallowed by medicare and medicaid to other payers.

I would like to call your attention to section B(1) and (2) on page 20 of the bill which specifically prohibits shifting of costs which are disallowed under medicare and medicaid.

Senator Dole?

Senator DOLE. What has been your experience in the use of a second opinion as it concerns unnecessary surgery?

It has been suggested by others as maybe another effort to reduce costs. What has your experience been?

Mr. MORRIS. Senator, we have second opinion programs in place in several plans. One of the difficulties of evaluating the approach is that the volume of second opinions has not been terribly high in any one place. We would like to have a larger data base to evaluate. We are trying to address that problem at the association level

by having a number of plans with those programs give us their experience so we can aggregate it and get a larger base and reach a valid conclusion.

It is my opinion at this point—and I have to express an opinion because I am not confident of the data we have nor the volume of data—that second opinion will not turn out to be cost effective when applied to all surgery. That has to do in part with the reasons that people get surgery, which are frequently reasonably subjective. They hurt and they want to stop hurting.

It may well turn out to be a very useful addition to the contract in certain kinds of surgery. There are differing rates of disagreement between the surgeons for various kinds of surgery.

One of the things that we hope to get out of that is the ability to feed the findings back into the continuing medical education process, so more attention can be paid to what the criteria really are and perhaps the rates of disagreement brought down.

Senator DOLE. I understand you have some disagreement with section 10 which deals with the calculation of statewide charges. How would you suggest we address the disparities in the system which lead to these sometimes unjustified differences in fee levels in a State?

Mr. MORRIS. Senator Dole, we do not have any disagreement with section 10 per se. It is entirely within the prerogative of the Congress to decide how it will choose to distribute medicare funds.

We simply pointed out that physician reimbursement is not an end, it is a means. Various systems can be absolutely appropriate depending upon what the target is.

The limitation on the top of the range relative to the median would have two effects, in our opinion. It would maintain and might well improve the relationship between the individual physician's charge and the medicare payment in low charge areas. In the high charge areas, it might tend to widen the range between the medicare allowance and the individual physician's charge. The impact on the individual patient would vary accordingly.

If the intent of the provision is to spread more equally across charge areas the medicare expenditures, I think it will achieve that. If the intent is to significantly increase the amount of full payment or 80 percent of full payment that medicare delivers, I am not confident that it will.

My disagreement is not with section 10 itself. It is a lack of understanding on my part of precisely what is intended to be achieved.

Senator DOLE. I read your comments with reference to section 6, which is a rather controversial section in the Talmadge/Dole proposal, regarding hospital based physicians.

As I understand it, you suggest we focus on the total amount paid rather than the type of payment arrangement.

Mr. MORRIS. Both the total amount paid and a clear definition of what is being paid for. The volume related arrangement, while subject like every other arrangement to abuses, does have the significant virtue that it packages a service making it, administratively, relatively simple to pay and relatively predictable.

In the financing of health services, it is sometimes as important to watch the side effects of a proposal as the direct impact of the proposal itself, for example, in pathology.

We envision the volume based arrangement as packaging some of the consultation, some of the personal interpretations, some of the things that the pathologist does himself, which could conceivably be subject to fragmentation if that system were done away with. It would certainly increase administrative costs and might well increase benefit costs.

I wish I had a good final answer on this point. It is a serious problem. The pathologists are aware of it and we are aware of it. We are meeting together to try to discuss how in our private business we can address it.

I suspect the long range answer is to change the concept of a bill. We might have to deal with a per-admission concept or a per-diagnosis concept.

It is a difficult problem that I do not feel we have finally resolved ourselves. I am simply pointing out that it does need some careful consideration.

Senator DOLE. Thank you.

Senator TALMADGE. Senator Long?

Senator LONG. It seems to me we ought to do something about some of defensive medicine. I think we have certain standards under the PSRO program that in certain situations, certain tests should be expected.

It would seem to me that perhaps we ought to say a doctor and a hospital would not be liable for failure to perform tests that go beyond that unless there is some medical reason. In other words, if there is some reason that additional tests might be necessary, I can understand perhaps they should run those tests.

It seems to me we should start legislatively taking some of this burden off the doctors for some of this defensive medicine.

Can you give me a suggestion along that line?

Mr. MORRIS. Senator, we have, as one of our retained attorneys, a gentleman who is one of the country's acknowledged experts on malpractice law. He served on the Secretary's Commission on Malpractice.

With your permission, I would be very happy to have him address that question and comment to the committee.

Senator LONG. Is he here now?

Mr. MORRIS. No, sir, he is not.

Senator LONG. It seems to me that one of the big savings we can make and perhaps should make is to do something about defensive medicine.

With regard to cost containment, I should think you have at least thought about it or struggled with the idea of trying to write policies to help hold down the costs by providing payment for certain type operations and procedures, depending upon what the health problem is. You could probably contract with doctors who would be willing to handle your business at the fees you would think appropriate.

Is that right or wrong?

Mr. MORRIS. That is correct. It is one of the basic concepts of the HMO or the alternate delivery system. We have done a great deal of work in that area.

With respect to the question of handling the malpractice threat in the conventional open system, we have had some experimentation in California, for example, with putting into the insurance contract an arbitration clause which says if the participating physician and the patient believe there is a malpractice problem, they can submit it to arbitration.

There has been some thought of implementing that in other States. I am advised that the laws of the States vary considerably on this and there just is not an opportunity to do that in all States because of the provisions of State law.

Senator LONG. In some way, we should try to solve some of this. I have been told by doctors, for example, that when someone is badly injured and lying unconscience on the side of the road, most are afraid to touch him because they are subject to being sued for malpractice even though the person obviously is very much in need of medical care at that moment.

Is that correct or not?

Mr. MORRIS. I am sure it is correct psychologically. I am not at all sure it is correct legally. Many of the States—I think the majority of the states—have enacted the so-called Good Samaritan laws which would give some protection to the physician in that situation.

I am told that the number of courts that have actually found physicians guilty of malpractice in situations in which they were trying to give emergency care, perhaps out of their specialty, has been almost nil.

I am sure it is a severe psychological problem for the physician. I am not sure it is really a very practical problem in terms of the awards that have been made.

Senator LONG. I should think for the good of the public that we ought to protect physicians from that type of thing. To take the automobile accident example, if the person does not have treatment he is likely to die right there.

A doctor comes along who has the potential to save that person's life; to hold that doctor liable, take him to court when he is doing the best he can, is completely contrary to conscience. I do not think he should even be sued, unless you can show there was some reason such as gross negligence.

If this was a case where a good samaritan would try to save the person and that is what the doctor tried to do, it does not seem right to me that he should be sued at all.

I can understand why a doctor seeing a colleague being sued would say that this is the last time I will try to help somebody on the side of the road.

It seems to me that in a case like that we should legislatively provide some additional protection for doctors.

Mr. MORRIS. You asked a similar question earlier, Senator, and I offered to try to provide some more expert help than I on the legal question, which seems to me, as a nonlawyer, a balancing of the interest of the physician who really is doing the very best he can to

help and should have that protection, and the interest of the patient who really may have been injured through negligence.

I am simply not enough of a lawyer to know how to balance those questions, which seem to me to be fundamental constitutional questions.

I would be very glad to get someone more expert than I to comment on it.

Senator LONG. Thank you very much. I have no further questions.

Senator TALMADGE. Thank you very much, Mr. Morris. We appreciate your contribution.

[The prepared statement of Mr. Morris follows:]

STATEMENT OF LAWRENCE C. MORRIS, SENIOR VICE PRESIDENT, THE BLUE CROSS ASSOCIATION AND THE BLUE SHIELD ASSOCIATION

Mr. Chairman and Members of the Committee, I am Lawrence C. Morris, a Senior Vice President of the Blue Cross Association and the Blue Shield Association. We appreciate the opportunity to comment on S. 505—Medicare-Medicaid Administrative and Reimbursement Reform Act of 1979, and on the broader issue of containing national expenditures for health care.

The Blue Cross and Blue Shield Associations, which operate under a single Chief Executive and staff, are the national coordinating agencies for the 69 Blue Cross and 70 Blue Shield Plans in this country. These Plans provide privately underwritten health care coverage to about 85 million Americans, and serve almost another 20 million as fiscal agents or intermediaries for the Medicare, Medicaid and CHAMPUS programs. Thus, the Plans serve about half the U.S. population.

These Plans, and more importantly, the individual subscribers they serve, would be directly affected by this legislation, as they are by any public or private action which bears on the costs of health care.

We share your concern about the level of health care costs. The problem must be resolved because of its effect on inflation generally, because of its effect on taxes and, most importantly, because of its impact on the ability to assure that people have adequate access to health services. Cost containment reforms are possible and should be made in both Medicare and Medicaid. They should be undertaken selectively and in a manner that does not allow costs to be transferred from government to other payers without containment of total costs.

In 1977, because of uncontrolled escalation of costs, the Blue Cross Association supported action by government to restrain total hospital costs. Since then, we have joined with major hospital, physician, business, labor and carrier organizations in a major new effort to bring health care costs under control voluntarily. This coalition has adopted specific, quantified goals to reduce health expenditures, with particular emphasis on its major elements—hospital expenditures and physician charges. This Voluntary Effort and efforts by Medicare and Medicaid to support containment of total health care costs can be mutually supportive.

The short-term goals of the Voluntary Effort have been stated clearly and publicly. They include a two percentage point reduction in hospital expenditures in 1978 and again in 1979; a one percent reduction in physician charges both in 1979 and in 1980; a stabilization of national hospital bed supply at December 31, 1977, levels, adjusted for any new beds for which certification of need or 1122 approvals were granted before December 31, 1977; a deceleration in capital expenditures; and a reduction in the growth of full time equivalent employees per bed.

From the beginning, the effort has been made public. Progress toward its goals has been measured and reported periodically to the public, the press, and, by agreement, to the President's Council on Wage and Price Stability.

In 1978, performance was impressive. Hospital expenditures fell from a 15.6 percent rate of increase in 1977 to 12.8 percent in 1978. Physician charges fell from a 9.3 percent rate to 8.4 percent, and also from 127.4 percent of the CPI (All Services less Medical Services) to 98 percent of that rate. Bed supply increased about 1 percent, which was probably within certificate of need extensions. Data on this last point and on capital expenditures are not yet conclusive. The goal in regard to FTE employees was instituted only a few weeks ago.

In the longer term, the Voluntary Effort's goal is to narrow the gap between the rates of acceleration of hospital expenditures and the Gross National Product, and between physician charges and the Consumer Price Index. Fundamentally, it is a

manifestation of our commitment to bring about the necessary changes in health delivery and financing while sustaining the high quality of care we have come to expect.

As we have reported to your Committee in the past, Blue Cross and Blue Shield Plans are committed to cost containment. Our record speaks for itself. We have been pioneers in developing and implementing the basic tools of cost containment: for example, health planning, utilization review, innovative payment systems, and alternative delivery systems. With the active cooperation of some of the major professional organizations, we have attempted to identify procedures and processes which could be subjected to more stringent tests of their medical necessity. In 1977, our two organizations jointly developed membership standards which require each Plan to have specified cost containment programs as a condition of membership in the National Associations. These efforts affect costs to all patients. They will help contain government expenditures for Medicare and Medicaid patients. We also desire to see that reimbursement arrangements reflect the full costs associated with services to their subscribers or beneficiaries. In the light of these interests, we have examined the various provisions of S. 505.

Overall, we believe S. 505 has potential for favorable cost containment effects, and we support many of its individual provisions either on a permanent or on an experimental basis.

We shall comment on what we believe are the advantages of the various provisions, and, where appropriate, note provisions that raise problems of administration, cost of implementation, and shifts of costs from one payer to another. Many of our suggestions, we believe, can be treated within the context of the responsibilities of a Health Facilities Cost Commission which we have supported.

Let me share with you now, our comments on the individual sections of S. 505 and the March 7, 1979, Senate Finance Committee Staff Alternatives for Possible Health Care Savings Proposals.

Section 2—Criteria for determining reasonable cost of hospital services

We support the emphasis that S. 505 gives to the use of incentive payments to promote hospital efficiency. Peer groups and prospective target levels can be important in determining incentive payments for good performance and penalties for excessive costs. Furthermore, these concepts can be sensitive to individual hospital characteristics. Such a system could be fair, and recognize the necessary cost of patient care.

We do not believe that there is yet a single best performance-based payment system. We also recognize the problems in the development of an effective cost containment program.

We are concerned about some of the specific characteristics of Section 2.

Payers covered.—We would like to see a provision that discourages shifting of costs from Medicare and Medicaid to other payers, whether by oversight or intent.

Peer group.—The bill provides for three major categories: acute general hospitals (8 subgroups by size); hospitals associated with medical schools; and specialty hospitals. There is also a distinction between hospitals located in rural and urban locations. The classifying system is intended to separate inefficient from efficient hospitals. In the development of penalties and incentive payments in this bill, there appears to be an unstated assumption that inefficiency means high cost and efficiency means low cost within each category. Unfortunately, there is no known way to classify hospitals by their efficiency. Various systems are being studied. Some ignore size, but consider affiliation and facility characteristics. No system has yet been adequately evaluated and found completely satisfactory.

We support the provision that the Health Facilities Cost Commission examine methods for classifying hospitals. It deserves a high priority. Any classification system needs to examine those hospitals which are closely associated with medical schools. The larger medical schools frequently have training programs in many hospitals.

If hospitals which now have contractual relationships are classified as other than "primary affiliations," they may be put into peer groups with substantially lower target rates, reducing their income and their ability to provide quality care to all their patients, including Medicare and Medicaid beneficiaries.

Target levels—average costs.—The bill provides for calculating average costs in each peer group on the basis of the sum of two parts: average personnel costs adjusted for area wage differentials, and average nonpersonnel costs. The adjustment for area wage rates seems intended to make the national peer average applicable to an area hospital. A government study of total hospital costs suggests that wage differentials may not account for all significant variations in cost among hospitals. The adequacy of wage data available for small geographic areas is not yet

proven. The provision in the bill that permits comparison of a hospital wage level with an area wage level may be administratively difficult and expensive, even if it is technically feasible.

Another matter of concern is the potential impact of determining a target rate across a wide range of hospitals. Medical practices are different among areas of the country. Specifically, hospitals with low lengths of stay may have higher per diem costs than others in their peer group which are not necessarily attributable to inefficiency. At a minimum, we need to monitor carefully how the target rate approach will affect hospitals, and prepare to make appropriate changes if this approach results in inequities. Monitoring and evaluating could be an important Commission responsibility.

To implement this provision of the bill, hospitals would have to maintain personnel costs for routine operating costs separately from personnel costs for ancillary and other operating costs. Such allocations are likely to be arbitrary and self-serving, and are not provided for in existing reporting forms.

Incentive payments.—Hospitals whose costs are below the average for routine operating costs receive an incentive payment equal to half the difference between their cost level and the target rate, but not more than 5 percent of the target rate. There is no incentive to operate below 90 percent of the target rate. As presently written, there is no incentive to improve performance unless a hospital is over the target rate plus the fixed allowance. The net impact of the incentive payment and penalty provisions may be that total costs will increase. The proposed Health Facilities Cost Commission should examine available data and model the likely effects. We support the incentive concept. Our concern is one of effectiveness in achieving desired objectives.

HEALTH FACILITIES COSTS COMMISSION

We support the creation of a Health Facilities Cost Commission. This is particularly important when new methodologies are being introduced while all their impacts are not yet known.

One of the responsibilities of the Commission should be to receive data and monitor the impact of the changes set forth in Section 2 and other sections of this bill. Among the specific effects to be monitored are:

(1) Impact on quality care.

(2) Selective adverse impact on hospitals because of utilization practice (i.e., length of stay) not related to inefficiencies.

(3) Inappropriate shift of costs within hospitals to non-routine areas (i.e., ancillary services or outpatient care).

(4) Shifts of costs to patients or other third party payers.

(5) Impact on hospital costs because of additional recordkeeping requirements.

In addition, the Commission should consider making recommendations with regard to:

(1) Appropriateness of peer grouping.

(2) Ways to reward hospitals for improving quality of care.

(3) Ways to establish more effective incentive arrangements.

Periodically, the Commission should report its findings on these matters to the Congress, with recommendations for appropriate changes.

In summary, Section 2 of S. 505 can have cost containment impact. We have attempted to point out some of the potential difficulties, and suggested changes where we think they are necessary. Most important, we believe that for the system to be effective:

1. It must be continually evaluated and modified as necessary.

2. It must allow for and encourage non-federal, locally developed experimental reimbursement programs. Out of these programs can come modifications in the basic system to improve its effectiveness and efficiency.

3. It must permit the establishment of systems that would reward or penalize hospitals along a continuous range of efficiency and performance levels. We note, however, that much work needs to be done on measuring efficiency in hospitals. This knowledge is needed for the development of an appropriate peer grouping system.

These activities should be important responsibilities of the Health Care Facility Cost Commission. The need to know more about several provisions of this section suggests the desirability of controlled demonstrations in selected areas or states before their universal application.

Section 3—Payments to promote closing and conversion of underutilized facilities

We support the "transitional allowances" provision for temporary financial support to hospitals which close or convert duplicate and unneeded services and facili-

ties. Because the industry's capital structure is a key determinant of costs, this provision (in combination with Public Law 93-641) represents an innovative step in developing appropriate long-term cost containment measures. You may be aware that the Blue Cross and Blue Shield organizations have already began examining the potential of the concept in the private sector.

While this provision introduces a novel approach, in need of testing and evaluation, we recommend that the provision be broadened in the following respect:

Section 1128(c) (1) and (2) should be modified to allow application to the Hospital Transition Allowance Board before the closure or conversion has started. This would provide hospitals considering qualified conversions another incentive—that of financial assurances before the fact.

Section 1128(e) should be broadened to provide for more than 50 hospitals during the test. We suggest a minimum of 100, which would provide a broader base for analysis of the provisions' impact and give greater latitude to the Secretary to accelerate application of the program on the basis of favorable test results.

As a technical modification, we recommend that the reimbursement provisions, which are different in the cases of hospitals that close and those that remain open, be dealt with in separate provisions for purposes of clarity.

As Section 1128(b)(3) currently reads, several issues are unclear. For instance, in the case of conversions, where the aggregate reimbursement is reduced, would the facility continue to receive any amount of the reduction? If so, does that amount include operating costs or just capital costs such as interest and depreciation? And where operating costs increase on an "interim basis," should time limits be specified for the "interim basis?"

In the case of complete closure, it appears the facility only receives a transitional allowance for debt obligations. We suggest that operating costs associated with the closure also be included.

A major issue in shift of function or closure is employment. Funds in addition to debt retirement should make it possible to retrain personnel and to assist them in obtaining new employment. However, the amount of funds that can be dedicated must be limited. At some point the desirable alternative of closing or correcting beds could become uneconomic.

Section 4—Federal participation in capital expenditures

We support the provisions in this section because we believe they will help achieve both a short- and a long-term constraint on rising health care costs through appropriate application of the planning process and related reimbursement.

This section attempts to address important aspects of this issue by further linking Medicare and Medicaid reimbursement to Public Law 93-641 and extending Section 1122 penalties to include direct operating costs associated with capital expenditures.

We support State Helath Planning and Development Agencies' (designated under Section 1521 of Public Law 93-641) serving as Designated Planning Agencies under Section 1122, the re-establishment of funding to State Health Planning and Development Agencies and Health Systems Agencies under Section 1122, and the extension of Section 1122 penalties to include direct operating costs of unapproved projects.

With respect to capital expenditures of providers located in inter-state SMSAs, we have several questions and concerns. What happens in an SMSA which infringes upon two or more jurisdictions, one of which is not an 1122 state? Assuming the State Health Planning and Development Agencies will be asked to review proposed capital expenditures in such areas, will the Secretary reimburse the non-1122 state for the cost of a review of a project located in a neighboring 1122 state? If the facility proposing the capital expenditure is located in an SMSA, but in a non-1122 state, can reimbursement be limited to the facility because the non-1122 state SHPDA concurs with a negative finding by a neighboring 1122 state, part of which is also in the SMSA? Is it the intention of this provision to extend 1122 authority to cover facilities in non-1122 states? Finally, 180 days may not be adequate time for multiple state reviews of projects in SMSA's. Even though a provider may be located in an inter-state SMSA, it is very possible that it serves few people residing in the neighboring state; from an equity standpoint, should such providers be subject to this provision? Finally, is the interstate SMSA problem of such a magnitude that the benefit to the public will outweigh the additional costs and administrative workloads for both states and providers?

Section 5—Agreement to accept assignment

This section would encourage a physician to accept assignments by giving the physician an option to submit claims on a simplified basis, including multiple listing of patients. Physicians would receive an additional $1 for each such claim submit-

ted, with certain exceptions that limit amounts paid to physicians under this arrangement.

We support the intent of this section providing incentives to encourage physicians universally to accept assignments under the Medicare program. For any full payment program to work with consistent predictability, there must be a commitment in advance by the physician. In return, physicians must have confidence that reimbursement for their services will be fair and equitable.

Blue Shield Plans have traditionally utilized the participating physician concept. We would welcome the opportunity to consult with the members of this Subcommittee and its staff in this regard. We support the provisions of this section that would reduce paperwork by simplifying claim forms and reimbursing for preparing these claims; but we have doubts that these incentives alone are sufficient to encourage a significant improvement in participation by physicians.

The definition of "participating physicians" should be expanded to include any licensed practitioner who will receive payment under an agreement.

Records and charges should be maintained in such a way that information necessary for subsequent audit can be retrieved. The requirement that an additional form be signed by each enrolled patient waiving confidentiality is administratively burdensome. Authorization of release of information could be included on the claim or billing form.

Section 6—Hospital associated physicians

We agree with the provisions in Section 6 that permit a hospital-associated physician to bill for professional fees for care of patients in situations where the physician is directly associated with the services rendered. Such provisions can provide a basis for realistic evaluation of the costs associated with this important component of health care cost.

We have concerns about the specific provisions limiting physician reimbursement on the basis of its being a "volume-related" arrangement because:

1. They are based on the form of the transaction rather than on the result (how much was paid for what services). We believe an arrangement for payment based on volume can produce a result that is a reasonable cost for Medicare to pay. On the other hand, salary or other non-volume arrangements could result in Medicare paying more than under a volume related arrangement.

2. They could result in physicians entering into direct billing arrangements. Such arrangements, with a separate contract for administrative functions and additional claim volume, could result in increased administrative cost to Medicare.

Limitations on revenue or cost should not be related to form or process, but should relate to the result. A more appropriate approach would be to develop provisions that attempt to assure that payments and increases in payments to physicians are appropriate. These provisions should: Focus on the total amount paid for the services provided rather than on the type of arrangement; reflect reasonable payments for the scope of the services being performed, with criteria for evaluation published in advance; and be consistent with the overall cost containment objectives and the programs adopted to meet those objectives.

Any changes made in the reimbursement for hospital associated physicians under this legislation should be monitored carefully and evaluated so that the impact is consistent with the intent of the law.

Section 7—Use of approved relative value schedule

This section directs the Secretary to develop a system of procedural terminology including definitions of terms. On the basis of our experience, this section imposes a substantial and time-consuming responsibility on HCFA. We urge that HCFA be authorized to examine and if necessary, build upon the existing systems of procedural terminology. That would save time and reduce cost to the government.

We do not understand how the relative value schedule contemplated by this section would be used. If the ultimate purpose is to substitute local or national fee schedules for the customary and prevailing charge method of payment, the proposal can only be evaluated from an understanding of how those fees will be established and what specific program objectives they are intended to serve.

Section 10—Criteria for determining reasonable charge for physician's service

This section has two major thrusts. The first is to limit upward movement of the prevailing charge screen in any area of a state relative to the median prevailing charge for that state. The purpose is to encourage movement of physicians into under-served areas by minimizing any discentives based on lower Medicare reimbursement patterns. The effectiveness of this approach rests both on an assumption that individual patients in high-charge areas will not be unduly disadvantaged by

increasing differences between usual charges and Medicare allowances, and on an assumption that Medicare fees levels are a major factor in many physicians' choices of location. We are not sure that either is true.

Physician reimbursement is a means, not an end. This section would distribute a given level of Medicare expenditure more equally across charge areas. It would maintain the relationship between charges and allowances in low-charge areas and might improve it. It would be likely to worsen that relationship in high-charge areas. Its effect on individual beneficiaries will vary accordingly.

The second thrust is to permit Medicare allowances for physicians entering practice in under-served areas to be at the 75th percentile rather than the 50th, to encourage location in these areas. When applied to a physician who has not made a decision about his location, and particularly to one in a specialty that deals extensively with the elderly, this provision could be a contributing factor to a decision about location, and would be a worthwhile initiative.

Section 13—Hospital providers of long-term care

We support the provisions in Section 13 that encourage acute care hospitals providing skilled extended nursing care to utilize existing facilities fully while appropriately meeting patient care needs. We are particularly pleased with the provision for evaluating the impact of such a change on utilization.

We urge that this section be modified to permit greater access to the possible benefits of the program and to provide a broader base for program evaluation. In that connection, we suggest:

1. The bed size limit be set at 100 beds or less. This change will include a number of hospitals and communities which could benefit effectively from this provision.
2. Because this is a change in service, there should be approval by appropriate agencies as mandated under Public Law 93-641.

Section 18—Repeal of section 1867

Large public, governmental programs can benefit from considered reactions of advisory panels. Such groups can provide the perspective of the community at large, industry, and others about the policies and operations of that program. This is particularly true in the complex health care delivery and financing environment and in the Medicare program, which directly affects the lives of millions of Americans.

We do not want to see the potential of this kind of public advisory group lost. We suggest that the public policy advisory role be assigned to an existing group or to a newly created organization. The activities of any such public advisory group would need to be differentiated from and coordinated with those of the Health Facilities Cost Commission.

Section 23—Disclosure of aggregate payments to physicians

We believe this prohibition against disclosure of payment data related to physicians is appropriate at this time; much of the information in the news media pertaining to physicians who have been paid large amounts of public funds for treating Medicare and Medicaid patients has been incorrect or misleading.

However, it would be appropriate to use the public advisory panel we suggested in connection with Section 18 to consider how meaningful information can be made available regarding health care financing and delivery.

Disclosure of financial and other pertinent information is required and useful for many other industries. However, where disclosure through annual reports and SEC filings has been a long standing tradition, debate continues over the extent and definition of the reporting requirements.

Similarly, problems exist with respect to what constitutes meaningful disclosure in the health care industry. Work needs to be done in determining what kind of information can be made available to increase public awareness of key aspects of health care financing and delivery.

Section 25—Rate of return on new equity for for-profit hospitals

Section 25 would allow a higher rate of return on equity capital for for-profit hospitals. We do not support the provisions in this section.

Its economic justification is doubtful. In the past, there has not been a shortage of capital for this industry. Further, the industry is troubled by excess capacity in some areas of the country. S. 505 recognizes this concern in two major provisions that relate to closing or converting unneeded or excess capacity.

The additional return on equity for hospital performance below the target rate would treat hospitals differently because of ownership characteristics. The increase in rate of return proposed for for-profit hospitals based on the target rate may be

unfair to hospitals only slightly above the target rate. If the intent is to encourage efficiency, the provision in Section 2 could be modified to increase the incentive to all hospitals below the target level, and penalize more severely hospitals above the target levels, thus achieving greater cost containment.

Given the complexity of this subject, the Health Cost Facilities Commission should be requested to examine and recommend to the Congress what appropriate incentive arrangements and return on equity provisions should be enacted, based on capital requirements, other needs of the industry, and general market conditions for obtaining capital for the health care industry.

Section 29—Repeal of 3-day hospitalization requirements and 100 visits limitation for home health services

We support the repeal of the 3-day hospitalization requirement, because it will provide access to more appropriate care by Medicare beneficiaries. The elimination of this requirement would reduce the barrier to lower cost care and, thus, promote cost contianment.

We question the need to liberalize home health benefits which would increase the number of visits by 100 under Parts A and B. Before Congress authorizes this change, we suggest the need for increased visits per spell of illness (or per year) be analyzed. This analysis should provide information on the extent of current utilization over the existing coverage; the pattern of delivery of the additional utilization and reasons for the need for the extra care. Our expectation would be that if additional coverage is needed, it would not be as extensive as the proposed 100 percent increase.

Section 31—Development of uniform claims forms

We strongly support the uniform billing concept. Efforts in this area can improve program administration and help reduce provider and program costs. Toward this end, we have played a major role in the development and implementation of current uniform billing demonstrations.

We are concerned that the provision which allows for the variability of Medicaid claims forms in a given state could undermine the potential of a uniform billing program. Because participation by the Medicaid component is critical in a uniform billing effort, exceptions should be granted, if at all, on an extremely limited basis.

Section 32—Coordinated audits under the Social Security Act

We support the concept of coordinated audits of governmental programs reimbursed on a cost basis. However, the approach to achieving coordinated audits needs careful consideration in order to obtain the benefits of such a program. The bill, as presently written, is silent on the criteria for deciding on how coordinated audits would be performed.

It is important to avoid fragmentation of program administration. The audit function is an integral part of a total program administrative function which includes claims reviews, claims processing, payment, data processing, etc. This total program administrative structure not only facilitates expertise on all aspects of the program, but also provides a single, consistent source of information for providers. The Secretary, in arranging for coordinated audits, should consider these factors.

The Medicare intermediary system has established a distinguished record and gained valuable experience in the conduct of Medicare-only audits and shared Medicare/Medicaid audits. This performance record provides a sound basis for assumption of additional responsibilities for coordinated audits in a responsible, cost effective way. Properly implemented coordinated audits can be effective with minimal additional costs.

Section 35—Coverage under Medicare of certain dental services

This section extends Medicare coverage to include services performed by a doctor of dental surgery or of dental medicine which he is legally authorized to perform and which would be reimbursible if performed by a physician.

We support this provision, which will correct an inequity.

Miscellaneous provisions

While we have not provided detailed comments on every provision of the proposal, we support Section 14 (Reimbursement Rates under Medicaid for Skilled Nursing Facilities and Intermediate Care Facilities) and 33 (Encouragement of Philanthropic Support For Health Care).

MARCH 7, 1979, SENATE FINANCE COMMITTEE STAFF ALTERNATIVES FOR POSSIBLE HEALTH CARE SAVINGS PROPOSALS

1. Reimbursement for outpatient hospital care

The alternative of limiting reimbursement for outpatient hospital care to the level of payment of services provided by an independent practitioner is wrong in principle and difficult to administer.

The demands on and the nature of the services performed by the outpatient departments of hospitals and free-standing clinics are more complex and difficult than those imposed in the independent practitioner setting.

The hospital and free-standing clinics provide service twenty-four hours a day, seven days a week. At some hours the volume of service is inadequate to support this service economically. The independent practitioner is open only part of the time.

The hospital or clinic stands ready to provide a range of services from routine to extreme emergencies. They provide a range of specialty services not routinely available in the typical office of an independent practitioner.

A single visit to a hospital or clinic may include a different range of services than would be available in an "equivalent" office visit.

Therefore, relating the cost of a hospital outpatient service to the price of an equivalent (if that could be identified) practitioner service would be difficult at best.

Current Medicare rules related to cost determination preclude the hospital from pricing many of its outpatient services on a basis which may be in line with equivalent services in independent practitioner settings.

The alternative suggested, rather than reducing costs, could have the effect of reducing the sharing of overhead expenses with outpatient care, thus shifting more costs to inpatients. In any event, sharing of overhead should be on soundly based accounting principles.

2. Disproportionate Medicare-Medicaid payment for hospital care

The proposed alternative would eliminate the 8½ percent Nursing Service allowance currently in effect and mandate payment of hospital malpractice costs derived only from claims of Medicare beneficiaries.

The 8 1/2-percent Nursing Service differential per se was introduced as a result of studies which were accepted as demonstrating that there was, in fact, additional nursing care given. At least one court has held that it should not be changed without a study that proves that the additional payment is in error. To date no such study has been published.

We are also opposed to changing to the direct costing approach in malpractice premiums. An overall evaluation should be made of the factors affecting malpractice cost in the hospital: How those costs should be allocated to Medicare given the proposed policy; why Medicare patients have disproportionately lower total settlements: Likely impact of hospital behavior relative to Medicare patients; Medicare beneficiary attitude toward possible malpractice situations, if it were known that the government is specifically underwriting its cost.

Basically, we support payment of the full economic cost of services rendered to beneficiaries or subscribers of various third party payers. The issue, however, is complex. To resolve it adequately would take an overall evaluation of the total Medicare-Medicaid reimbursement structure. Piecemeal and selective application of the economic cost principle to individual elements of hospital cost is inappropriate. Fragmentation of the institution's costs (particularly given the present state of the art) could lead to a bewildering array of cost determinations, i.e., by age, condition, etc. Importantly, management of the institution could be complicated. This result in management action that results in increased costs.

3. Prohibit Medicare-Medicaid payment at hospital rates for patients medically determined to need lesser levels of care

The proposed alternative would promote conversion of acute-beds to long term care beds where there is a surplus of acute-beds and would reimburse hospitals at skilled care rate, not acute care rate, for patients in need of long-term care.

This proposal has merit, but it needs to be considered within an overall strategy of community health care needs and hospital and health care resources.

The "swing bed" projects undertaken by Medicare provide experience on which to structure such a program. Those projects have dealt with the issues of access, payment levels for services received, impact on hospital costs of the new arrangement, and nursing staff training. Currently, Section 13 of S. 505 incorporates into the Medicare program, on a limited, experimental basis, additional "swing bed" sites.

The proposed alternative should be undertaken after development of an overall strategy in a community which weighs the need of preventive care, terminal care, and other programs, and evaluates the best settings for such programs.

4. "Stand-by" limitation for Medicare-Medicaid on allowable increase in ancillary hospital costs

The proposed alternative would establish standby limits on reimbursement for ancillary services to become effective if the hospital industry's Voluntary Effort cost containment goal is not met. We believe this provision is unnecessary at this time because of the resources that have been committed to make the Voluntary Effort work in many areas that affect health care costs. We think the Voluntary Effort approach is wise because it focuses on overall hospital costs and therefore also deals with the issue of hospital ancillary service costs.

Another limit for Medicare related to ancillary services would represent additional fragmentation of hospital costs and drive the purchaser further into hospital management. If both routine and ancillary costs are to be controlled, a combined limitation might be less complex, easier to understand, and more acceptable to the parties concerned. Insofar as a hospital operates as a single entitity, it could establish policies and controls over all of its operations, instead of different controls in accordance with legislative language.

6. Competitive bidding and negotiated rates under Medicaid

The proposed alternatives would permit states, at their option, to purchase certain limited medical devices and services for Medicaid purposes through competitive bidding or appropriate negotiated arrangements. These include such items as wheelchairs and laboratory services.

States have been prohibited from doing this by judicial interpretation of the Social Security Act's "Freedom of Choice of Provider" provisions, which are designed to allow Medicaid recipients to choose among qualified medical professionals. We believe that the purchase of these items does not interfere materially with the recipients' "freedom of choice" and support these changes so long as appropriate quality or performance standards can be met and monitored. This is consistent with our belief that contractors should be judged on a continuous basis by performance standards. Our experience in programs such as CHAMPUS and Medicaid has demonstrated that without proper safeguards, competitive bidding can lead to false economies. The lowest administrative price can lead to higher total costs or unacceptable service.

7. Direct professional review toward avoiding unnecessary routine hospital admission services and excessive preoperative stays

The proposed alternative would require PSRO's to review such "areas" of relatively frequent over-utilization as week-end admissions for elective conditions and elective pre-operative stays of two or more days duration, in order to reduce reimbursement for presumably unnecessary care.

Blue Cross and Blue Shield Plans now attempt to achieve savings by paying for only those health care services considered medically necessary. The Medical Necessity Program, including the policy related to routine hospital admission tests, is an example of a program used by the Blue Cross and Blue Shield Plans for dealing with medically unnecessary services.

The techniques for dealing with some of these issues are not yet fully developed. We hope that newer PSRO's, at least, are permitted to phase into these programs as their staffing, experience and data are more fully developed.

One approach is to devote less review time to those hospitals that officially certify their policies and procedures to be consistent with the program intent.

We endorse the intent of this proposal. Our concern is with finding the most effective and least expensive administrative procedure to achieve the desired goals.

9. Delete statutory requirement specifying State payment of "reasonable cost-related" reimbursement to hospitals under Medicaid

The proposed alternative would allow States the discretion of determining appropriate Medicaid reimbursement to hospitals without reference to reasonable cost. This may result in states establishing unreasonably low reimbursement levels related more to state budgeting than to the reasonable cost to the hospital of services provided. Because this proposal could encourage the development of two classes of health care, we cannot support it.

Reimbursement for Medicare and Medicaid should be cost related. There is little justification for a government program requiring care at less than cost. Inadequate reimbursement from Medicaid would have the undesirable effect of forcing hospitals

to make such choices as refusing Medicaid patients, shifting overhead costs not paid by the state to other payers, or altering its quality of care. This is not sound public policy.

10. Delete statutory requirement specifying State payment of "reasonable cost-related" reimbursement to skilled nursing and intermediate care facilities

The proposed alternative is similar in intent as to item 9 above, and could have the same consequences. We do not favor states or any other purchaser of care reimbursing at a rate lower than one established on a "Reasonable Cost-Related" basis.

11. Apply "prudent buyer" limit to purchases by hospitals of certain routine supplies

The proposed alternative would provide for maximum allowable cost limits for reimbursement purposes of certain frequently purchased medical supplies.

We believe that purchasers have the right to insist on prudent business practices by their suppliers. We are concerned that the piecemeal, individual transaction approach proposed here fails to recognize that prudent buying is an attitude and a process.

As in the case of utilization review where appropriate processes are approved, Medicare could focus on the providers' processes to accomplish prudent purchasing.

Purchasers can also achieve the objective of obtaining hospital services at a cost which reflects prudent buyer practices by focusing on larger units of hospital cost. If the hospital meets the overall tests, purchasers should not be directly involved in the process for the purchase of detailed components.

12. Medicare payment liability secondary where payment can also be made under accident insurance policy

This alternative would allow Medicare to collect from the party at fault in any accident that resulted in Medicare reimbursements for patient care.

We believe Medicare should pursue such a policy whenever the expected return, on a case-by-case basis, will exceed collection costs. Although this procedure will not reduce medical care costs—it shifts the costs to other parties—it may help to allocate costs and premiums for accident insurance selection and coverage.

The alternative is correct in principle. Its implementation requires prudence.

Senator TALMADGE. Our next witness is Dr. Robert B. Hunter, chairman of the board of trustees, American Medical Association, and Dr. James H. Sammons, executive vice president.

Gentlemen, we are happy indeed to have you back before our committee again. You have been here several times before. We appreciate your contribution and your cooperation.

You may insert your full statement into the record and summarize it in not over 10 minutes, please.

STATEMENT OF DR. ROBERT B. HUNTER, CHAIRMAN OF THE BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION

Dr. HUNTER. Thank you, Mr. Chairman.

I am Robert B. Hunter of Sedro Woolley, Wash., and I serve as chairman of the board of trustees of the American Medical Association.

On my right is Dr. James Sammons, and we are accompanied by Mr. Harry Peterson and Mr. Ross Rubin of the legislative department of the American Medical Association.

In the interest of conserving your time, we will summarize our summary statement and be responsive to your questions as best we are able.

Let me say we are pleased that this subcommittee is continuing its efforts in investigating ways to reduce health care costs and to develop appropriate changes in the medicare and medicaid programs.

One of the major issues concerning the delivery of health care today is the subject of increased hospital costs. It is of great con-

cern to the President, the Congress, the public, and the medical profession, as well as other elements of society.

AMA, along with many other groups, believes it is preferable to address problem areas of this type in the private sector. Although you have heard it from previous witnesses, as cochairman of this effort I must with pride again tell you of the Voluntary Effort, which we organized along with the American Hospital Association and the Federation of American Hospitals.

We feel this is indeed a private-sector response to hospital cost increases. As you heard, during the past 2-year period, when the administration adhered to its 9 percent cap and when the committees of the Congress sought remedies and affirmative steps to meet the underlying problem, our goal was to reduce the rate of increase in hospital expenses by 2 percentage points per year for each of 2 years starting in 1978.

The first year results, as you have heard, indicate that this goal has been surpassed, with an actual decrease of 2.8 percentage points, reducing the rise from 15.6 percent to 12.8 percent.

It has not previously been mentioned that one of the actions taken by the steering committee of the Voluntary Effort is to arrive at the conclusion that this cannot be a temporary effort but will be an ongoing effort on the part of the parties involved.

This record of success was accomplished at a time when inflation continued to rise markedly in our overall economy.

The VE's success can be measured as a savings of almost $1.5 billion in this first year of its effort. To our knowledge, this is the only organized effort—significantly effective—by an industry to curb inflation in response to the President's call for voluntary cost inflation efforts.

Speaking of the President's call to the country for voluntary efforts, Mr. Chairman, what was the response of the administration to this good faith bona fide action by the health care industry? We all know the answer. Their answer was mandatory controls. Notwithstanding the President's prior denunciation of mandatory controls for the rest of the economy and notwithstanding strong statements stressing their undesirability and their unworkability, they are now being proposed for hospitals.

I do not have to remind you, Mr. Chairman, that almost everyone abhors mandatory controls. Yet the administration has nonetheless approached this issue by introducing complex discriminatory legislation to create a national program that would arbitrarily impose ceilings and limit the increase in hospital expenditures and revenue.

The result would be national ceilings on revenues and placing the hospitals of this country under the direct control of the Federal Government.

Mr. Chairman, we ask your committee to examine that proposal carefully. The bureaucratic layers of redtape and administrative costs alone to be laid upon the health industry are sufficient to reject this proposal.

Moreover, from your examination, we are sure you will not be misled by the so-called voluntary approach therein. There is nothing voluntary in an arm-twisting approach that says you will

either reach a 9.7 limit voluntarily or you will reach 9.7 percent under heavy penalty to be imposed by law.

We also ask you to examine carefully the crystal-ball, multiyear projections of alleged savings through its bill. We are sure this committee, so familiar with administration financial projections, later proven erroneous, will scrutinize this aspect in minute detail.

Mr. Chairman, I want to come to the bottom line, the interest of our patients. The program would not only be inordinately expensive to administer, creating as it does new bureaucracy and imposing almost limitless regulation, but it would quickly result in a reduction in availability of care, a rationing of care if you will, according to the financial whims of the Secretary of HEW.

The medical profession will not sacrifice the patient's interest. We ask you likewise to reject S. 570, which is the administration's approach.

Your bill, S. 505, offers another approach dealing with hospital costs. It would create a new program for hospital reimbursement limitations centered on the medicare and medicaid programs. While this approach is more limited than that offered by the administration, it too is of national scope but with a provision for flexibility to better promote high quality health care delivery in an efficient and cost-effective manner. Cost efficiency, sir, is much more important than cost containment.

We would also like to point out that existing programs have already helped contain health care costs in the medicare medicaid, and title V programs. The PSRO program, only of recent maturity, has helped insure that program beneficiaries are receiving necessary quality care in an appropriate setting.

The approach found in S. 505 is a much more positive and equitable legislative approach in attempting to meet the hospital cost problems. Even with this approach, however, we are uncertain of the impact and we suggest that, if enacted, it be implemented on an experimental basis and demonstrated in a limited geographic area, a problem area, if you will.

I want to emphasize again, Mr. Chairman, that we believe in the continued ability of the Voluntary Effort to contain hospital costs. We also believe that in these times of high inflation in all sectors of the economy that it is improper and highly discriminatory to single out one area for mandatory controls as proposed by the administration.

Dr. Sammons would like to comment further on S. 505.

STATEMENT OF DR. JAMES H. SAMMONS, EXECUTIVE VICE PRESIDENT, AMERICAN MEDICAL ASSOCIATION

Dr. SAMMONS. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, I would like to discuss with you certain changes proposed in S. 505 that apply to the administration of the medicare and medicaid programs. Many provisions we support but some important provisions could have a detrimental effect on the availability and quality of care under these programs and, because of the time limitation, I will only address those provisions at this point.

The first relates to the creation of a special class of practitioners designated "participating physicians." This proposal is designed to

bolster the present sagging rate in acceptance by physicians of assignments under the medicare program yet it does not reach the central issue of why assignments are not more widely accepted. The major deterents to acceptance of assignments are the insufficient reimbursement rate and delay under medicare.

Increasing the acceptance of assignments can only be achieved by establishing levels of reimbursement to reflect accurately the costs of the service provided.

We believe that even without legislation there are simplified billing and claim procedures that could markedly speed up the entire matter of reimbursements and we have great difficulty in understanding why after 3 years of discussion, corrective procedures have not been implemented. We question the good faith of the administration in delaying this implementation.

Our second area of concern is the new criteria for determining medicare reasonable charges for physicians' services. The Secretary, under these proposed provisions, would determine statewide prevailing charge levels for each State based on the 50th percentile of the charges made for similar services in the State.

The real effect of that change would be a further restriction on reimbursement levels in the State achieved primarily through a reduction in the already limited increases which would otherwise be allowed under the medicare economic index.

We believe this stifling of proper fee recognition for all physicians would be detrimental to maintaining a proper level of care under the program and could further induce a shifting to medicare patients and to private patients of those expenses not reimbursed by medicare, despite the prohibitions to that effect, which Senator Talmadge pointed out earlier.

We believe section 10 should not be adopted.

Another area of concern relates to the redefinition of "physician's services" in section 6. This would exclude those services the physician performs as an educator, an executive, or a researcher and would exclude even patient care services unless, as the bill says, "personally performed by or personally directed by a physician" for the benefit of the patient and unless the service is of such a nature that its performance "by a physician" is appropriate.

This new limitation would apply to all "physicians' services" under medicare, not just hospital associated physicians as the section title implies.

Mr. Chairman, we object strongly to this modification. All activities of physicians customarily recognized as part of the physician's practice should be reimbursable as "physicians' services."

A strict application of the proposed language would have dire consequences for proper recognition of and payment for all services of physicians under medicare and would attempt to allow HEW to determine what constitutes the practice of medicine.

We strongly urge section 6 not be adopted.

S. 505 would also authorize the development by HEW of a system of uniform procedural terminology and of a relative value schedule. We believe this provision is laudable because it recognizes and attempts to ameliorate unfavorable restrictions upon the use of such schedules.

While the RVS as found in S. 505 attempts to overcome restrictions, we believe it would do so in an undesirable manner. The

provision would not recognize any schedule unless developed and approved by the Secretary; medical organization participation is limited; adoption of the RVS by the Secretary would require its use only in Federal programs; and only the RVS developed and approved by the Secretary could be used in non-Federal programs.

We believe that this provision in S. 505 provides too much power and authority in the Secretary.

As to the provision for developing and establishing uniform procedural terminology, we believe this too is restrictive and does not properly recognize the widespread acceptance of the system already adopted by the profession, "Current Procedural Terminology," now in its fourth edition.

We would urge section 7 be modified to reflect these comments.

We are pleased to note this committee's interest in the confidentiality of PSRO records as reflected in section 28 of S. 505. As this committee well knows, confidentiality is critical to the success of the entire PSRO program.

We believe section 28 is a step in the right direction toward insuring PSRO confidentiality and should be adopted. Consideration at the same time should be given to making it even stronger.

On page 10, Mr. Chairman, you will find a series of some 11 provisions that we support; to save time, I will not read them. There are many more than the 11 that we do and can support but those 11 we strongly support.

Mr. Chairman, we have only touched on some of our major concerns but we will be delighted at this time to respond to your questions and we express our appreciation for the opportunity to be here.

We would also ask that our full statement be inserted into the record.

Senator TALMADGE. Your full statement will be inserted into the record.

Thank you very much, gentlemen. We appreciate your cooperation and your valued testimony.

You heard some of Senator Long's questions talking about the enormous cost of malpractice insurance for hospitals and doctors and the idea that they are forced to practice defensive medicine to defend themselves against suits.

Do you have any idea to what extent hospital costs have been forced up because of the threat of malpractice and any idea to what extent physicians' fees have been forced up because of the fear of a malpractice suit?

Dr. SAMMONS. Mr. Chairman, that is an almost impossible question to answer. It is a subjective decision on the part of the physician when he orders the test or when he performs a procedure. It is very difficult even for the individual physician to clearly differentiate between his fear of suit, at least his apprehensions on the one hand and his desire for additional medical information on the other.

We do know that the increase in malpractice insurance premiums has obviously been reflected in increases in charges. There is no other place to get the increased premium. You can quantify that.

I am not at all convinced that anyone can accurately quantify the answer to your question. I would submit to you that in some areas of the country, because of the litigious nature of the citizenry and the behavior of the courts in those areas, that it may well be substantial.

Senator TALMADGE. Do you have any experts in this field who could work with our staff and try to devise some scheme so we could protect doctors and hospitals in this area? We are reluctant to override the laws of some 50 States.

There seems there is a near national crisis at the present time. For instance, I understand there is no statute of limitations on a malpractice suit. Is that correct?

Dr. SAMMONS. That is only partially correct, Senator, and it does vary from State to State. In many States, the statute of limitations runs some period beyond actual discovery, and in others it is coupled to the age of the individual. There is a multiplicity of limitations in the States.

It is true that our experts prepared some 17 different proposed changes to State tort statutes; some 300 different changes have been made in 50 States in the last several years relative to the malpractice problem.

It has not been resolved, as you very accurately point out. We are still seeing some incredible behavior patterns by some juries and some remarkable decisions that have no relationship to the extent of injury whatsoever.

We will be happy to have our people continue to work with Mr. Constantine and his staff as we address this mutual problem.

Senator TALMADGE. Thank you.

Secretary Califano, yesterday, in arguing the administration's proposal, stated in the hospital area, the usual mechanisms of the marketplace, like competition, do not work to bring costs down. He cited increases in hospital costs between 1975 and 1977 as warranting mandatory price controls for hospitals.

Cannot the same thing happen to physicians? HEW has often argued that there is little real competition in the physician area.

Expenditures for physician services increased by 31 percent between 1975 and 1977, exactly the same as hospitals for the same period.

Expenditures for physician services were $32 billion in 1977; given all the similarities, do you have any concern that HEW may propose mandatory price or revenue controls on physicians?

Dr. SAMMONS. Senator, he simply is again demonstrating his total lack of knowledge of the system and his inability to look at the numbers with any degree of clarity. He has picked the time frame that was immediately following the lifting of controls under the Wage/Price Stabilization Act of the Nixon administration, and as the members of this committee will recall, the medical profession, the hospital industry, and the petroleum industry were the people that were retained in that act for the longest period. The petroleum people are still trying to get out.

After the medical profession and hospital industry had been there for the longest time frame, there was indeed a rise in physicians' charges immediately following the lifting of controls which should have come as no surprise to anyone.

Doctors do in fact run offices. They do have payrolls to meet. They have other expenses. There was a legitimate catch-up.

If the Secretary had chosen to look at the figures for 1978, for example, he would have found that in 1978, the increase in the physicians' portion of the CPI was below that of the all items index and it was below that of the total health care index.

The Secretary has picked a bad time frame to attempt to justify erroneous conclusions from which he started.

Dr. HUNTER. Mr. Chairman, if I may add to that, the Secretary may be very conversant with the practice of law but he does not know much about the practice of medicine. I feel I do. I have practiced for 36 years in a small community. Every day that I have been practicing, I have been competing against the other doctors of that community and I have been competing for every patient that came to see me and that is equally true of the other physicians of this country.

Senator TALMADGE. Thank you. Senator Dole?

Senator DOLE. Although I had to leave momentarily, I was able to hear your comments. I was meeting with a group of cattlemen in there and we were talking about the price of hamburger. They are worried about cost containment, too, for beef imports.

In any event, have you addressed specifically, since we asked the hospital witnesses when they were here, the routine hospital tests requested by a physician.

Is there an effort to reduce some of the tests and I will not say needless tests because I do not know whether they are needless or not but I know they are plentiful.

Dr. HUNTER. Yes, sir. Let me say the message we are spreading to our fellow practitioners across this country is that, in order to obtain and attain cost effectiveness, there must be appropriate professional utilization of diagnostic procedures, appropriate utilization of theraupeutic procedures and appropriate utilization of ancillary services within the hospital setting.

If these are done, there will be greater cost effectiveness and a reduced total cost of care.

Dr. SAMMONS. In addition, Senator, if I might add, I think there was some misunderstanding earlier. We heard that exchange. As we understand what Blue Cross and Blue Shield have said, it addresses itself to standing routine orders. All of us in the practice of medicine, and I have practiced for 23 years in a small town in Texas, are all aware of the need for the careful evaluation.

Mr. Morris pointed out at the tailend of that exchange that if nothing else, the Blues were hopeful that it would cause a reassessment of the advocacy and the need for those routine standing orders. We certainly share that concern and that point of view.

There has been no attempt that we are aware of to disallow any order, any test, any procedure that was ordered by a physician for a specific patient.

As to Senator Talmadge's concern about his toe in the emergency room, I think the answer there is different. If you had walked into the emergency room limping with the sore toe, you might not have had any routine tests done at all until the attending physician had ordered the X-ray of the toe. On the other hand, if you had been admitted to the hospital directly with the limp and the sore toe, it is those routine admitting orders that are in fact being re-examined.

I think perhaps there was a little misunderstanding in the terminology.

Senator DOLE. I guess that is the point I want to make clear. There are standing orders. If you are admitted, they do certain things.

Dr. SAMMONS. Yes, there is a difference between an inpatient set of circumstances and an outpatient set of circumstances.

Senator DOLE. There should be an all-out examination to determine whether or not the so-called orders could be revised. I assume they are different all across the country.

Dr. HUNTER. They are different for every practitioner but the thrust of the Blues' effort and one which we agree is that physician over whose name those orders are written should think about them each time they are ordered.

Dr. SAMMONS. It is an excellent re-examination process and one that should go on continuously anyway.

Senator DOLE. What about section 6 of our proposal? I think that is somewhat controversial. I have not heard from all my radiologists and pathologists.

Dr. SAMMONS. Senator, this gives us a great deal of concern. I suppose if I had to quantify provisions of the bill by importance, I would say that this particular provision gives us the greatest concern of all.

This is a clear redefinition of the practice of medicine. The power to redefine and to extrapolate whatever good intentions the Congress may have had, if it becomes law, would be ultimately vested in the hands of the Secretary who has not been a part of the process of making the law.

The redefinition of "physicians' services," have already been accomplished as it applies to the teaching setting, to only those things in which the attending physician actually engages in the laying on of hands or is standing looking over the shoulder of the individual. You have disrupted the entire teaching process in this country, as section 227 would do if fully implemented in the old law and as section 6 if interpreted in that fashion at HEW would do and could do here.

You not only have totally disrupted the teaching process and interfered with teh availability of care but if that is then extrapolated as the language of section 6 could allow it to be extrapolated, it would redefine the "practice of medicine" for every single physician in this country to exactly those two same criteria.

What happens when you do that is you increase the total cost of health care in this country. You increase the total cost of physician charges because somewhere in the process those people who are employed in institutions and in physicians' offices who carry out orders of the physician, who render care to people and who are part of the total health care delivery system, have to be paid and reimbursement has to occur.

Senator TALMADGE. Will you yield at this point, Senator Dole?

Senator DOLE. Yes.

Senator TALMADGE. Our staff has talked to the pathologists and others about the point you raised. I think your point is well taken. We will clarify that. We think that is a physicians' service and it will be so stated in the bill.

Dr. SAMMONS. Thank you, Senator.

Senator DOLE. I guess there is some room for clarification if that authority has been determined to indicate we are making some progress through the process of testimony and raising what may be good or bad provisions and that leads to another section.

You suggest deletion of Section 5 which provides a limit of incentives for physician assignments. I guess in the question there may be the level of reimbursement.

In spite of that, do you think this provision would be of some assistance or that it could be disruptive and non-productive?

Dr. SAMMONS. Senator, I have two concerns about this.

One is a concern as it applies to the psychology and the understanding of the patient. The other is a concern as it applies to the straight assignment process and the cost of doing business.

One of the problems with this is you talk about participating physicians. You and I may understand you are talking in terms of participating in the acceptance of assignment but to the patient who hears that terminology or who is given a list, and there is no way HEW is not going to prepare a list under the provisions of this section that would list the "participating physicians". So there has to be a list.

When you prepare a list with that kind of a title, the average medicare and medicaid beneficiary may very well misinterpret that to mean that all other doctors are not rendering care because they are not participating or there is no way they can be reimbursed.

I think that is a very serious problem and one that you should very carefully re-examine. It will create a great deal of misunderstanding in the minds of the beneficiaries and could be effective.

The other thing which is just as bad is the so-called business of the administrative cost savings allowance of $1. That is just going to increase the total cost, in our view. We do not believe that $1 is going to be much of an inducement except in those practices that are 100 percent medicare anyway, and somewhere in the process of determining the reimbursement levels all of that sort of thing could normally be accomplished in the present billing process.

By its very nature this provision creates a difference in reimbursements between a service rendered in an institution and one rendered in a physician's office. It creates, an artificial barrier between the rendering of those services and it is going to provide, in our view, an increased cost because there will have to be additional allowances for service.

Mr. PETERSON. Senator, just to add to that, if I may, the physician then who may by inference be a nonparticipating physician may very well be taking assignments as well. The patient who is a patient of that physician may feel that his own physician is no longer going to take an assignment and that is not true. That adds to the confusion.

Patients may feel they are denied the access to their physician of choice.

Senator DOLE. I am just trying to think of some way to revise that section.

Dr. SAMMONS. Senator, I think there is a simple solution to the assignment of benefit problem. We addressed that earlier on but I would like to reiterate the point.

If the payments under medicare and medicaid were conforming to the rest of the payments made in the health care industry and they really use reasonable and customary fees for the determination, on a local basis and across the spectrum of an individual doctor's profile, and if we got rid of these artificially reduced payments and went to the same payment that the rest of the industry is doing, you would not have the problem.

Senator DOLE. We have had some indications in the rural areas that there would be physicians in those areas that find this provision acceptable.

Dr. SAMMONS. Find this provision of the $1 acceptable?

Senator DOLE. Section 5.

Dr. SAMMONS. I do not really believe they fully understand it, Senator, or they are in an area in which their patient population is——

Senator DOLE. Mississippi, Georgia, Colorado.

Dr. SAMMONS. Certainly the Deep South States you have alluded to may well be the result of a very high medicare population and that may in the short run look attractive. In the long run, however, it is going to increase the cost of the two programs and it is going to produce still another level of payment. There has to be a payment in there someplace for services.

If you insist that there is going to be a differential and you start from a base that is artificially lowered to begin with, and then you have a cap on the ability to increase that standard payment, the program will fall apart.

That provision needs a very careful review.

Senator DOLE. Thank you.

Senator TALMADGE. Senator Long.

Senator LONG. As you know, I am a lawyer by practice. I was just trying to think of some way you might manage to cut down the legal expense of the medical profession.

Dr. HUNTER. China has done it very well, Senator. They have no attorneys.

Senator LONG. Right now we are spending about $16 billion a year taking care of disabled people. When people in your profession do the best they can to try to help someone and the person is left with a disability, of course, we have a program and we are spending a lot of money and the cost is going up.

As a matter of fact, I really think we have more potential savings in the disability area than we do in your area, to be honest, just seeing how the costs have been moving forward

In view of the fact the Federal Government is going to undertake to care for people who are disabled with our disability insurance program, there is something of an overlap where you have a doctor sued and a large award made against the doctor. The insurance company more often has to pay it than the doctor.

A lot of the costs are needless. I am not thinking about essential medicine. I am talking about needless defensive medicine.

It seems to me that we should provide a recourse somewhere else. We could perhaps limit the doctors' liability and have some provision somewhere where we would establish a fund to provide relief to someone who is disabled as a result of an unsuccessful surgical or medical procedure.

I wonder what the American Medical Association has to offer us in the way of trying to cut down on tests and reduce the cost for defensive medicine.

Dr. HUNTER. The first thing would be to re-emphasize what Dr. Sammons said. At the state level reform of the tort system within the individual State is an obvious part of the answer along with limitations on pain and suffering awards, and the throwing out of certain resipsa loquitar provisions.

There are many features that we have in our model act that we have submitted to the States and where those States have accepted them and passed them, the malpractice climate has improved.

I would painfully tell you that our board of trustees heard a direct quote from the faculty of one of the law schools in Chicago to the effect that students are being taught in regard to liability to go where the money is, not to concern themselves with justice.

If that kind of teaching is going on in the law schools of our country, the problem is going to become compounded.

Dr. SAMMONS. Senator, we would be very pleased to offer the services of our experts in our own Office of General Counsel and others we have who have been studying this problem for some time to you and your staff for further consultation to help you try and resolve this problem.

We would be delighted to share in those discussions.

Senator LONG. I appreciate that.

It seems that we have situations where you have an HMO or some industrial group with their own health plan where physicians and surgeons are hired to provide services.

If someone like Blue Cross or Blue Shield undertook to try to get an agreement with doctors, that is, those who would work with them for negotiated amounts, would your organization be opposed to that?

Dr. HUNTER. That is currently in existence in many parts of the country, Senator Long. In my own part of the country or in my own State, 50 percent of the population is insured under prepaid plans with the physicians at risk.

Chairman LONG. Do those plans actually have some particular limit on how much the physician would charge or a particular agreed fee that he would be paid for doing a specific thing?

Dr. HUNTER. They operate within an agreed upon fee schedule, yes, sir.

Senator LONG. Does the AMA have any objection to that?

Dr. HUNTER. No, sir.

Dr. SAMMONS. Senator, we would never object to the multiplicity of programs for payment. Again, I think there was a misunderstanding earlier when you asked that question before.

There are Blue Cross and Blue Shield plans in the United States now that have participating physician agreements in which it is a 100 percent prenegotiated payment. There are other plans in the country that are reimbursing their policyholders on prenegotiated rates.

There is a whole series of different methodologies that are being applied in the country today. The so-called HMO concept is not new. You and I are both from the Deep South and we remember

there used to be plantation doctors, too, that worked by contract in company stores.

The thing is that there is, across this country today, a wide variety of repayment mechanisms and a wide variety even within the health insurance industry itself.

Senator LONG. I have sometimes said that the difference between the lawyer who makes a lot of money and a lawyer who does not make a lot of money is the fact that one has the guts to look a client in the eye and ask for a big fee. In Baton Rouge, we tell the story that one of the most successful lawyers there used to tell on himself. He said he had one of his clients in his office and he told the man what the fee was for the work he had performed. The man sat very still for about 30 seconds and then said, I am glad you said that. The lawyer said, why? The man said, because my doctor told me I had a bad heart and now I know it is not true.

I know the fees do vary among professional people. I am not in the position to pass judgment on it. Someone was telling me that for a certain type of operation performed on his son and performed on a neighbor's son, one doctor charged $800 and the other doctor charged about $3,500 for the same operation.

Those fees can vary. I guess ordinarily they do vary widely. I would take it the AMA would have no objection if the insurer sought to get an agreement in advance with a particular doctor or more than one, that they would perform a particular operation for a negotiated figure.

Dr. HUNTER. I would suspect on the ratio of 4 to 1, which you have expressed on the difference in fee, that that fee would be reviewed by a group of physicians somewhere, perhaps at the county level, perhaps as a claims review committee within the hospital, perhaps a claims review committee of an insurance company, perhaps even at the grievance level of the State.

Senator LONG. I do not believe there was any argument about the fees in this particular case. They just paid it.

Dr. HUNTER. Maybe there should have been; 4 to 1 is a pretty big difference.

Senator LONG. I do not think that it was the same doctor. It seems that one doctor charged a lot less than the other doctor for the same type procedure.

Dr. SAMMONS. Senator, you have to look at a multitude of factors, varying circumstances within even the same community, levels of competence that may be reflected in differential fees and not necessarily always the highest fee paid to the most competent individual. Do not misquote or misunderstand my comment there.

There are differences. As we look across the country, there are major differences in reimbursements between various geographic sections of the country. There are good and sufficient reasons for that, if one explored still further the underlying economics of those areas.

You may find very substantial differentials even in the same locality in the same specialty. You have to look at the individual circumstance each time. There are no pat answers to that. That is one problem we have had with HEW. There are no simply uniform answers that can solve that problem.

Senator LONG. I know that among lawyers, where one might charge a great deal more than another, the attitude of the lawyer who charges more feels he is being paid for his judgment. If someone thinks they can find someone who could do a better job or equally as good a job and charge a lot less, the attitude is cheerfully by all means, go hire that person if you think you will get better service.

The lawyer feels he sets his fee based on what he thinks is fair under the circumstances, what he thinks he needs for his business. If you do not like it, he cheerfully respects your right to take your business somewhere else.

I think some of that probably plays a part in the medical profession, too, or does it?

Dr. SAMMONS. Yes; I am sure some of it does but a degree of reasonableness also has to apply in medicine. After all, we are dealing with people who are ill, who do not always have the freedom of choice that you have just talked about. Sometimes a lawyer's client may not have that freedom of choice either.

We believe, Senator, that the usual customary and reasonable fee concept in medicine is the appropriate method for reimbursement of physicians' charges. They do take into account variations. There are certain differences.

The best cardiovascular surgeon in the world may charge more, but then the best general practitioner in the world may charge more, too. We believe there are differences that are appropriate.

We also very strongly believe that the Federal Trade Commission and the Department of Justice in this country have done a grave disservice to the American people in preventing efforts to bring a degree of reasonableness to physicians' charges in their refusals to allow relative value studies to be used in the one instance and, in the second instance, forcing out of existence medical society adjudication and review committees that were established for the sole purpose of protecting the public.

That is a great disservice and it has been done by two agencies of the Federal Government. The medical profession strongly objects to that and strongly objects to the absence in today's marketplace in medicine of any mechanism that can be used for the protection of the general public in those instances.

Senator LONG. Thank you very much, gentlemen.

Senator TALMADGE. Senator Baucus?

Senator BAUCUS. I have no questions.

Senator TALMADGE. Senator Dole, do you have further questions?

Senator DOLE. I have one quick question. How do we address the question of reimbursement levels? You talked about section 10 and indicate that you think it will worsen that problem.

Dr. SAMMONS. I think it would worsen the problem, Senator. I understand what you are trying to do, I think.

Senator DOLE. We get back to the same thing Senator Long was talking about. We have a reasonable amount for an office call in Los Angeles and Chicago of $60 and somewhere else it would be $50 and in New York it would be $40.

How do we address that?

Dr. SAMMONS. I think there is another component to that, too, and that is the difference between the rural and the urban reimbursement methods in medicaid, particularly, across the country.

I am sympathetic as we all are to what you are trying to do and the problem you are trying to solve. On the one hand is the reasonableness and the evaluation, which I just addressed to Senator Long, and the other is the question of the urban versus the rural which in many States is a very severe problem.

What this does, it seems to us, is not necessarily to resolve the rural physicians' problem where it exists and he or she is underpaid for services but is actually going to, over time, bring down the fees that are paid in other areas of the States in which direct operating costs are entirely different from the rural location.

For example, you are going to find that the leveling process is not going to be a leveling process to take care of the rural physician who has a problem. The leveling process here is going to force down the medicare reimbursement. When that happens, there will be a transfer of those reduced payments to the general public not covered under the Federal programs.

If the purpose of the section is to transfer the cost over to the general public, then I think you are going to accomplish that given time. I do not believe that, is your intent. I do not think your intent is going to be met because I do not believe you are going to get the leveling process to handle the variations in rural/urban reimbursement without further distortions, of the Northeast versus the Midwest versus the west coast.

We think section 10 is not appropriate and that is why we recommended it not be considered.

Senator DOLE. Just tell me how we could do that.

Dr. SAMMONS. I hope Mr. Peterson is going to tell you.

Mr. PETERSON. That provision does not allow any increased charges to the rural physician other than what he would already be eligible for under the current law. It holds down the others in the metropolitan area perhaps, as Dr. Sammons said, which would result in this transfer of costs over to the private sector.

Senator DOLE. I am not sure I hear that would be totally accurate if you allow them in at a higher percentile.

Dr. SAMMONS. We would be very pleased to have our experts in this area meet again with Mr. Constantine and your staff and your own personal staff, Senator. I know of your interest in this. We will be happy to look at it again with you.

I raise the cautionary flag that the way it is written, as we read it, it is going to be a leveling down and it is not going to solve the problem of the rural physician or the low paid physician.

I urge you to carefully review that before you make a final decision.

Senator TALMADGE. Have you checked with the medical societies in Georgia, Mississippi, and Colorado on that issue?

Dr. HUNTER. Yes, sir. Georgia is one of the most explosive States in the Nation on this issue.

Dr. SAMMONS. Senator, I am so familiar with the strong feelings that exist in your State and my old State of Alabama and our neighboring friends in Mississippi, that I almost feel I could write a book about it.

My concern here is what it says in the proposal is not going to resolve the problem in Georgia.

Senator TALMADGE. The Mississippi Medical Association helped us draft the language.

Dr. SAMMONS. That is like two people looking at the same sick patient. You may not always come to the same conclusion but if you stay there long enough, you may kill or cure and in this instance, I hope we can cure and not kill. I urge you to re-examine and re-evaluate this.

Senator TALMADGE. We will carefully re-examine it. Thank you, gentlemen. We appreciate your contribution.

Dr. HUNTER. Thank you for having us.

[The prepared statement of Dr. Hunter follows:]

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION

HOSPITAL REIMBURSEMENT CHANGES

Reasonable determinations for hospitals under medicare (Sec. 2)

Section 2 creates a new program for hospital reimbursement limited to Medicare and Medicaid effective for accounting periods after July 1, 1980. Under the proposal, reimbursement would apply to an "average" cost reimbursement as established for routine costs of hospitals. Hospital routine costs would be compared by classifying hospitals by size, type, location and other criteria. A per diem "target" rate for each class would be established. Hospitals whose routine costs were less than the "target" rate would be entitled to an incentive equal to one-half the difference between actual rates and "target" rates (with the incentive limited to 5 per cent of the "target"). Hospitals with costs in excess of the "target" would be paid actual costs but not in excess of 115 per cent of the "target" rate.

Special allowances would be made in shortage areas for hospitals which were certified as being necessary by an appropriate planning agency and which were underrutilized. In addition, provision is made for hospitals that demonstrate that their unusually high routine costs are charges for services caused by: (1) An unusual patient mix which results in a greater intensity of routine care; (2) changes in services due to approved consolidations or sharing of services with another hospital; and (3) start up costs associated with a new hospital.

To the extent that such additional costs could be justified, they would be excluded from the reimbursement criteria outlined above.

This Section would also establish a Health Facilities Costs Commission that would study hospital reimbursement under Titles V, XVIII and XIX of the Social Security Act and make recommendations to the Secretary. The Secretary by regulation would make appropriate modifications in reimbursement for routine hospital costs under those three Titles and for all other hospital costs, and for costs of other entities which are reimbursed on a reasonable cost basis.

Medicaid reimbursement to hospitals could not exceed the amount determined under the new Medicare formula.

In addition, institutions would agree under Medicare and Medicaid not to increase amounts due from any individual, organization, or agency in order to offset reductions made under these cost determinations.

An exemption from this program would apply to hospitals in a State having a program for hospital rate-making provided the program applies to all hospitals in the State, it applies the same costs as the federal program, all hospitals conform to uniform accounting and reporting, and aggregate payments are equal to or less than they would be under the federal program.

We are deeply concerned that the quality of patient care could be sacrificed in some situations due to this proposed methodology for the determination of reimbursable hospital costs, if this methodology were to be applied across the country. A hospital would be paid not on the basis of its actual costs, but on the relationship of its actual costs to average costs for its hospital classification. These determinations for hospital reimbursement would not operate as a standard for the reasonableness of each hospital's costs; they would constitute restrictions on the reimbursement of actual costs to a hospital.

Reimbursement ceilings for individual hospitals, as established by Section 2, are not based on an actual assessment of what it costs to provide hospital services. The leeway permitted hospitals whose actual costs are above average, the special allowance for those which are below average, and any special consideration for hospitals which are understaffed or which have special cost problems or serve needy areas

are commendable. But clearly, as an end result, the payment of actual and necessary costs of providing hospital care is no longer the controlling factor; instead a system is created for setting arbitrary limits on hospital reimbursement.

Furthermore, the restrictions on a hospital's ability to pass on unreimbursed costs mean that hospitals will be forced to absorb the differential between actual costs and reimbursable costs. Hospitals can no better absorb continuing loss than other establishments and, therefore, this program can only result in an eventual diminution of services offered or a decline in their quality. Neither result is desirable from any point of view.

The proposal provides no assurance that inefficiency will be corrected. The prescribed methodology simply creates a pressure to reduce costs to a set dollar amount without regard to how such reductions may be attained.

We recommend that Section 2 not be adopted as proposed for full implementation. Medicare and Medicaid are represented to provide health care in the mainstream for their beneficiaries. The federal government must meet this commitment. We cannot subscribe to or condone "average" health care services for our elderly, our disabled, and our disadvantaged in order to accommodate payment "on the average".

However, we do recognize the need to work out appropriate solutions to problems of health care costs. As indicated in our Summary Statement, the Voluntary Effort is addressing the issue of increasing hospital costs. Therefore, we would suggest that this particular cost containment measure be instituted on an experimental basis with limited geographical application for a sufficient period of time so that its effects might be properly monitored and evaluated before determining when the nationwide system should be instituted. We believe that to attempt this system on a national basis, without any data as to its effects, would be unwise. Section 2 should be modified to make this proposal initially a local experimental one.

Payments to promote closing and conversion of underutilized facilities (Sec. 3)

Section 3 would authorize increased payments from Medicare, Medicaid and Maternal and Child Health Care funds to cover a "reimbursement detriment" as a result of a qualified conversion or closure of underutilized facilities. An increase in federal payment would be authorized if recommended by the Hospital Transitional Allowance Board, and approved by The Secretary, after finding that such conversion or closure resulted in a reduction in capital-related reimbursement or in costs above those reimbursable under the "reasonable cost" determination formula.

We support the principle of providing assistance to hospitals that would suffer a "reimbursement detriment" as a result of voluntary conversion or closure of facilities which are underutilized and for which adequate alternative sources of care are available in the area. This could encourage a more effective use of hospital facilities. Initiating this support on a pilot basis, as provided in the bill (for 50 hospitals) would enable an assessment to be made of this mechanism before more widespread application is attempted.

However, we do have some reservations concerning the use of Social Security health care funds to finance a program of assistance for the conversion or closure of facilities. In effect this would be devoting Social Security health care funds for other than direct health services. In our view, funding for conversion or closure of facilities would more properly be provided from other sources.

Federal participation in hospital capital expenditures (Sec. 4)

Reimbursement of expenses incurred by planning agencies under Section 1122 of the Social Security Act would be available out of any health care funds under Social Security including the Federal Hospital and Supplementary Medical Insurance trust funds.

Additional amendments would provide for disallowance for any reimbursable amount allocable to capital expenditures or direct operating costs (to the extent associated with the capital expenditure) if the designated planning agency had not approved a proposed capital expenditure (in excess of $150,000) and had granted to the person proposing the capital expenditure an opportunity for a fair hearing with respect to the finding. Any facility seeking a capital expenditure approval and located in a Standard Metropolitan Statistical Area encompassing more than one jurisdiction would have to obtain unanimous approval of all relevant planning agencies.

We believe that it is inappropriate to reimburse state agencies for planning functions from funds earmarked for patient care services. The expenses should be paid out of appropriations made for that purpose, not from Social Security trust funds.

We also believe that requiring unanimous approval of all planning agencies associated with a multi-state SMSA is unnecessary. Such a requirement builds in additional delays to the approval process. The recommendation of the planning agency in the state where the institution is located should be sufficient.

PRACTITIONER REIMBURSEMENT AMENDMENTS

Agreement with physicians to accept assignment (Sec. 5)

This Section would create under Medicare a special class of physicians designated as "participating physicians".

A "participating physician" would be one who agreed with the Secretary to accept all Medicare reimbursement for his services on the basis of an assignment. The amounts recognized as the reasonable charge under the assignment would have to be accepted by the physician as the full charge. In addition, the "participating physician" would obtain from each Medicare recipient a signed statement authorizing the assignment and releasing any medical information needed to review claims.

"Participating physicians" would be permitted to submit claims on a simplified basis, including a multiple-listing basis (rather than on an individual patient basis), and would be allowed an "administrative cost savings allowance" of $1.00 for each patient as in inducement to participate.

No "cost savings allowance" would be payable for physicians' services performed in a hospital (whether on an inpatient or outpatient basis) unless the physician ordinarily bills directly (and not through the hospital) and such services were surgical or anesthesiological services or were performed by a physician who personally examined the patient and whose office or regular place of practice was located outside a hospital.

No cost savings allowance would be recognized for services consisting solely of laboratory or x-ray services for hospital inpatients or outpatients or performed outside the office of the physician claiming payment.

This proposal is designed to increase the sagging rate of acceptance of assignments by physicians. Certain inducements are offered to achieve this goal. A "participating physician" would receive an "administrative cost savings allowance" for each patient. The provision also implies that the claims of "participating physicians" would be processed faster than those of non-participating physicians. Thus the bill creates two classes of physicians—participating and non-participating. To the Medicare patient, the message will be clear—patronize the "participating" physician rather than the non-participating. Furthermore, use of the term "non-participating physician" when referring to physicians who do not agree to accept all assignments could deceive program beneficiaries into thinking that they are prohibited from using such physicians.

However, the cost of inducements, direct or indirect, does not reach the issue of why the assignment is so little used. The fact that inducements are necessary in order to buttress a sagging assignment rate should cause an examination of basic factors involved. Without question the current system, with its insufficient reimbursement rate, is the major deterrent to assignments. The artificial and discriminatory payment mechanism under Medicare has caused a rejection of the assignment method of receiving payment. The 75th percentile formula, applied to outdated and unrealistic data (at times almost two years old) and further curtailed through application of the economic index, has caused many physicians to be disenchanted with the assignment method. It also should be observed that in seeking to foster acceptance of assignments S. 505 is dichotomous. In one section it seeks to provide inducements for assignments, while in another it discourages such use through the imposition of more reductions in payment.

Rather than seeking new devices to bolster assignment usage that are based on the perpetuation of artificial and arbitrary payment levels, it is time to examine and make realistic the basic Medicare reimbursement formula and payment mechanisms. If indeed it is the intent of Section 5 to achieve more widespread acceptance of assignments, it would be better accomplished by making the reimbursement level under the system more acceptable in accord with usual and customary practices. Medicare reimbursement limitations are discriminatorily imposed, and should be removed.

As to the multiple list billing, one assumes there are administrative advantages for Medicare and the physician that underlie this proposal. If so, there is no reason why this payment feature should not be put into effect immediately. The provision for early—or more appropriately, timely—payment is certainly no more than physicians are entitled to and should receive at the present time, without the necessity of statutory mandate. It would be disheartening if convenient administrative aids are now available—but are not being utilized.

Section 5 as now written will not contribute to the continuation of quality care under Medicare and should not be adopted.

Hospital-associated physicians (Sec. 6)

Section 6 would establish a stringent definition of "physicians' services"; would enact statutory definitions of reimbursable anesthesiology and pathology services; would reduce the Medicare payment for radiology and pathology services if the physician providing them did not accept assignment; and would limit physician reimbursement based upon the form of financial arrangement.

Medicare law now defines "physicians' services" as "professional services performed by physicians". S. 505 would amend that definition to exclude those services the physician performs as an educator, an executive, or a researcher. The amendment would exclude even patient care services unless "personally performed by or personally directed by a physician" for the benefit of the patient and unless the service is of such a nature that its performance "by a physician is appropriate."

It should be made clear that although this amendment comes under the heading "Hospital-Associated Physicians" the amendment is not so limited, and the placement of this amendment under that heading is misleading. In fact this provision amends the general definition of "Physicians' Services" in Section 1861(q) and consequently the new limitations apply to all physicians' services" under Medicare.

We object strongly to this modification. All activities of physicians customarily recognized as part of the physician's practice should be reimbursable as "physicians' services" under Medicare. A strict application of the proposed language would have dire consequences for proper recognition of, and payment for, all services of physicians under Medicare.

Even if the provision was intended to affect only the inpatient services of "hospital-associated physicians", the modification would still be objectionable.

The writers of regulations, armed with this proposed statutory language, could arbitrarily redefine the practice of medicine as recognized today to the detriment of both the patient and the profession.

Whatever its intent, a legal definition that states that a physician acts as a physician only when directly treating a patient and when performing services only a physician can perform will ultimately lead to confusion in the Medicare program and further dismemberment of health care.

Furthermore, the physician as educator, researcher, or administrator does not cease to be a physician; indeed, since the earliest days of the medical profession, teaching and research have been recognized as intrinsic parts of the practice of medicine. As medicine has become more organized and technologically sophisticated, administrative tasks have developed which can be performed most effectively only by a practicing physician.

We protest strongly any artificial division of the physician's role.

We further protest, therefore, the attempt to define precisely what are "personally performed" or "personally directed" services in the fields of anesthesiology or pathology. Medicine is a living science, which changes rapidly and dramatically. Laws may take years to change. Even the regulatory process, as this Congress is well aware, can be dilatory and inflexible. The language of these sections goes further in limiting medical practice than the laws under which these physicians are licensed to practice. The restrictions on anesthesiology and pathology are not only unwise legislation in themselves, but tend to undermine the very mechanism established by Congress in 1972 designed to improve care under Medicare, Medicaid and Maternal and Child Health programs. Congress then established PSROs to determine whether patients under the three programs receive care which meets appropriate professional standards of quality. Decisions as to what constitutes proper physician services were delegated to local professionals who are better equipped to make such determinations than government employees.

This bill would superimpose on PSRO deliberations specified arbitrary standards as to how many patients a physician could personally treat, or personally direct treatment for, and still have the treatment considered a "physician's service". It would say which services of pathologists are "physician's services" and which are not. PSROs were properly given the charge to determine the propriety of medical services and if they meet professional standards. Congress should not undermine this function.

We suggest that this Committee consider very carefully the limitations this law would set on care recognized as properly provided by anesthesiologists. For purposes of the program, an anesthesiologist could "personally perform" physicians' services for only two patients at a time. The "reasonable charge" for "personally directed" care will be half that for "personally performed" care.

By this standard, an anesthesiologist will receive the same payment for two patients for whom he provides all the listed services as for four patients for whom he provides all but one of the listed services, but for whose care he still remains legally liable. This change could well result in a reduction in the anesthesiology services available to Medicare, Medicaid and Title V patients.

The redefinition of pathology services is also of serious concern to us. Besides the "personally performs" limitation, we believe that excluding from professional services the services a pathologist performs in autopsies, supervision, quality control, and other aspects of a clinical laboratory's operations is a serious error. There is a physician's component in all pathology services.

This attempt to redefine pathology services for purposes of Title V, XVIII and XIX reimbursement savings can only have an adverse impact on the availability of pathology services for those program patients.

The Congress should not set in inflexible statutes the elements that constitue acceptable performance of practice by anesthesiologists or pathologists or any other physician.

In Section 6, the bill would also enact an approach which is intended to encourage physician acceptance of assignments—but it does so by penalizing the patients if they do not. Under present law, pathology and radiology services to hospital inpatients are paid under Part B at 100 percent of the "reasonable charge", whether the physician has accepted assignment or not. S. 505 would change the amount of Medicare payment to the usual 80 percent of the "reasonable charge" if the physician does not accept assignment, and permit crediting of the patient's 20 percent of the "reasonable charge" towards the annual Part B deductible. We point out that the Medicare "reasonable charge" for pathology and radiology services remains the same, whether or not the physician accepts assignment.

The Association questioned whether the coinsurance factor should be eliminated for specific segments of medical care during the discussions prior to passage of Public Law 90-248. We question even more strongly the establishment of different rates of payments for Medicare for similar services when provided on assignment or when billed to the patient. We believe that this approach violates basic principles of equity to the Medicare beneficiaries, who pay the same out-of-pocket premium but would receive different degrees of coverage as a result of factors over which they have little or no control.

A further provision of Section 6 also affects the amount a physician may be reimbursed. The charges of a physician or other person related to income or receipts of a hospital or hospital subdivision would not be taken into consideration in determining his customary charge to the extend that such a charge exceeded what a salary (plus certain expenses), as determined by the Secretary, would reasonably have been if the physician or other person had been employed by the hospital. We believe that freedom of contract should not be so limited.

These proposed definitions of "physicians' services" are described as an effort to control health care costs by limiting reimbursable services under Medicare. In actuality, it is an effort by the government to evade its responsibilities to Medicare beneficiaries who depend on this program for their health care. Changing the definitions does not change the true costs of services, but merely shifts the burden of financial responsibility from the government to the patient who can ill afford such a shift.

For the government to renege on its promises to the elderly can only result in a further diminution of confidence in our federal system.

The changes, ostensibly aimed at the physician, will in the end cause the most harm to the patient.

We strongly urge that Section 6 not be adopted.

Use of approved relative value schedule (Sec. 7)

The Secretary of HEW would establish a system of procedural terminology under Medicare, Medicaid and Maternal and Child Health as developed by the Health Care Financing Administration (HCFA) with the advice of professional groups and other interested parties. Upon development of the procedural terminology, it would be published in the Federal Register for six months' comment and for recommendations as to relative values for procedures and services designated.

Any association of health practitioners in "good faith" preparing or submitting a relative value schedule would not be barred from doing so because of any consent decree waiving its rights to recommend fees provided such schedule is not disclosed to anyone other than those preparing the schedule or their counsel, until made public by the Secretary. HCFA would recommend that the Secretary adopt a specific terminology system and its relative values for use under Part B of Medicare, but

only after analyzing and evaluating the system and determining that its use would enhance the administration of the federal health care financing programs.

After adoption of a system by the Secretary, any organization or individual could use it for purposes other than for this bill. The Secretary could adopt a terminology system without adopting a relative value system and could modify any system adopted.

The use of relative value schedules (RVS) can, if properly designed and implemented, be a useful administrative tool in any system of health care reimbursement. However, a RVS must not be so rigid as to preclude adjustments in fees based on regional cost-of-living differences, overhead or other factors that affect physicians' fees in a particular locality.

Above all, a RVS should not be used to "fix" fees either by practitioners or the government on a regional or national level.

We are concerned about this particular proposal because of the discretion available to the Secretary, and residing solely in the Secretary, in establishing the relative values. In determining any RVS, he is not required to adopt the recommendations of the Health Care Financing Administration or of any professional association and is also free to modify any RVS at any time. Such unlimited authority is not conducive to effective use of the RVS in federal reimbursement programs.

Nothing prevents the Secretary from using the RVS to create a federal fee schedule. We would oppose such a move.

Likewise, there is nothing in this provision that prevents the Secretary from using the RVS as a lever to lower the already inadequate reimbursement levels under federal health payment programs. Such a move would only make it more difficult for the beneficiaries of Titles V, XVIII, and XIX to obtain quality care.

We urge the committee to incorporate in Section 7 appropriate safeguards for the development and use of the RVS to insure its proper implementation, and to keep it from being used as a fee reduction system.

We again remind the committee that a lowering of reimbursement levels represents cost savings only to the government. The actual cost of the service does not change and the difference between actual cost and reimbursed cost usually is made up by higher prices on other services to non-government patients or an increased cost to the Medicare beneficiary.

It is unrealistic to expect physicians to donate services on a massive scale. A system of inadequate reimbursement can only lead to inferior health services.

We note that this provision would permit other uses of the approved RVS. This is an effort to overcome certain legal obstacles that now prevent the use of an RVS. However, because of the complexity of the legal situation surrounding the use of the RVS, we are not sure that the language of Section 7(e) is sufficient to overcome the present restrictions on its use. We urge that the language be re-evaluated. We oppose adoption in its present form. Legislation should recognize and provide for use of terminology and relative value schedules as developed by the profession. There should be proper recognition of the wide acceptance in the profession of the Current Procedural Terminology (CPT).

Teaching physicians (Sec. 8)

This provision would postpone the effective date of Section 227 of Public Law 92-603 which would alter the method of Medicare reimbursement for physician services in teaching hospitals until October 1, 1979.

The AMA believes that implementation of Section 227 will create inappropriate distinctions between Medicare beneficiaries and other patients regarding the delivery of their care. Such a result is directly contrary to the intent of Congress when it enacted the Medicare program.

We are also concerned that Section 227 could have very negative effects on medical teaching programs across the country by exacerbating the financial pressures already faced by many of these programs. The strength of these educational programs must be sustained if we are to continue providing quality medical care to all citizens.

The AMA opposed enactment of Section 227 in 1972 and we have consistently supported repeal efforts since then. We continue to believe that Section 227 should be repealed; however, on an interim basis, we believe that delay of its effective data is an appropriate solution.

The American Medical Association believes this provision is a beneficial one. We recommend support of Section 8, but would suggest the date be extended beyond October 1, 1979, in view of the closeness of that date.

Reimbursement provisions relating to certain surgical procedures performed on an ambulatory basis (Sec. 9)

The provision would permit Medicare reimbursement on the basis of an all-inclusive rate to free-standing ambulatory surgical centers and to physicians performing surgery in their offices for a listed group of surgical procedures. Such procedures include those which are often provided on an inpatient hospital basis but consistent with sound medical practice, can be performed on an ambulatory basis. The rate would encompass reimbursement for the facility, physician and related services, including normal pre- and post-operative visits and routine laboratory and other diagnostic tests usually associated with the procedure.

The list of procedures eligible for such reimbursement would be specified by the Secretary following consultation with the National Professional Standards Review Council and appropriate medical organizations including specialty groups. Subsequently, procedures could be added or deleted as experience dictated.

Currently, Medicare can reimburse the physician for his professional services in any setting. Also, the institutional costs of ambulatory surgery in a hospital outpatient department can be reimbursed. However, a charge for the use of special surgical facilities in a physician's private office or a free-standing surgical facility that is not hospital affiliated is not now reimbursable.

Under the bill the physician performing surgery in his office would be compensated for his special, surgical overhead through the all-inclusive rate if he accepts an assignment; there would be no deductible and coinsurance applied in such cases.

Similarly, reimbursements would be provided for the use of the facilities in an ambulatory surgical center, without deductible or coinsurance, where the center accepts assignment. In the case of an ambulatory surgical center, the overhead allowance could be paid directly to the center and the professional fee could be paid directly to the physician. The deductible and coinsurance would be waived for the physician fees for services performed in connection with listed surgical procedures in hospital outpatient departments and other ambulatory surgical centers where the physicians accept assignment.

The overhead factor is expected to be calculated on a prospective basis (and periodically updated) utilizing sample survey and similar techniques to develop reasonable estimated overhead allowances for each of the listed procedures which take account of volume (within reasonable limits).

While we are supportive of the concepts embodied in this provision, many questions are raised concerning the alleged benefits to be gained.

We are concerned that an ambulatory surgical procedure list promulgated by the Secretary could become a list that would require such surgery to be performed in the ambulatory setting. Would Medicare payments to hospitals be disallowed for performing these so far unnamed procedures?

Would the Secretary's judgment then stand in place of the physician's as to where surgical procedure was to be performed? We surely hope not. It is our understanding that reimbursement to physicians currently performing surgical procedures in their offices include overhead.

Under the bill, the payment of his costs (including a special overhead factor on a prospective basis) raises the concern that the Secretary may require auditing of the physician's financial records in order to determine his specific overhead allowance. By securing his records for this purpose, the Secretary may well impose his own accounting procedures and practices and thereby obtain financial control of the physician's practices.

We are fearful of this possibility. For these reasons, we must recommend that this provision not be adopted as written.

Criteria for determining reasonable charges for physician's services (Sec. 10)

The bill would significantly change determinations of reasonable charges under Medicare. At the present time prevailing charge levels are set in localities so that the prevailing charge level would cover 75 percent of the customary charges made for similar services in that locality. Certain additional limitations are imposed so that the charge level for any fiscal year beginning after June 30, 1973, would not exceed the level determined during the fiscal year that ended on that date, except to the extent that a higher level is justified by economic changes determined to be acceptable by the Secretary on the basis of appropriate economic index data.

Under S. 505, however, the Secretary would determine statewide prevailing charge levels for each State. The prevailing charge level of the State would be based on 50 percent of the customary charges made for similar services in the State.

Prevailing charge levels in a locality would remain subject to the economic index but the bill specifies that for an economic index increase for any particular service,

"no prevailing charge level for physicians' services shall be increased to the extent that it would exceed by more than one-third the statewide prevailing charge level * * * for that service."

This procedure could, in many cases, result in a diminution in future increases in the reimbursable amount which physicians might otherwise receive. It appears that the real effect of the new methodology would be to cause a leveling of reimbursement. This leveling would be accomplished, however, through a reduction (particularly in metropolitan areas) in the amount of increases which otherwise would be due under the economic index and to which physicians currently are entitled. While the reimbursement levels in non-urban areas might for a period of time undergo normal increases which could be higher (as a percentage) than those to be recognized in metropolitan areas under the economic index, this stifling of proper fee recognition for all physicians would be detrimental to maintaining a proper level of care under the program.

Discrimination in the application of the economic index in states with two or more localities would result. Some physicians would receive the full amount allowed by the index, others would not. Further discrimination would result because the index would apply fully to all physicians in states constituting a single locality. The artificial ceiling imposed on Medicare reimbursements could affect participation by physicians and affect the availability of care for Medicare patients. This type of limitation would also further aggregate the shifting of expenses not reimbursed by Medicare and Medicaid to patients under private programs.

In our opinion, reimbursement levels imposed upon physicians are already substandard. This provision would further reduce this standard and thus adversely affect Medicare patients. This provision should not be adopted.

We note that one provision in Section 10 is intended to permit greater flexibility in the recognition of charges in physician shortage areas. The intent of this provision is salutary. The current needs of certain areas for medical care are well recognized and a variety of ideas should be tried in order to solve these shortages. We would recommend, however, that the definition of a shortage area be consistent with that in other laws. There is no need to create yet another definition of shortage areas exclusive to Medicare that will overlap areas established under other statutes.

Payment for certain antigens under part B of medicare (Sec. 11)

There would be added to the definition of "medical and other health services" provisions to include antigens (as limited in quantity by the Secretary) prepared by an allergist for a particular patient. Included also would be antigens prepared and forwarded to another qualified person for administration to the patient by or under the supervision of a physician.

We believe that this provision is a beneficial one. It would answer questions concerning payment that have been raised with respect to antigens prepared by allergists. Providing payment for these services will be beneficial for many Medicare beneficiaries. We recommend support for Section 11.

LONG-TERM-CARE REFORMS

Hospital providers of long-term-care services (Sec. 13)

Title XVIII would be amended to allow rural hospitals of less than 50 beds to enter in agreements with the Secretary to provide extended care services using inpatient hospital facilities. The Secretary is given discretionary authority to allow rural hospitals with more than 49 and less than 101 beds to provide extended care services on a demonstration basis only. These hospitals would have to meet other conditions prescribed by the Secretary, obtain a certificate-of-need for provision of long term care services from the health planning agency, and would be reimbursed at the Medicaid level of skilled nursing facilities in the State. A hospital having such an agreement would be considered as meeting most of the otherwise applicable Medicare requirements for providing extended care service.

Medicaid would also be amended to provide reimbursement for skilled nursing services and intermediate care services of a hospital having such an agreement.

This provision is designed to allow certain rural hospitals flexibility in their use of hospital beds. Under present law, long term care services offered by a hospital must be located in a separate unit of the hospital. Such a requirement often works a hardship on rural hospitals with limited facilities since they cannot reasonably comply with the separate location requirement.

This amendment recognizes this handicap of many small, rural hospitals and allows them to use available bedspace for multiple purposes for which they will be reimbursed under Medicare and Medicaid.

This is a sensible response to this situation and we support the provision.

Medicaid certification and approval of skilled nursing and intermediate care facilities (Sec. 15)

This Section provides that the Secretary would enter into an agreement with any State able and willing under which the services of the State health agency, or other appropriate State or local agencies, would be utilized by the Secretary for the purpose of determining whether an institution in the State was qualified as a skilled nursing facility or intermediate care facility for purposes of the Medicaid program. Notwithstanding certification by the State agency, however, the Secretary is empowered to accept or reject such certification. However, a facility dissatisfied with the Secretary's findings would be entitled to a hearing and judicial review.

In our opinion this Section of the bill would create confusion and uncertainty in the program and constitutes an unnecessary and unwarranted involvement of the Federal government. The present procedure which recognizes certification by state agency as determinant of eligibility for Federal Medicaid payment to the states should be retained. This provision of Section 15 should not be adopted.

However, a provision of Section 15 recognizes that whenever the Secretary certifies a rural health clinic for Medicare purposes such clinic will be deemed certified for the delivery of rural health clinic services under Medicaid.

We recommend support of this provision of Section 15 as it will help ensure that the disadvantaged located in rural areas will have access to needed health care services.

Health Insurance Benefits Advisory Council (Sec. 18)

Section 18 of S. 505 mandates the dissolution of the Health Insurance Benefits Advisory Council originally enacted under Public Law 89-97. When the 89th Congress created (as part of the original Medicare and Medicaid enactment) HIBAC, it was not its intent to establish this as an "ad hoc" or temporary advisory body. Congress envisioned an active and constructive advisory role for HIBAC and expected that the Secretary would take full advantage of it.

We recognize that HIBAC has not been as active or contributory as it might have been. However, the fault lies not with the body itself, but rather with its use—or disuse—and to the staffing—or lack of staffing—it has received. In our view the Congress, rather than abolishing HIBAC, should strengthen it by requiring that it receive the support necessary to permit it to function as an effective advisory body to the Secretary.

We therefore urge that Section 18 be rewritten to strengthen HIBAC and make it truly effective.

MISCELLANEOUS CHANGES

Ambulance service (Sec. 20)

We recommend a slight modification of Section 20 relating to "Ambulance Service", and offer our support for this Section as modified.

Under this Section of the bill, Medicare would be extended to provide for ambulance service to the nearest hospital which was both adequately equipped and had medical personnel qualified to deal with, and available for the treatment of, the individual's illness, injury or condition.

Improved ambulance coverage for Medicare patients is highly desirable. However, this provision is not clear as to who will make the determination of which hospital is nearest the individual. An amendment to this Section should be made to provide that within reasonable limits, this determination could be made by the patient. This would assure that the patient could enter the hospital at which his physician has medical staff privileges, but which may not in fact be the hospital "nearest" the patient. We would recommend that Section 20 be changed to provide for reasonable determination by the patient.

Disclosure of aggregate payments to physicians (Sec. 23)

The Social Security Act would be amended to prohibit the Secretary from making available (and to prohibit any requirement of a State Medicaid agency to make public) information pertaining to amounts paid physicians for or on behalf of beneficiaries of Medicare or Medicaid except to the extent necessary to carry out the purpose of the programs or as required by other federal law.

The AMA is pleased to see a legislative effort finally being made to terminate the annual publication of lists of providers receiving funds above a certain level from Medicare and Medicaid. The disclosure of this information has served no useful public function, but merely has been a means of attacking the profession through

innuendo. The revelations of massive error in a list issued by HEW underscore the need to put an end to this practice.

We strongly support the provisions of Section 23.

Confidentiality of PSRO data (Sec. 28)

Section 28 amends the PSRO provision that prohibits the disclosure of information by indicating that any data or information which "identifies (either by name or inference) an individual patient, practitioner, provider, supplier or reviewer" be held in confidence and not disclosed except in certain limited and defined circumstances.

We believe this provision provides additional protections that are necessary to present wholesale disclosure of confidential PSRO records pursuant to the Freedom of Information Act.

We support the enactment of Section 28.

Removal of 3-day hospitalization requirements and 100-visit limitation for home health services (Sec. 29)

The bill removes a provision in existing law that limits Medicare home health benefits to 100 visits per spell of illness under Part A and 100 visits per year under Part B. In addition, the bill removes the requiremetn that a beneficiary has to be an inpatient in a hospital for at least three days before he can qualify for Part A home health benefits.

By removing the numerical limit on home health visits and the 3-day prior hospitalization requirement, we believe that the home health benefit will become more widely available to eligible persons in need of such care.

Accordingly, we recommend support for this provision.

Payment for laboratory services under medicaid (Sec. 27)

This provision would authorize states to purchase laboratory services for the Medicaid program through competitive bidding arrangements for a three-year experimental period. Under this provision, services may be purchased only: (1) From a laboratory meeting appropriate health and safety standards; (2) if no more than 75 percent of the charges from such services are for services provided to Medicare and Medicaid patients; and (3) only if the laboratories charge the Medicaid program at rates that do not exceed the lowest amount charged to others for similar tests.

We are concerned about certain potential ramifications of this amendment.

We recognize that a State should take proper steps to control costs under its Medicaid program, but any cost control measure must be examined in light of its effects on the patient.

If a State contracts with a laboratory to provide all services for Medicaid patients, the State would be restricting Medicaid patients to services of that laboratory. If this meant that the physician could not provide laboratory services, the beneficiary would be greatly inconvenienced. This could mean that instead of one visit to a physician's office for examination and lab work, two visits could be required—one to the physician and another to the lab. This could be a considerable hardship for many Medicaid patients. Even if the physician takes the specimen at his office and transmits it to the lab, there will be a delay for the patient while waiting for the results to be returned to the physician. When the results are returned, a second office visit would often be required. Had those tests been performed in the physician's office much of the delay and inconvenience could have been avoided.

Such a contractual limitation would also interfere with the freedom of choice by patient and physician. Physicians could not select the laboratory which they thought best under the particular local circumstances.

In allowing the State to dictate the provider of care for Medicaid patients this amendment could return Medicaid patients to a two-class system and limit care to restricted Medicaid providers. Medical determinations should not be based on cost factors alone.

This measure could also have the effect of driving small labs out of business. The larger facilities, because of greater volume, would generally make the low bid. Domination of the market by larger laboratories would lessen the price competition that now helps to restrict prices and to encourage new technology. The unintended result could be higher future costs for services and a retardation of the development of new procedures.

Uniform health insurance claim form (Sec. 31)

The Association concurs fully in the idea that a single, uniform health insurance claim form would greatly simplify the paperwork involved in not only Medicare and Medicaid, but also the private health insurance industry. To this end, the AMA has

developed, and periodically updated, a Uniform Claim Form for accident and health insurance, for the reporting of physicians' services.

The claim form has been developed with the assistance of a work group representing not only the private insurance industry and Blue Shield plans, but also both Medicare and Medicaid and the Department of Defense's CHAMPUS program. It meets the requirements of virtually all public and private payment programs, and is in fact the required claim form for Medicaid in a number of states. The Federal government's own Paperwork Commission has recognized its potential for reduction of duplication of forms.

We would urge the Committee not to seek yet another "study" of claim form simplification, at least so far as physicians' services are concerned, when the work has already been done.

CONCLUSION

We have discussed many of the provisions of S. 505. As we have indicated, this bill would have serious and far-reaching ramifications with respect to services furnished under the Medicare, Medicaid and Maternal and Child Health Programs. While the thrust of the bill is cost containment for these programs, the full effects would be broader, affecting the quality and availability of care not only to program beneficiaries, but also to other patients.

In view of the continuing inflationary pressures in our economy, we are indeed sympathetic with the intent of this legislation to seek limitations upon rising health care costs. It must be recognized, however, that arbitrary curtailments of increases in costs will have natural consequences with respect to maintaining quality and availability of care. Each element cannot be treated separately without expectation of impact on the others. Any changes in reimbursement levels must be carefully evaluated in terms of their ultimate effects on patient care.

In our discussion we have indicated those provisions which we believe are not in the interest of program beneficiaries. We have also indicated our support for other provisions. Taken as a whole, however, the bill should not be enacted as it is not in the best interests of Medicare-Medicaid patients.

As the Subcommittee continues its deliberations on this bill, we urge that our comments and suggestions be carefully considered. The American Medical Association is ready to work with the Subcommittee and its staff in developing appropriate modifications to the Medicare and Medicaid programs.

Senator TALMADGE. Our next witness is Mr. Kenneth Young, director of the Department of Legislation, AFL-CIO.

Gentlemen, we are delighted to have you with us. You may insert your prepared statement and summarize it in not more than 10 minutes, please.

Mr. YOUNG. Thank you. I will ask the statement be inserted into the record.

Senator TALMADGE. Without objection, your prepared statement will be inserted into the record.

STATEMENT OF KENNETH YOUNG, DIRECTOR, DEPARTMENT OF LEGISLATION, AFL-CIO

Mr. YOUNG. Thank you, Mr. Chairman.

With me, on my left, is Mr. Richard Shoemaker, assistant director of the AFL-CIO department of social security. On my right is Mr. Robert McGlotten, a legislative representative for the AFL-CIO.

Senator TALMADGE. We are delighted to have you, gentlemen.

Mr. YOUNG. Mr. Chairman, the AFL-CIO appreciates the opportunity to appear before the Health Subcommittee with respect to the Medicare and Medicaid Administrative and Reimbursement Reform Act, S. 505 and the Hospital Cost Containment Act, S. 570.

Medical care costs continue to escalate at about twice the rate of all goods and services as measured by the Consumer Price Index.

Health care costs are almost doubling every 5 years. The impact of these rising costs on the Federal budget is substantial.

Over 40 percent of health expenditures come from public funds. Federal payments for medicare and medicaid and other health programs total about $57 billion and will rise to $102 billion by 1983. The combination of direct and indirect Federal, State, and local government payments to the health industry makes that industry one of the most heavily subsidized industries in the country. In 1978, this subsidy amounted to $76 billion.

There is no way to control these escalating costs until Congress enacts a comprehensive national health insurance program such as the Health Care for All Americans Act which will shortly be introduced by Senator Kennedy.

Under this proposed bill, the Congress would establish a budget for health services and provide the financial resources to pay for these services. Medical societies would be obligated to negotiate realistic fee schedules so that the budget for physician services could not be exceeded.

Likewise, hospitals and other health institutions would have to negotiate their budgets so that total expenditures for hospitalization could not exceed the amount of funds allocated for institutional care. A budgeting system of cost control is far more flexible than regulation and is less costly as well.

The bill introduced by the distinguished chairman of this subcommittee, S. 505, includes some worthwhile features but also other provisions which we strongly oppose. Nevertheless, it is 13 years since medicare and medicaid have been implemented and Congress has taken no effective action to control health care costs. We do congradulate you and Senator Dole for your initiative in introducing S. 505.

There are two main thrusts in this bill. One, it would establish a single prospective reimbursement system for hospitals. Two, it would attempt to induce physicians to accept usual and customary fees under medicare.

If a prospective hospital reimbursement program is to control hospital costs, it must deal with three elements; intensity of care, utilization and routine operating costs.

Intensity of care is the primary cause of hospital cost inflation. Excessive utilization of hospital beds is the second most important cause of escalating costs. S. 505 only deals with routine operating costs which have contributed to only a minor degree to this inflation.

We conclude therefore that S. 505 will not significantly contain the escalation of either hospital costs or total medical care costs.

We find particularly objectionable the provisions of S. 505 which would in effect establish a system of wage control. Hospital wages are too low in most communities and average less for the Nation as a whole than those of workers generally or even service employees. They have played almost no role in generating the inordinate escalation of hospital costs.

S. 505 in effect would place a ceiling on hospital wages keeping them permanently below general wage levels. These provisions are unacceptable to us as an infringement of the rights of hospital

workers to negotiate their wages with hospital management through the process of free collective bargaining.

We believe that a negotiated budget is a far more effective and flexible tool for controlling hospital costs than the complicated system provided in S. 505. However, hospital budgets would have to be negotiated across the board and not just for patients covered by medicare and medicaid. Otherwise, costs could too readily be passed on to private patients whose premiums are paid by negotiated health benefit packages, group insurance and individual health insurance policies.

The bill treats physicians very gently. Physicians would be induced to accept assignments by a possible $2 per encounter increase in their income from medicare patients if they agreed to become participating physicians.

This simply will not work because nonparticipating physicians in the medicare program would make more than $2 extra per encounter from their over 65 patients.

The AFL-CIO strongly recommends a negotiated fee schedule for physicians. Such a fee schedule should be applied across the board and not just for medicare and medicaid patients.

In addition, physicians should be free to elect payment by capitation. It is quite possible that some physicians would prefer this method of reimbursement since it provides improved continuity of care for the patient and almost complete elimination of paperwork for the physician. In fact, more and more physicians are accepting capitation as a method of reimbursement in HMOs.

Turning to S. 570, we believe the administration's bill is, in our opinion, a substantial improvement over section 2 of S. 505. We detail our support for this legislation on pages 11 through 13 of our statement.

S. 570 would be easier to administer. It would deal more effectively with the causes of hospital cost escalation which are in order of importance; intensity of care, utilization and operating costs. The incentives for efficiency in the administration's bill should reduce operating costs. The bill would allow free collective bargaining in the hospital industry which is a major concern to the AFL-CIO.

In conclusion, we believe the most effective way in which to achieve control over escalating health care costs is to budget health expenditures for hospital and physician services along with the lines of the proposed Health Care for All Americans Act.

For the interim period, we favor the approach of S. 570, the administration's hospital cost containment bill. We approve some sections of S. 505 which if not enacted separately might well be part of a comprehensive and universal national health insurance program.

We are strongly convinced that Congress should not now enact a long term program which might have to be dismantled when a national health insurance program is developed. We urge that only a temporary cost containment bill be reported out to be effective until Congress has an opportunity to review the national health insurance proposals to be submitted to Congress by Senator Kennedy and the administration.

45-558 O - 79 - 25

Senator TALMADGE. Thank you very much, Mr. Young, for your contribution.

Senator Dole?

Senator DOLE. I just have one question and I think it relates to the last portion of your testimony.

Are there some provisions that I missed about 570 being short term? You said we should just have a short term legislation until we get into national health insurance. I did not know they had a cutoff time in S. 570.

Mr. YOUNG. We think under proposals being suggested by Senator Kennedy, and we would hope under proposals being suggested by the administration, that you could fold in S. 570.

Senator DOLE. Thank you.

Senator TALMADGE. Senator Baucus?

Senator BAUCUS. I have no questions.

Senator TALMADGE. Thank you, Mr. Young.

[The prepared statement of Mr. Young follows:]

STATEMENT OF KENNETH YOUNG, DIRECTOR, DEPARTMENT OF LEGISLATION, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

The AFL-CIO appreciates the opportunity to appear before this subcommittee today to present our views with respect to S. 505, the Medicare-Medicaid Administrative and Reimbursement Reform Act, introduced by the distinguished Chairman of this subcommittee and S. 570 the Hospital Cost Containment Act of 1979, the Administration's bill.

The time is ripe for Congress to take action to control the unconscionable escalation in medical care costs. The Administration estimates that medical care costs are $182 billion in 1978 which amounts to 8.8 percent of the Gross National Product. Medical care costs will be $329 billion in 1983 or 10 percent of the GNP. Compare this to Canada which has a social insurance health program which provides for its entire population comprehensive benefits without any deductibles for only seven percent of its GNP. Canada's costs are lower because they have a single social insurance program rather than the fragmented private insurance system we have in the United States.

The average cost per day of a hospital stay has been increasing at a rate of about double the rate of increase of the Consumer Price Index. The average per day cost of a hospital confinement was $215 in October of 1978. This represents a 14 percent increase over the same month in the previous year.

The impact of these escalating costs on the federal budget is substantial. Over 40 percent of health expenditures come from public funds. Federal, state and local government payments for health care total $76 billion. Total federal payments for health care, including Veterans Administration and Department of Defense hospitals, construction and research, come to $57 billion and will rise to $102 billion by 1983. The combination of direct and indirect federal, state and local government payments to the health industry makes this one of the most heavily supported industries in the country.

It is disturbing that in the thirteen years that have elapsed since Medicare and Medicaid were implemented, Congress has yet to take effective action to control health care costs. The AFL-CIO, therefore, congratulates you, Mr. Chairman, on your initiative in introducing S. 505.

COMPREHENSIVE NATIONAL HEALTH INSURANCE

It is our opinion that there is no way to control these escalating costs until Congress enacts a comprehensive national health insurance program such as the Health Care for All Americans Act which will shortly be introduced by Senator Kennedy (D-Mass.). Under this proposed bill Congress would establish a budget for health services. The goal would be to hold future health expenditures to a constant percentage of the GNP. The Administration is also expected to introduce a national health insurance bill shortly.

As it is now, the government, Blue Cross-Blue Shield and insurance companies are simply issuing blank checks for the providers to fill in as they please.

Because of built-in cost controls in a budgeting system, detailed regulation is not needed to control costs. Essentially, providers would have far more freedom to experiment and innovate under a budgetary system than under a regulatory system. Moreover, the budget approach provides incentives for physicians to become involved in better organizational arrangements for the delivery of care.

This is the approach of the Health Care for All Americans Act.

There is no question that the health industry can absorb virtually unlimited amounts of money. One unique aspect of medical care is the degree to which physicians control the demand for health services. Seventy percent of the demand for health services is generated by physicians. Yet, physicians seldom think about the cost of the care they engender.

After the first contact with the physician, which is initiated by the patient, the doctor establishes the patient's course of treatment. The doctor advises the patient when he or she should come back for a follow-up office visit—next week, in ten days or next month. The doctor orders the lab tests and X-rays. If the doctor deems it advisable, he or she hospitalizes the patient and decides when the patient can be discharged. The doctor writes the prescriptions, usually for costly trade name drugs and gives instructions to interns, residents and nurses.

Another unique aspect of medical care is that the training of a physician emphasizes that any medical expense is justified. Thus, marginal improvements in the quality of care, even if achieved at substantial cost, can always be supported.

THE MEDICARE-MEDICAID ADMINISTRATIVE AND REIMBURSEMENT REFORM ACT (*S. 505*)

S. 505 includes some worthwhile features but others which we strongly oppose. The bill's principal thrust is in two directions: Section 2 would establish a single prospective reimbursement system for hospitals; and Section 5 would attempt to induce physicians to accept usual and customary fees under Medicare. A major weakness of the bill is that the controls apply only to reimbursement under Medicare and Medicaid and not to reimbursement by private insurance. It is, therefore, easy to shift costs from the public to the private sector.

S. 505 is a very complex bill which would essentially rely on detailed regulation. Its implementation would require a large number of investigators and enforcers. Unless sufficient funds were provided to police the providers there would, undoubtedly, be widespread evasion of its provisions.

Considering the cost of administration that would be required by S. 505, we question whether, in fact, it would save any money. The bill would probably reduce hospital costs. But the impact of the bill would undoubtedly result in a transfer of hospital costs to other health care services: outpatient care, nursing home care and x-ray and laboratory services.

For example, in the state of Massachusetts, which has a state program of hospital cost containment, the radiologists and pathologists who had been salaried employees of some hospitals were allowed (and probably encouraged) to bill patients separately under fee-for-service arrangements. This transferred their services from the budget of the hospital to the cost of doing business by physicians. Their charges for Medicare patients were transferred from Part A of Medicare to Part B and charges under Blue Cross were transferred to Blue Shield. Since physician charges remain uncontrolled under S. 505, it would be likely to produce the same results as in Massachusetts.

Other services can also be readily transferred. For example, most CAT (Computerized Axial Tomography) scans can be conducted in the doctor's office as well as in the hospital. No one should be under the illusion that such transfers of cost really save money.

The fact is that hospital financial officers are probably smarter than those entrusted to enforce the law. And, they have much more sharply focused motives.

Hospital reimbursement

The major thrust of the bill would be to establish an incentive reimbursement method rewarding hospitals whose routine operating costs are less than 115 percent of the average for all hospitals in each class. Hospitals whose routine costs are more than 115 percent above the average could not receive more than the 115 percent ceiling. While some high cost hospitals would have to become more efficient, or be phased-out, the upward trend of average hospital costs would continue because the organization of hospital services would not be altered and the growth in utilization of new services and technology would continue unabated.

To be effective, a prospective hospital reimbursement scheme must deal with three elements: (1) Intensity of care; (2) utilization; and (3) routine operating costs. By focusing on only one of the above elements, routine operating costs, every hospital can too easily increase its revenues by expanding the other two elements.

The 1977 staff report of the Council on Wage and Price Stability, "The Rapid Rise of Hospital Costs" shows that the intensity of care has been the primary cause of hospital cost inflation.

A study sponsored by teh National Planning Association, "Technological Diffusion in the Hospital Sector," shows that intensive care units (ICUs) in hospitals were relatively rare in 1958 when nine percent of all community hospitals reported them. By 1974 virtually all hospitals with 200 or more beds reported having ICUs, 85 percent of those with 100-199 beds had them and 40 percent of those with fewer than 100 beds had them. We would suggest that the great majority of ICUs in hospitals with less than 200 beds are probably an unnecessary expense if they are within one hour of a medical center or large hospital by motor or air ambulance.

The study reported similar problems with respect to therapeutic radiation equipment and open heart surgery units. Not covered in the study is the proliferation of CAT (Computerized Axial Tomography) scanners. No doubt the CAT scanners are a useful diagnostic tool but must every hospital have one? Once purchased at a cost of $300,000 to $500,000, they have to be amortized.

It is important to recognize that new technology and new equipment are invariably purchased without evaluation as to their effectiveness. One study in Britain found that survival rates for heart attack victims were at least as good for patients cared for at home as for those who received intensive care.

Yet, we find very little in S. 505 which addresses the problem of proliferation of medical technology which is never evaluated in terms of life savings potential nor cost effectiveness. In fact, S. 505 would invite escalation of these costs.

Secondly, the ancillary service costs would continue to be uncontrolled so that medical technologists required for the operation of new equipment would be exempt from the reimbursement control provisions of the bill.

Third, Section 2(bb)(4)(H) states: "If a hospital satisfactorily demonstrates to the Secretary that, in the aggregate, its patients require a substantially greater intensity of care than is generally provided by the other hospitals in the same category, resulting in unusually greater routine operating costs, then the adjusted per diem payment rate shall not apply to that portion of the hospital's routine operating costs attributed to the greater intensity of care required."

What patients require with respect to intensity of care is a medical decision and there is a community of interest between the medical staff and the hospital administrator. It is our conclusion that S. 505 would accelerate the trend to more and more intensive care—the primary cause for hospital cost inflation.

S. 505 does not have any provision that would stop hospitals from increasing utilization, the second most important factor in controlling hospital costs.

As we understand the bill, the Secretary would be required to establish a classification system for short-term general hospitals based on the number of beds in the hospital. The "routine operating costs" of all the hospitals in each category would be averaged. This average cost would become the hospital's per diem payment rate for "routine operating costs" for services to patients covered by Medicare and Medicaid. After the per diem payment rate had been thus established, therefore, any increases in hospital utilization would result in lower average costs, the only costs the bill recognizes, but higher total costs. In addition, there would be a larger surplus which would have to be shared with the government since hospitals with routine operating costs below their target rate would receive one-half of the difference between their costs and the target rate. This would be a built-in incentive for hospitals to increase utilization for Medicare and Medicaid patients. Thus, utilization, the second largest factor responsible for rising hospital costs, would be encouraged.

Hospital administrators are not going to look favorably upon returning one-half of any savings back to the government. They would have, on the contrary, an incentive to increase the intensity of care by, for example, purchasing a CAT scanner or some other expensive equipment. Hospital administrators are in no position to resist the demands of the medical staff because their customers are really doctors, not patients. The transfer of the affiliation of even one doctor to another hospital would result in a substantial loss in hospital revenues.

While S. 505 does little to control the most inflationary elements of hospital costs, it would control the wages of hospital workers. It is th eposition of the AFL-CIO that the wages of nonsupervisory employees must be determined by free collective bargaining where such employees are organized.

The incentive reimbursement system applies only to routine operating costs such as the cost of supplies and food which are only marginally controllable by the hospital. The controllable items of routine operating costs, the wages of nurses, the wages of clerks and stenographers, the wages of janitors and engineers in the

maintenance department, would be controlled by the bill. Teh costs of capital, costs of education and training, physician costs, energy costs, fuel costs, malpractice insurance expense and ancillary service costs would continue to be reimbursed on a cost-plus basis under Medicare and Medicaid. While routine operating costs would include the salaries of managemetn and supervisory personnel, it is highly unlikely that management would cut their salaries or even hold them constant.

What all this adds up to is that despite its lofty intentions, S. 505 is not a cost containment bill. Rather, it is a wage control bill. In areas where wages and salaries are generally low, it would limit wages and salary increases for hospital employees but not for doctors. Paradoxically, in highly organized areas where wages were already at more adequate levels but where wages in some hospitals lagged behind the average, some hospital wages would be allowed to rise to the average wage level provided the hospitals were not in the high cost bracket. But high cost hospitals at or close to the 115 percent ceiling would not be able to raise the wages and salaries of their employees even if they were below the average in a given area. Where hospital wages are higher than the average wage level, such as might happen in small communities where the only organized employees are hospital workers, the wages of hospitals would have to be lowered in future years to the average wage. We find this is completely unacceptable and clearly inconsistent with the principles of free collective bargaining.

There are other difficulties. Area data on the average general wage levels are simply not available throughout the country. Nor are area data on the average wage levels of hospital employees. The gathering of such information would run into millions of dollars. Moreover, even if it were possible to gather this data it would not be useful. It would be like trying to compare oranges and apples. The mix of skills in hospital employment is very different from the mix of skills in the general community.

The recent staff report of the Council on Wage and Price Stability, "The Rapid Rise of Hospital Costs," clearly shows that hospital wages have been only a minor factor in escalating hospital costs. Total labor costs were the source of only about one-tenth of the annual increase in average costs per patient per day. According to the American Hospital Association, payroll expenses have steadily declined as a proportion of total hospital expense from 66 percent in 1962 to 50 percent in 1978. But AHA payroll data includes salaries of supervisory employees. The percent of hospital expenses represented by nonsupervisory employees is only 35 percent. Thus, wage increases of nonsupervisory employees have almost no bearing on the runaway inflation in hospital costs.

The principal cause of hospital cost inflation is not wages but the way in which doctors control the manpower and capital resources of the hospital. This control in voluntary hospitals is exercised without any accountability to either the hospital or to the public. The hospital administrator has little or no control over expenses generated by the medical staff. The result is weak administration, poor planning, duplication of expensive and seldom used equipment and the purchase of new equipment the effectiveness of which is seldom evaluated.

Hospital wages still lag behind the average wages for all private nonsupervisory employees and even behind the average wages for service employees. In 1978, the average hourly earnings of nonsupervisory employees in manufacturing amounted to $6.16. For all industry it was $5.68 and for hospital workers only $5.10. Assuming a full work-year of 2,080 hours, the annual earnings of the average hospital worker would come to $10,608, below the level of an austerity budget of $11,420 for a family of four in an urban community and substantially below the level of an intermediate budget of $18,645. From 1968 to 1978 the wages of hospital employees increased by only $2.79 while those of all nonsupervisory employees in private industry increased by $2.83 and the wages in manufacturing rose $3.15 even though it was during this period that hospital employees gained coverage under the Fair Labor Standards Act and for the first time large numbers of them were benefited by collective bargaining negotiations. (See Appendix A for the average hourly earnings for manufacturing, all private employment and hospital employment from 1968-78.)

AFL-CIO unions with substantial membership in the hospital industry are the Service Employees International Union, the American Federation of State, County and Municipal Employees and Local 1199 of the Retail, Wholesale and Department Store Union. Representatives of these unions will be testifying in more detail with respect to wages in the hospital industry and their collective bargaining contracts.

HOSPITAL COST CONTAINMENT ACT OF 1979 (S. 570)

The Administration's approach to hospital cost containment would initially establish a voluntary goal for the rate of increase in hospital costs for 1979. Only if the

hospitals failed to achieve this goal, which is estimated to be 9.7 percent at the current rate of inflation, would mandatory controls be imposed.

The 9.7 allowable rate of increase is arrived at as follows: 7.9 percent for expected increases in the cost of goods and services, including the wages of nonsupervisory employees, that the hospitals would have to purchase; 0.8 percent for population growth; and 1 percent for increases in the intensity of care.

The hospitals would, therefore, have the opportunity to contain the escalation in hospital costs themselves.

The guidelines are flexible. Should the rate of inflation exceed 7.9 percent for the goods and services hospitals purchase, the cap on expenditures would be raised. If the rate of inflation were less than 7.9 percent the cap would be lowered.

S. 570 also places a one percent cap on cost increases due to intensity of care, the major cause of hospital cost escalation.

S. 570 contains provisions to reward efficiency and penalizes inefficient hospitals.

S. 570 would allow free collective bargaining since the cap on cost increases would apply to all hospitals and not to individual hospitals.

In our opinion the approach to hospital cost containment of the Administration's Bill, S. 570, is far superior to that of S. 505. S. 570 establishes a ceiling on each hospital's total revenue. The result would be that each hospital would have to address itself to all three elements that cause hospital cost inflation; namely: (1) Intensity of care; (2) utilization; and (3) efficiency of operation. Although the cost constraints would be more effective, each hospital would have more flexibility than under S. 505. To hold to the estimated "cap" of an allowable 9.7 percent increase in total revenues, a hospital could, for example, close down a seldom used open heart surgery unit, eliminate its intensive care units, sell its seldom used high voltage radiation therapy unit or defer purchase of a CAT scanner provided, of course, such units and scanners were available elsewhere in the community. The hospital could bring pressure to bear on its medical staff to reduce unnecessary utilization or increase the efficiency of its operation. All these options and more would be available to the hospital.

The Administration bill, moreover, would require only a small staff to enforce its provisions. S. 505, on the other hand, would require an army of investigators and volumes of regulations. Moreover, S. 570 would permit free collective bargaining within the framework of an overall cap which would take account of wage increases.

The AFL-CIO strongly supports S. 570 although we have some suggestions for improving it. The bill would establish a National Commission on Hospital Cost Containment with two-thirds of its members composed of representatives of the hospitals and the insurance industry. In other words, the regulated would control the regulators. We suggest the Commission be composed of one-third management, one-third labor and one-third public representatives. Labor, management and the public are the payors for health care.

We do recognize that S. 570 can only be a short-term solution to escalating hospital costs. Under the bill the high-cost inefficient hospital can increase revenues by 9.7 percent—the same percentage increase that is allowed an efficient low-cost hospital. Thus, inefficiency could be rewarded and efficiency penalized. But that is why S. 570 should be a short-term program.

Attached as Appendix B is the statement by the AFL-CIO Executive Council on Hospital Cost Containment adopted just last month. S. 570 meets the essential goals set forth in the statement for an effective and fair hospital cost containment bill.

S. 505 deals with some matters not directly related to hospital cost containment. With respect to physician reimbursement, S. 505 treats doctors very gently. Under the bill there would be "participating" physicians under the Medicare program. A participating physician would be one who agrees to accept assignments in full reimbursement for services to Medicare patients.

Participating physicians would be allowed to submit their claims on a simplified, multiple-listing basis rather than submitting individual claim forms. It is estimated that the simplified multiple-listing form would save $1.00 in administrative expense which would be passed on to the participating physician. In addition, it is claimed that the simplified multiple-listing forms would also save the participating physician another $1.00 in billing, collection and office paperwork costs and thereby result in a total $2.00 additional income for the participating physician.

While we find the $1 reduction in Medicare administrative costs creditable, the experience of the United Mine Workers of America with their simplified multiple-listing claim forms for their participating physicians indicates the doctor does not save anywhere near an additional $1 in his office costs.

But even if participating doctors could save $1 in their office expense by using simplified multiple-listing claim forms, this together with the extra $1 allowed by

Medicare would come to an increase in income of $2 per patient encounter for the participating physician. Most doctors who refuse to accept Medicare assignments charge more than $2 over the usual and customary fee allowed by Medicare. Thus there would not be sufficient incentive for most doctors to accept assignment.

As an alternative to the bill's approach, we recommend a negotiated fee schedule for Part B of Medicare and for Medicaid. Physicians should then be required to accept such fee schedules in full payment for services rendered. However, to be fully effective such fee schedules should be applied across-the-board, not just to Medicare. Otherwise, physicians would likely raise their fees for private patients, thereby creating three levels of care: one level for private patients, another level for Medicare patients and a bottom level for Medicaid beneficiaries.

Physicians should also be free to select payment by capitation for patients who choose to receive all of their primary care from such physicians. Physicians who elect capitation as a method of reimbursement for their services might well discover that such a payment mechanism results in better continuity of care for the patient and almost no paperwork since a separate claim for each service is unnecessary. More and more physicians are accepting capitation in lieu of fee-for-service in HMOs.

The experience of HMOs has shown that capitation payments reverse the incentives of physicians. Under fee-for-service, doctors make more money for treating sick patients; and the sicker the patient, the more the doctor makes. Under capitation, doctors make more money if they keep their patients well. This is the primary reason hospital use in such plans is two-to-two and one-half times lower than in fee-for-service reimbursement by Blue Cross-Blue Shield and commercial insurance plans.

We strongly support the section which allows the Secretary to determine that an exclusion of expenses related to any capital expenditure by a Health Maintenance Organization, which has demonstrated that it can provide health services economically, can be allowed.

While the AFL-CIO strongly supports the Administration bill, there are sections of S. 505, which S. 570 does not include. We approve some sections of S. 505 which, if not enacted separately, might well be a part of a comprehensive and universal national health insurance program such as the Health Care for All Americans Act. There are other sections we oppose in S. 505 and which we would also oppose as part of a national health insurance program.

CONCLUSION

In conclusion, Mr. Chairman, we believe the cost control provisions of a budgeting system for all health services as well as institutional services would be the most effective way by which the escalation of hospital costs could be contained. Until a comprehensive and universal national health insurance program can be enacted, the AFL-CIO strongly supports the Administration's approach to hospital cost containment and opposes the approach of S. 505 which would disrupt free collective bargaining in the hospital industry.

In order for such a program to work, it is quite clear, in our opinion, that the budget review must encompass the hospital's total budget and not just that part of the institution's budget that would apply to Medicare and Medicaid beneficiaries. This is the approach of S. 570, the Administration's proposal. Caps on only the part of the hospital budget for federal and state beneficiaries, the approach of S. 505 would leave health care institutions free to raise charges to private patients. This merely shifts costs but does not contain them. The premium cost to collectively bargained health plans would increase, along with all other premiums, to cover any shortage of payments for Medicare and Medicaid beneficiaries.

For physicians, we would support negotiated fee schedules which should be accepted by doctors as full payment for services rendered. These fee schedules would also have to be applied across-the-board. Capitation payments should be an alternative method of reimbursement for those practitioners who elect this method of payment.

We hope the Health Subcommittee of the Senate Finance Committee will give consideration to our views and that only a temporary cost containment program along the lines of the Administration's proposal but embodying the changes we have suggested should be enacted until such time as Senator Kennedy and the Administration have the opportunity to introduce their national health insurance bills.

With your permission, Mr. Chairman, we would like to have this statement and the attachments incorporated into the record of hearings.

APPENDIX A.—AVERAGE HOURLY EARNINGS, NONSUPERVISORY EMPLOYEES

	Manufacturing	Total private	Hospitals
1968	$3.01	$2.85	$2.31
1969	3.19	3.04	2.57
1970	3.36	3.22	2.79
1971	3.56	3.43	2.96
1972	3.81	3.65	3.08
1973	4.07	3.92	3.22
1974	4.41	4.22	3.45
1975	4.81	4.54	3.83
1976	5.19	4.87	4.18
1977	5.63	5.25	4.68
1978	6.16	5.68	5.10
Dollar increase 1968–78	3.15	2.83	2.79

Source: Bureau of Labor Statistics

APPENDIX B

STATEMENT BY THE AFL-CIO EXECUTIVE COUNCIL ON HOSPITAL COST CONTAINMENT

The AFL-CIO urges prompt congressional action on a hospital cost containment program which effectively reduces runaway inflation in hospital costs without providing additional burdens on already low-paid hospital workers. Hospital wages only account for 10 percent of hospital cost increases, according to the Council on Wage and Price Stability.

While we believe that the cost control features of the Health Care for All Americans Act are superior to single programs, such as hospital cost containment, we recognize that the fight against inflation requires immediate action on hospital costs.

The major factors in hospital cost inflation are duplicative services, unnecessary hospital beds, sloppy administration and unnecessary procedures. No voluntary effort will be successful to control these costs. And a program which totally ignores increases in professional fees would be a failure.

Therefore, we urge Congress to promptly consider a mandatory hospital cost control program, with appropriate safeguards for hospital workers.

BACKGROUND REPORT OF AFL-CIO EXECUTIVE COUNCIL ON HOSPITAL COST CONTAINMENT

In the last Congress, two hospital cost containment bills received serious consideration. One was an administration bill and the other was a bill introduced by Senator Talmadge (D-Ga.) entitled the Medicare-Medicaid Administrative and Reimbursement Reform Act.

At the Executive Council meeting on May 10, 1978, the AFL-CIO supported hospital cost containment in principal, but with the following reservations:

Hospital cost containment should not interfere with free collective bargaining in the hospital industry, and, specifically, there should be a provision for a pass-through of any wage increases negotiated for low-paid nonsupervisory hospital workers in the final legislation.

Except for six states that had, at that time, state hospital rate control commissions established and operating, any federal cost containment legislation should be administered by teh federal government. If, however, the final legislation did allow more states to supercede the federal program, there would have to be a federal requiremetn that such state laws would also be required to provide a wage pass-through for nonsupervisory employees

Without these employee protections, the AFL-CIO made it clear to the Administration and Congress that the AFL-CIO would oppose passage of the legislation when it came to the floor of either the House or the Senate. Hospital workers continue to rank among the worst paid of all nonsupervisory employees earning an average of $35 a week less than nonsupervisory employees in other industries.

Moreover, the Council on Wage and Price Stability in a staff report, "The Rapid Rise of Hospital Costs," showed that hospital wages were the source of only one-

tenth of the increase in hospital costs. The main cause of inflation in hospital charges has been nonlabor costs.

In the final days of the last Congress, the Talmadge bill was reported out by the Senate Finance Committee and was debated on the floor of the Senate. Senator Nelson (D-Wis.) introduced an amendment that guaranteed workers in the hospital industry the right of free collective bargaining in any hospital cost containment program, federal or state, set up pursuant to the legislation. With strong support from the AFL-CIO and its affiliated unions in the hospital industry, both the Nelson amendment and the amended bill passed the Senate but not the House.

No hospital cost containment legislation was, therefore, enacted in the 95th Congress. The Administration has announced it will push for passage of such a bill in the current Congressional session.

The Nelson amendment gave the hospital industry an opportunity to implement a voluntary cost containment program. Only if the voluntary effort had failed would the mandatory cost containment provisions of the Talmadge bill, as amended, have become operable. The main reason why the AFL-CIO and its affiliates in the hospital industry supported the Nelson Amendment was that it would have instituted mandatory controls on hospital costs, in the event the voluntary effort failed, and would have left the wages of hospital workers subject to free collective bargaining.

To date, it does not appear the voluntary effort of the hospital industry to control hospital cost inflation is working. Therefore, if the voluntary effort continues to be inadequate, legislation assuring mandatory cost containment, with proper safeguards for hospital workers, is needed.

The AFL-CIO had some reservations with respect to the cost containment bill which the Senate passed. These included:

Whether legislation that focused solely on containing hospital charges could control total health care costs. It is too easy for hospitals to shift expenses from their own budget to the other segments of the health industry. For example, pathologists and radiologists can shift from salary to fee-for-service and bill patients for x-ray and laboratory work previously billed by the hospital. This decreases the on-budget costs of the hospital but increases total costs unless doctors' fees are also regulated. Effective control over health care costs can only be achieved when all parts of the medical care delivery system including hospitals, nursing homes, home health services and, especially, doctors' fees can be brought under budgetary ceilings.

Whether legislation focused on hospital cost containment would be compatible with a comprehensive and universal national health insurance program.

The Health Care for All Americans Act which the AFL-CIO supports would phase-in temporary cost controls over both hospital costs and physician fees until an administrative structure for implementing the Act could be established.

It is anticipated the Administration will shortly introduce a new cost containment bill. Senator Talmadge is also expected to reintroduce a revised version of his bill.

The AFL-CIO will support hospital cost containment legislation if it includes effective employee safeguards and is compatible with the stronger cost control features of the Health Care for All Americans Act.

Senator TALMADGE. Mr. Welsh, I owe you an apology. I skipped over your name a moment ago.

Our next witness is Mr. Robert Welsh, Jr., Assistant to the President, Service Employees International Union, AFL-CIO/CLC and Ms. Judith Berek, Legislative Director, District 1199, Retail, Wholesale, and Department Store Union.

STATEMENT OF ROBERT WELSH, JR., ASSISTANT TO THE PRESIDENT, SERVICE EMPLOYEES INTERNATIONAL UNION AFL-CIO/CLC, ACCOMPANIED BY RONALD HOLLY, PRESIDENT, DISTRICT 1199, RETAIL, WHOLESALE & DEPARTMENT STORE UNION

Mr. WELSH. Thank you, Mr. Chairman. I would ask our full statement be inserted into the record and I will summarize it under the time constraints.

Senator TALMADGE. Your full statement will be inserted into the record.

Mr. WELSH. Mr. Chairman, my name is Robert Welsh. I am the assistant to the president, Mr. Hardy, of the Service Employees International Union. With me is Ronald Holly replacing Ms. Berek, president of District 1199E of the National Union of Hospital & Healthcare Employees, RWDSU, in Baltimore. Md. representing Leon Davis, presidnet of District 1199.

Also with us this morning is Dr. Stanley Wisniewski, staff economist with the Service Employees.

Together our two unions represent more than 300,000 healthcare workers in the United States.

We appreciate the opportunity to present our views before this committee on the subject of hospital cost containment.

Our two unions strongly feel that it is imperative for Congress to pass a strong and effective bill this year. Everyone on this committee is aware of the problem of health care inflation, especially in hospital costs.

We believe that no issue is more important to the American people than the guarantee that quality health care will be available to them at a price they can afford.

As you well know, hospital costs today are rising at unconscionable rates. Total health care costs will consume 10 percent of our gross national product in 1983 without cost containment.

Prior to the passage of medicare and medicaid in the early 1960's, we spent only about 5 percent of the GNP on health care.

Consumers and wage earners are hard hit by these increases. Private insurance premiums for hospital care will double between 1975 and 1980. The medicare deductible for inpatient care has increased fourfold in the last 10 years. In collective bargaining the cost of maintaining health insurance coverage is seriously impacting on wages and pension coverage requiring annual increases of 10 to 15 percent just to maintain present coverage.

Over the last 3 years, excessive inflation in this industry has added substantially to our overall inflation rate.

We believe that everyone wants to do something that will slow these increases substantially. In order to be effective such action must recognize certain basic facts about this industry.

First of all, the health care system really should not be thought of as an industry at all. There are thousands of hospitals in the United States of all shapes and sizes, serving different constituencies, providing differing services. Each hospital is like a feudal barony, jealous of its own role and making its own rules.

Second, as is widely recognized, the economics of this nonindustry are completely upside down. The usual laws of supply and demand seem reversed in a situation where there are strong incentives to provide as many services at as high a cost as possible and where almost all costs are routinely paid for initially by someone other than the consumer.

A recent article in U.S. News & World Report called this Alice in Wonderland economics where more beds guarantee higher costs, where more doctors per patient assure higher fees, where slowdowns by surgeons cause dramatic reductions in mortality rates.

Under our present nonsystem, no incentives exist to control costs, no competition keeps hospital administrators penny con-

scious, no comparative shopping can help a consumer find lower cost care.

Congress has tried many times in recent years to make corrections in this system. You have provided for health planning, for rate review experiments, for the development of alternative delivery systems.

Still, the basic fact remains that in health care, no national decisions are now made as to how much health care we should provide and how this care can be delivered. Cosmetic attempts at cost consciousness by the industry, however well intentioned, cannot succeed in the long run. For in the long run, what we need is an intelligently organized national health care financing system.

That is why the labor movement has strongly supported national health insurance as a major legislative goal for all these years. That is why the AFL-CIO and our unions now support the Health Care for All Americans Act soon to be introduced by Senator Kennedy.

We strongly believe that only such a national prospective budgetary process will keep a lid on costs while insuring equal access to care for all our citizens. We certainly hope Congress will seriously debate this issue this year.

Short of a national health insurance system, some legislation must be passed now that will immediately deal with the problem of rising hospital costs. The Congress considered several bills last year but unfortunately for American consumers, industry lobbyists were successful in thwarting a reasonable compromise in the last Congress.

We hope that this bowing to corporate industry interest will not be repeated this year.

Of the two major bills that have now been introduced, we strongly favor the approach taken by the administration. The President's proposal would permit present voluntary efforts to continue if successful.

If the voluntary efforts are not successful, then mandatory controls would be triggered, controls that would allow hospitals reasonable cost increases as determined by actual market basket changes.

A provision similar to that in Medicaid and Medicare Reform Act, S. 505, the chairman's bill, would provide incentives for individual hospitals that hold costs below a group norm.

We believe that this approach is far preferable to the one taken in the Medicare and Medicaid Reform Act, S. 505, providing much stronger controls while maintaining some of the better provisions in the chairman's bill and producing far greater savings to consumers, perhaps $50 billion in the next 4 years.

Claims by the industry that this legislation ignores their successes in the so-called voluntary effort and that it imposes massive regulatory requirements are so much nonsense.

We cannot see how when costs go up close to 13 percent a year, the industry can claim success. We are also confident that the data needed to enforce the program is almost all available now in HEW.

Our unions enthusiastically support President Carter's initiative. We believe his bill will provide American workers and consumers with immediate relief from the burden of health care inflation,

thus taking a large step forward in the administration's efforts to slow down the overall inflation rate in the American economy.

We are especially happy that the administration's approach properly focuses on the real causes of hospital inflation, mismanagement, duplication and excess services.

S. 505 on the other hand, would impact more on labor costs which are clearly not responsible for hospital inflation.

It is indeed ironic that hospital workers are among those hardest hit by inflation in this industry. Hospital workers earn about 60 cents an hour less than the average worker in the private sector and more than a dollar an hour less than workers in manufacturing. In the last 5 years, their real earnings have actually declined from $2.60 an hour to $2.55 an hour.

Two years ago, a study by the Council on Wage and Price Stability showed that increases in hospital wages accounted for only a ninth of total hospital inflation.

Since then, the increases in hospital wages have actually been less than the average wage increase in teh economy. A summary of this wage data is attached to our written statement.

The administration's bill has other advantages over S. 505 other than its more equitable treatment of nonsupervisory wages.

The administration's bill would provide for greater savings to consumers, since it covers all cost payers. Under S. 505, we fear that hospitals will shift costs away from medicare and medicaid patients and perhaps even discourage their treatment.

As providers of health care and as consumers, our members are deeply concerned that Americans continue to receive the best medical care available. Hospital workers are proud of the vital services we provide to the American people.

We are convinced that it is not unreasonable to ask hospitals to hold down cost increases to a more moderate level. We do not think that the quality of care will suffer with a national limit of approximately 9.7 percent. Many hospitals, in fact, will do much better than this.

In any event, this voluntary limit, based on actual market basket measurements, compares the industry's performance with its real needs. We believe this to be a fair and effective requirement.

We would urge this committee to act favorably on this legislation as quickly as possible.

Senator TALMADGE. Thank you very much, Mr. Welsh, for your contribution.

Do you know how many of the nine States that have State laws trying to control hospital costs have a wage pass through?

Mr. WISNIEWSKI. Mr. Chairman, the question is difficult to answer in that the methodology that each of those nine States use varies quite a bit. For example, in Washington State, you look at services provided and you break down costs for services. In the State of Maryland, you focus on such things as unit labor costs. That is a very great difference. It is hard to say what the effect is on one state as opposed to another.

In terms of a pure pass through of labor costs, I do not know of any in those nine States.

Senator TALMADGE. I do not believe any of those nine States have that pass through.

Inasmuch as nonsupervisory personnel amount to about 35 percent of the average cost, I do not see how you can have effective controls if you have an exemption that proves a pass through of 35 percent of the cost to the hospital.

Mr. WISNIEWSKI. In the first place, Senator, the bill, S. 570, does not provide for a pass through. Those costs are in fact reflected in the formula. In the second place, although the wages do account for 35 percent of the bill, nonsupervisory wages, in fact, they have not been responsible for the actual huge rate of increase in health care costs.

The Council on Wage and Price Stability study which was cited by Mr. Welsh shows that if in fact you take out the increase in hospital wages over what they would have been had they been limited to the percentage increase in the private sector wages, then the the annual percentage change over the period 1955 through 1977 would have been only 9.4 percent as opposed to 10.3 percent.

In other words, it is a savings of less than one full percentage point. The real culprits, if you will, in this particular malady are waste, duplication, inefficiency and mismanagement. They are not the increase in labor costs.

Senator TALMADGE. Hospital employees in nonsupervisory personnel have gone up rather substantially in recent years. I hold in my hand a comparison of trends in the nonsupervisory employee hourly earnings, hospitals, private sector, nonagriculture employees and service employees, for the years 1969 through June 1978.

The source is the Bureau of Labor Statistics, Employment and Earnings, August 1978.

The ratio of hospitals to the service industry now is 101.3. For a long period of time, it was less than 100. It reached 100 in the year of 1977 and 1978. It passed the service industry and it is now 101.3.

I ask unanimous consent to insert that table into the record at this point.

[The table follows:]

EARNINGS DATA—COMPARISON OF TRENDS IN NONSUPERVISORY EMPLOYEE HOURLY EARNINGS: HOSPITALS, PRIVATE SECTOR NONAGRICULTURAL EMPLOYEES, AND SERVICE EMPLOYEES

[1969–June 1978]

Year	Hospitals	Private sector nonagricultural industry	Ratio of hospitals to private	Service industry	Ratio of hospitals to Services
Hourly earnings, nonsupervisory employees:					
1969	$2.57	$3.04	84.5	2.61	98 5
1970	2.79	3.22	86.6	2.81	99 3
1971	2.96	3.44	86.0	3.02	98 0
1972	3.08	3.67	83.9	3.23	95.4
1973	3.22	3.92	82.1	3.46	93.1
1974	3.45	4.22	81.8	3.76	91.8
1975	3.83	4.54	84.4	4.06	94.3
1976	4.18	4.87	85.8	4.36	95.9
1977	4.68	5.25	89.1	4.68	100.0
June 1978 preliminary	5.11	5.67	90.1	5.04	101.3
December 1978	5.23	.....	.....	5.16	....
Annual rates of increase (percent):					
1969 to 1970	8.6	5.9	.....	7.7	....
1970 to 1971	6.1	6.8	.....	7.5	....

EARNINGS DATA—COMPARISON OF TRENDS IN NONSUPERVISORY EMPLOYEE HOURLY EARNINGS: HOSPITALS, PRIVATE SECTOR NONAGRICULTURAL EMPLOYEES, AND SERVICE EMPLOYEES—Continued

(1969-June 1978)

Year	Hospitals	Private sector nonagricultural industry	Ratio of hospitals to private	Service industry	Ratio of hospitals to Services
1971 to 1972	4.1	6.7	.....	7.0	.....
1972 to 1973	4.5	6.8	.....	7.1	.....
1973 to 1974	7.1	7.7	.....	8.7	.....
1974 to 1975	11.0	7.6	.....	8.0	.....
1975 to 1976	9.1	7.3	.....	7.4	.....
1976 to 1977	12.0	7.8	.....	7.3	.....
Average 1969 to 1977	7.8	7.1	.....	7.6	.....

Source: Bureau of Labor Statistics, employment and earnings, August 1978.

Senator TALMADGE. Senator Dole?

Senator DOLE. That is the point I wanted to make. I am not certain, you say there is no way to pass through. Do they not permit in the formula an allowance for the actual rate increase in non-supervisory wage rates experienced by that hospital?

Mr. WISNIEWSKI. In terms of the voluntary aspect of S. 570, that language does not remove hospital workers from the voluntary guidelines currently in effect and administered by the Council on Wage and Price Stability. There is no such set of similar guidelines for hospitals on the price side.

Senator DOLE. This is mandatory, as I understand it.

Mr. WISNIEWSKI. It is only mandatory if the voluntary side of the program fails.

I might add just another point on the issue raised by Senator Talmadge with respect to comparing hospital workers wages to service sector wages as a whole. One of the things that has to be recognized there is that the composition of the hospital worker labor force has changed dramatically over the last 10 to 15 years so that the hourly wage rate in fact covers a great many more professionals and technical occupations than is true of the service sector as a whole.

It is very difficult to make such comparisons.

Senator DOLE. Do you support the President's wage and price guidelines at 7 percent? You probably do if you support the mandatory program.

Mr. WELSH. We recognize that both under the voluntary effort of the hospital industry and under the President's guidelines that hospital workers are being impacted in their bargaining. That has been clear.

Senator DOLE. Are you going to accept the seven percent?

Mr. WELSH. Our position is that there should be mandatory controls on all industries.

Senator DOLE. We do not have mandatory controls. Do you have a contract coming up?

Mr. WISNIEWSKI. Senator, by way of implication, if you look at the settlements we have reached over the last two years and that data is appended to the testimony, you will find our settlements in fact have come within the voluntary guidelines as they now exist.

Senator DOLE. We have a different inflation rate now. You cannot look back over the past years.

You are willing to accept the 7 percent wage increase even though the inflation rate might be 11 or 12 percent?

Mr. WELSH. In many of our contracts, I am sure the hospital workers would be eager to try to get seven percent. We believe collective bargaining should be the way in which hospital wages are determined.

Senator DOLE. My point is you are willing to come in and say the industry ought to accept a mandatory program but what are you willing to accept? You are protected in the mandatory program. It is easy to come in and say it is all the industry's fault and it is not labor's fault. I am not suggesting it is anyone's fault.

The point is, is it being consistent.

Mr. WELSH. We believe the administration's bill is consistent in recognizing that a hospital requires cost increases each year to reflect where actual cost increases are incurred by the hospital.

Senator DOLE. If it is consistent, are you willing in addition to that to follow the wage and price guidelines of the President in his so-called voluntary program, not the cost containment program.

Mr. WELSH. Our position on the wage and price guidelines is that the way it is presently constituted is illegal. We believe the Congress is the proper body.

Senator DOLE. That is what the industry thinks about the mandatory cost program, that it may be illegal.

Mr. WELSH. We think Congress is the best judge of that.

Senator DOLE. I think the only point I am making is it is easy to come in and say it is the industry's fault and maybe it is but I guess on the other side, if you were facing the same question and someone said you could only have a 7- or 8-percent increase, would you accept that, and obviously you do not.

Mr. WELSH. No. Our position is we do favor mandatory controls over the entire economy as is the position of the AFL-CIO. The controls that would be fairly enforced across the board and we control everything, wages, prices, interest rates, et cetera, we would support these.

Senator DOLE. We do not have that. That is not what we are dealing with now. We are dealing with this mandatory containment program on the one hand and the President's broad voluntary wage and price guidelines on the other.

I just wondered if you supported both or half an dapparently half.

Thank you.

Senator TALMADGE. Senator Baucus?

Senator BAUCUS. No questions.

Senator TALMADGE. Thank you, gentlemen, for your contribution.

[The prepared statement of Mr. Welsh follows:]

JOINT STATEMENT OF SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO AND DISTRICT 1199, NATIONAL UNION OF HOSPITAL AND HEALTH CARE EMPLOYEES, RWDSU, AFL-CIO

Good morning, Mr. Chairman, my name is Robert Welsh. I am the assistant to the president of the Service Employees International Union. With me is Judith Berek, Legislative Director of District 1199, RWDSU, National Union of Hospital and Healthcare Employees.

Together our two unions represent more than 300,000 healthcare workers in the United States.

Our members are especially aware of the consequences of runaway healthcare inflation. Annual increases in negotiated contributions to health plans must average 10 to 15 percent, just to maintain the same level of benefits. To obtain more comprehensive medical care coverage, workers are often forced to forego increases in wages and other benefits which would enable their families to enjoy a decent standard of living.

Over the 10-year period, 1965–75, total employer-employee contributions to health benefit plans in the United States rose some 240 percent, from about $7 1/2 billion in 1965 to more than $27 billion in 1975. Workers believe that there is something seriously wrong with our present healthcare delivery system when they have to trade off upwards of a month's wages to cover the cost of their medical bills. Workers we represent in such cities as Detroit and Syracuse have the equivalent of 4 1/2 weeks wages spent to cover the cost of their hospital bills, while just a short distance away in Canada, workers we represent in the same occupation in Ontario have only half as much in weekly wages claimed by hospital costs.

Many of our members are low-wage service workers and, consequently, find it difficult to cope with the rising cost of medical care. Indeed, given the rampant course of general inflation over the past 5 years, these workers have suffered a serious reduction in their standard of living. Low-wage workers spend a greater proportion of their income on basic necessities, and it is prices for the necessities of life that have increased the most.

Over the last 2 years, food costs went up 20.6 percent, the cost of shelter rose 21 percent, fuel and utilities prices increased 14.6 percent and the cost of medical care jumped 18.5 percent. The net result, over the past 5 years, is that the average hourly real wage of service workers has declined from $2.60 in 1973 to $2.55 in 1978.

Indeed, it is ironic that among the workers hardest hit by healthcare inflation are healthcare service workers whose wages still remain below the level of earnings enjoyed by workers in most other sectors of the economy (as illustrated in appended table I).

Most healthcare workers have inadequate healthcare benefits and find it extremely difficult to shoulder the burden of rising healthcare costs. Based on a 40-hour week, the average nonsupervisory hospital worker's annual salary in 1978 would have been $10,608. By comparison, in autumn, 1978, the cost of an estimated lower level budget for an urban family of four was $11,340, while the intermediate level budget cost was $18,508. table II vividly demonstrates that the typical nonsupervisory hospital worker's earnings are far below these modest living standards.

As a result of the inadequate wages received by healthcare workers, the gap between their earnings and the price of medical care has widened over time. Therefore, we welcome initiatives aimed at moderating the rise in healthcare costs, provided that hospital workers are assured of equitable treatment with respect to collective bargaining and wage increases. We believe that to be effective, hospital costs containment proposals must address the real causes of inflation—poor planning, inefficient utilization of resources, and wasteful duplication of services—rather than impose additional hardships on poorly compensated wage earners.

Over the past 15 years, less and less of the hospital dollar has been spent on labor costs. This trend is remarkable in view of the ever-increasing demand for more and better skilled healthcare workers throughout the period. Yet, despite tremendous increments in both the quantity and quality of hospital labor inputs, payroll, outlays as a proportion of total hospital expenses, have steadily declined from 66.5 percent in 1962 to 50 percent in 1977.

While total labor costs in the hospital industry now account for about one-half of operating costs, the salaries of administrative and supervisory personnel account for a proportionately larger share of the labor cost bill relative to their numbers, because of their higher salary levels.

Supervisory employees constitute approximately 15 percent of the hospital work force but earn about 30 percent of the compensation paid in the hospital. In other words, supervisory and administrative personnel compensation absorbs 15 percent of total hospital operating costs.

As Table III clearly shows, employees identified as administrative personnel registered the largest percentage increase in salaries last year among five broad occupational categories surveyed.

Yet, some well-intentioned hospital cost containment proposals, such as the Medicare-Medicaid Administrative and Reimbursement Reform Act of 1979, make no effort to distinguish between supervisory and nonsupervisory wage and salary data. The net result of this glaring oversight is that low-paid nonsupervisory workers can

have their wages restricted because they happen to be employed by a hospital with a highly compensated administrative staff. This treatment of the nonsupervisory hospital worker is completely inequitable if the object of the legislation is to constrain the largest increases.

The overwhelming preponderance of evidence available demonstrates that nonsupervisory labor costs, even those bargained for collectively, have had little to do with the inflation in healthcare prices. Two years ago, the Council on Wage and Price Stability released a study which estimated that limiting the rise in the rate of earnings increase of hospital employees to the same increases experienced by all private non-farm production workers over the 1955–75 period would have reduced the annual rate of increase in average cost per patient day from 9.9 percent to 8.8 percent.[1] In other words, total labor costs were the source of only about one-ninth of the annual increase in hospital costs.

Table IV employs the same methodology utilized in that study in order to extend it to cover more recent data. The results demonstrate that if wage increases for hospital employees between 1975 and 1976 were limited to private sector wage increases, the net effect would have been to reduce the rate of hospital costs by only 1.1 percent that year. Moreover, if hospital workers had enjoyed the same rate of pay increase as private sector workers between 1976 and 1977, hospital costs would have actually risen by even more than the increase that in fact occurred. In other words, between 1976 and 1977, one of the few factors that held down costs in the hospital industry was the lower rate of labor cost increase experienced by hospitals compared to the rest of the non-farm economy.

Collectively bargained wage increases in the healthcare industry have not been excessive as indicated by the data provided in Table V. The average increase[2] that became effective in SEIU contracts in 1976 was 7.1 percent, while for 1977, the average increase was 6.6 percent. In 1978, those increases based on negotiated settlements averaged 7.0 percent. These increases can hardly be termed excessive inasmuch as the effective wage rate changes reported by the U.S. Bureau of Labor Statistics for wage settlements in the private sector as a whole averaged 8.1 percent in 1976, 8 percent in 1977, and 8 percent in 1978, respectively.

Clearly, labor costs have played a minor role in pushing hospital costs upward. Hospital workers not only do not fuel the fires of healthcare inflation, they are less able to afford such price increases. Today, a hospital worker earns 59 cents per hour less than the average private sector employee and $1.06 less than the typical worker employed in manufacturing. Therefore, we find S. 505 highly objectionable, because to the extent that it "controls" hospital costs, it threatens to place the greatest burden on the backs of low-wage hospital workers.

S. 505 classifies hospitals on basic characteristics such as bed-size, specialty-type, etcetera, and proposes reimbursing individual hospitals according to their performance as measured by their respective group. Reimbursement is proposed on the basis of average per diem routine operating costs as divided between personnel costs and non-personnel costs. Personnel costs reimbursement may be adjusted upward if the individual hospital's ratio of personnel costs to general labor for comparable work in the area exceeds a similar ratio constructed for the remaining hospitals in the group. The practical effect of such legislation is to force wage levels to remain at artificially low levels in the hospital industry. For example, if the Secretary of Health, Education and Welfare decides that one criteria to be used in establishing comparable hospital groups is to categorize them by geographic location, it would virtually eliminate the wage adjustment process since the denominator in each respective ratio would be identical leaving no possibility for an upward adjustment.

Incredibly, the wage adjustment methodology of S. 505 seeks to measure hospital worker wages against wages for "comparable work" in the area when, in fact, comparable occupations either do not exist outside hospitals, or else, do not exist in sufficient numbers to permit meaningful comparisons.

Occupations which make up the bulk (80–85 percent) of the nonsupervisory hospital work force, such as nurses aides, psychiatric aides, licensed practical nurses, medical records technician, medical technologists, admitting clerks and registered nurses are not found employed outside the healthcare industry in significant numbers and, even where they are found elsewhere, their job responsibilities are often vastly different.

As a consequence, the impact of the "wage adjustment" provision of S. 505 would simply be to reimburse hospitals for less than their actual labor costs, putting

[1] Martin Feldstein and Amy Taylor, "The Rapid Rise of Hospital Costs: A Staff Report of the President's Council on Wage and Price Stability," 1977, p. 17.

[2] A weighted average increase including both first-year adjustments deferred increases resulting from prior settlements.

additional leverage in the hands of hospitals who seek to depress their wages in order to obtain additional funds to be spent just as inefficiently as in the past. Thus the problems of excess waste and poor quality which characterize our healthcare system today are not likely to be seriously addressed by hospitals if S. 505 is enacted.

To be effective, our healthcare system must provide for total care—both remedial and preventive. It must include built-in quality controls, as well as strong cost containment incentives. In the long run, what we need is a national healthcare financing system with a rational budgeting mechanism. We believe a comprehensive system of national health insurance should be put in place without delay. However, in the interim, an immediate halt must be called to the inflationary march of medical care prices. We believe that the recent proposal put forward by the Carter Administration, the Hospital Cost Containment Act of 1979, offers the best hope for stemming the tide of hospital waste, duplication and inefficiency which foster inflation.

In contrast to S. 505, the Administration's proposal is applicable to the full range of cost payors rather than restricted to Medicare-Medicaid reimbursement. We believe such an approach is absolutely necessary to prevent higher costs or charges from reappearing elsewhere in the system. Only coordinated action by all purchasers can effectively deal with monopoly selling power.

S. 505 would control only 30 to 40 percent of hospital costs. Auxillary service costs are excluded.

There will, therefore, be incentives for a hospital to shift costs to noncontrolled payors. There is thus a great potential for discrimination against Medicare and Medicaid patients.

In addition, since S. 505 measures per diem costs there are no incentives to decrease lengths-of-stay.

The Carter legislation would provide for fair treatment of each hospital individually and hospitals as a group. If hospitals in the aggregate are able to hold down their price increases to a reasonable rate which reflects their actual costs based on purchases in the market, target price increases will remain voluntary goals. The revenue targets suggested by the legislation not only are responsive to the inflation rate in the general economy, but also provide allowances for population growth and net new services. In short, the national voluntary limit is constructed in such precise fashion in order to zero in on ineffective management and unnecessary new services.

Moreover, even if hospitals in the aggregate exceed the voluntary limit established, an individual hospital which meets a target tailored to its own case mix and area inflation rates is not required to alleviate costs resulting from another hospital's inefficiencies.

One of our major concerns, of course, is that nonsupervisory workers receive equitable treatment under a hospital cost containment program. The administration's legislative initiative would guarantee fair treatment to low-wage hospital workers by concentrating on eliminating inefficiency and waste. Too often we have seen proposals forwarded at both the state and national levels which prefer to slash wages rather than face up to the more difficult issue of full and proper utilization of our healthcare resources.

For example, in the state of New York, the available evidence showed that, while total hospital operating costs increases were held below the national rate of increase in 1976 and 1977, this achievement came primarily at the expense of hospital workers instead of by streamlining hospital operations. In 1976, New York held the increase in total hospital expenses to 3.1 percent, primarily through measurers which concentrated on payroll costs. That year payroll costs actually declined 0.08 percent, while at the same time, non-payroll expenses climbed 8.7 percent. Similarly, the following year, New York held the increase in total operating expenses to 11.6 percent, but only by holding payroll expenses to a rise of 9.8 percent, while permitting nonpayroll expenses to jump 13.98 percent. Misdirected efforts such as the New York program must be provided direction if the sources of healthcare inflation are to be addressed.

The Carter proposal challenges hospitals to manage their resources efficiently and, through its state voluntary limit provision, assures that hospitals in every area of the country will be faced with the same task—to eliminate waste and mismanagement. In short, while the Administration's bill does not claim omniscience with respect to methods of dealing with the problem of rising medical care costs, it does call for recognition of the fact that we can all agree on the sources of healthcare inflation.

It has been long recognized that good health is a prime requisite for any society that wishes to realize its full productive potential. At the same time, for our healthcare system to provide adequate care, it must efficiently use the resources at its disposal. Unnecessary services and procedures drain resources that could be used in alternative ways, thus pushing up the price of services by creating an artificial scarcity. Duplicative facilities and equipment lay idle at times, raising the unit costs of services which utilize such plant and equipment. Therefore, we must eliminate obstacles to a good healthcare system, and hence good health, in order to assure all Americans of an equal opportunity to fulfill their potential.

APPENDIX

TABLE I

AVERAGE HOURLY EARNINGS
(Non-supervisory Employees)

Year	Total Private	Manu-facturing	Hospitals
1968	$2.85	$3.01	$2.31
1969	3.04	3.19	2.57
1970	3.23	3.35	2.79
1971	3.45	3.57	2.96
1972	3.70	3.82	3.08
1973	3.94	4.09	3.22
1974	4.24	4.43	3.45
1975	4.53	4.83	3.83
1976	4.86	5.22	4.18
1977	5.24	5.67	4.68
1978	5.69p	6.17p	5.10p
Dollar Increase Since 1968	2.84	3.16	2.79

p - preliminary

Source: Bureau of Labor Statistics

TABLE Ia

MANY HOSPITAL OCCUPATIONS WERE PAID SALARIES BELOW THE AVERAGE MANUFACTURING SALARY, 1978

Average Manufacturing Salary 1978: $12,833

Hospital Position	Average Salary, 1978	Difference Below 1978 Average Manufacturing Salary of $12,833/year
Medical Lab Asst. (CLA)		
0-100 beds	$ 9,300	$ 3,533
100-300	10,200	2,633
300-500	9,900	2,933
500+	10,700	2,133
Laboratory Aide		
0-100 beds	7,500	5,333
100-300	7,700	5,133
300-500	7,700	5,133
500+	8,300	4,533
EKG Technician		
0-100 beds	7,600	5,233
100-300	8,300	4,533
300-500	8,200	4,633
500+	8,600	4,233
Staff Nurse		
0-100 beds	11,700	1,133
100-300	12,400	433
300-500	12,700	133
500+	13,200	above
LPN		
0-100 beds	8,900	3,933
100-300	9,200	3,633
300-500	9,200	3,633
500+	9,800	3,033
Nursing Aide		
0-100 beds	7,000	5,833
100-300	7,300	5,533
300-500	7,700	5,133
500+	8,200	4,633

Hospital Position	Average Salary, 1978	Difference Below 1978 Average Manufacturing Salary of $12,833/year
Orderly		
0-100 beds	6,800	6,033
100-300	7,500	5,333
300-500	6,800	6,033
500+	7,600	5,233
Surgical Technician		
0-100 beds	10,400	2,433
100-300	8,900	3,933
300-500	9,400	3,433
500+	9,700	3,133

Sources: American Management Association's Executive Compensation Service, Hospital and Health Care Report, 1978/1979; and Bureau of Labor Statistics.

TABLE II

MANY HOSPITAL OCCUPATIONS WERE PAID SALARIES BELOW THE LOWER AND INTERMEDIATE LEVELS OF THE ESTIMATED URBAN FAMILY BUDGET, 1978[a]

Hospital Position	1978 Average Salary	DIFFERENCE BELOW 1978 FAMILY BUDGET[a] Lower Level $11,340	Intermediate Level $18,508
Medical Lab Asst. (CLA)			
0-100 beds	$ 9,300	$ 2,040	$ 9,208
100-300	10,200	1,140	8,308
300-500	9,900	1,440	8,608
500+	10,700	640	7,808
Laboratory Aide			
0-100 beds	7,500	3,840	11,008
100-300	7,700	3,640	10,808
300-500	7,700	3,640	10,808
500+	8,300	3,040	10,208
EKG Technician			
0-100 beds	7,600	3,740	10,908
100-300	8,300	3,040	10,208
300-500	8,200	3,140	10,308
500+	8,600	2,740	9,908
Staff Nurse			
0-100 beds	11,700	above	6,808
100-300	12,400	above	6,108
300-500	12,700	above	5,808
500+	13,200	above	5,308
LPN			
0-100 beds	8,900	2,440	9,608
100-300	9,200	2,140	9,308
300-500	9,200	2,140	9,308
500+	9,800	1,540	8,708
Nursing Aide			
0-100 beds	7,000	4,340	11,508
100-300	7,300	4,040	11,208
300-500	7,700	3,640	10,808
500+	8,200	3,140	10,308
Orderly			
0-100 beds	6,800	4,540	11,708
100-300	7,500	3,840	11,008
300-500	6,800	4,540	11,708
500+	7,600	3,740	10,908

Hospital Position	1978 Average Salary	DIFFERENCE BELOW 1978 FAMILY BUDGET[a] Lower Level $11,340	Intermediate Level $18,508
Orderly			
0-100 beds	$ 6,800	$ 4,540	$11,708
100-300	7,500	3,840	11,008
300-500	6,800	4,540	11,708
500+	7,600	3,740	10,908
Surgical Technician			
0-100 beds	10,400	940	8,108
100-300	8,900	2,440	9,608
300-500	9,400	1,940	9,108
500+	9,700	1,640	8,808

[a] 1978 Urban Family Budget estimated by increasing 1977 Budget by the increase in CPI between Autumn 1977, and Autumn 1978.

Sources: Executive Compensation Service of the American Management Association, Hospital and Health Care Report, 1978/1979; Bureau of Labor Statistics.

TABLE III

PERCENTAGE CHANGE IN ACTUAL RATES

Category	Salaries	Salary Range Minimums	Salary Range Maximums
Administrative	9.0%	7.0%	8.6%
Technical	7.5	5.7	7.5
Nursing	8.0	7.1	7.6
Theraputic	7.0	7.2	7.7
Dietary	5.7	6.6	7.7

Source: American Management Association, Hospital and Health Care Report (3rd ed., 1978-1979), p. 16; compensation information in effect as of August 1978.

TABLE IV

ANNUAL RATES OF CHANGE IN EARNINGS AND LABOR COSTS

Annual Percentage Rates of Change of:

Year	Earnings of Hospital Employees	Earnings of All Private Nonfarm Employees	ACPPD	ACPPD if Hospital Employee Earnings Increased With All Private Nonfarm Earnings
1955-60	4.8%	3.6%	6.9%	6.2%
1960-63	3.9	3.1	6.5	6.0
1963-66	4.0	3.8	7.4	7.3
1966-69	9.5	5.1	13.3	10.6
1969-70	10.1	4.2	15.7	12.2
1970-71	10.3	6.5	13.9	11.7
1971-72	8.1	7.0	14.0	13.5
1973-74	4.6	6.8	9.0	10.2
1974-75	10.8	6.1	18.3	15.7
1955-75	6.3	4.5	9.9	8.8
1975-76	9.1	7.0	14.2	13.1
1976-77	7.0	7.5	14.7	15.0
1955-77	6.4	4.8	10.3	9.4

Source: Council on Wage and Price Stability, The Rapid Rise of Hospital Costs, 1977; American Hospital Association, Hospital Statistics, 1978; and U.S. Bureau of Labor Statistics, Employment and Earnings.

TABLE V. SEIU COLLECTIVELY BARGAINED HOSPITAL AGREEMENTS

State	Increase Dates	Unit Percent Increase	Percent Increase, Selected Occupations				
			Nurse's Aide	Maid	Porter	LPN	Other
CALIFORNIA				Hskp. aide			
14,900 employees	1976	8.2%	8.5%	8.7%		8.1%	
(more than 26	1977	7.2	7.2	7.4		7.1	
hospitals)	1978	6.8	7.4	7.6		7.0	
	1979	6.5	6.5	6.5		6.5	
COLORADO			Clinic aide				
272 employees	1975	11.0	11.0			11.0	
(1 hospital)	1976	12.0	12.0			12.0	
	1977	6.5	6.5			6.5	
	1978	6.0	6.0			6.0	
DISTRICT OF COLUMBIA							
2,150	1975*	9.7	11.0	11.0		9.2	
(2 hospitals)	1976*	6.3	7.1	7.2		6.0	
	1977*	7.1	7.3	8.0		6.8	
	1978	6.8	7.0	7.0		6.9	
	1979	6.5	6.5	6.5		6.7	
	1980*	7.0	7.0	7.0		7.0	
ILLINOIS							
5,200 employees	1975	7.4	7.1	6.8			
(4 hospitals)	1976	7.9	8.0	7.3			
	1977	6.0	6.1	6.2			
	1978	5.4	5.5	6.0			
	1979*	5.3	5.4	5.8			

*1 hospital

TABLE V - 2

State	Increase Dates	Unit Percent Increase	Percent Increase, Selected Occupations				
			Nurse's Aide	Maid	Porter	LPN	Other
MASSACHUSETTS							
1,000 employees	1976*	8.0%	8.0%	8.0%		8.0%	
(4 hospitals)	1977						RNs
	1978	5.0					5.0
	1979	5.0					5.0
MICHIGAN				Maid/Porter			RNs / Med. Techs
3,800 employees	1975	8.2	8.1	7.7%		10.1	
(11 hospitals)	1976	6.4	7.1	7.1		6.3	7.8% / 5.6%
	1977	5.9	6.5	6.5		5.4	2.1
	1978	7.4	8.0	8.1		4.5	
	1979	6.4	5.7	6.8			
	1980	6.1	6.4	6.5			
MINNESOTA							
5,000 employees	1976	5.0	5.0	5.3		5.3	
(20 hospitals)	1977	8.0	7.8	8.6			
	1978	6.7	6.7	7.0			
MISSOURI							
550 employees	1976	10.6	11.4	11.4			
(2 hospitals)	1977	9.6	10.2	10.2			
	1978	9.4	10.0	10.0			
	1979	2.6	2.7	2.7			

*1 hospital

TABLE V - 3

State	Increase Dates	Unit Percent Increase	Percent Increase, Selected Occupations: Nurse's Aide	Maid	Porter	LPN	Other
NEW YORK							
6,000 employees (14 hospitals)	1976	5.0%	5.0%	5.0%	5.0%	5.0%	
	1977	5.0	5.0	5.0	5.0	5.0	
	1978	7.5	7.5	7.5	7.5	7.5	
	1979	4.0	4.0	4.0	4.0	4.0	
	1980	4.0	4.0	4.0	4.0	4.0	
OHIO							
2,400 employees (4 hospitals)	1975	6.4	6.6	6.9	6.5		
	1976	6.6	7.5	7.9	6.8		
	1977	3.8	3.5	3.9	8.2*		
	1978	8.5	9.0*	9.6*	7.6*		
	1979	8.0	8.6	9.0			
	1980*	8.2	8.7	9.1			
OREGON				Hskp.			Clericals
2,200 employees (7 hospitals)	1975	8.0	8.6	8.5		8.0	
	1976	7.3	7.3	7.7		7.7	9.0
	1977	7.3	7.3	7.3		7.4	7.1
	1978	6.3	7.0	8.1		8.1	6.8
	1979	6.9	6.9	6.9		6.7	
PENNSYLVANIA							
650 employees (5 hospitals)	1976	11.3	11.0	12.4		9.8	
	1977	8.8	10.0	7.6		9.6	
	1978	10.4	13.1	8.7		11.4	

1 hospital

TABLE V - 4

State	Increase Dates	Unit Percent Increase	Percent Increase, Selected Occupations: Nurse's Aide	Maid	Porter	LPN	Other
				Hskp.			
WASHINGTON							
60 employees	1975	8.0%	9.2%	9.2%			
(3 hospitals)	1976	8.2	9.7	9.3		9.5	
	1977	7.5	7.2	7.3		7.6	
	1978	8.8	8.6	8.7		8.1*	
	1979	7.7	6.8	7.1		6.7*	
Total SEIU	1975	7.8%					
weighted average	1976	7.1					
	1977	6.6					
	1978	7.0					

*1 hospital

Senator TALMADGE. Our next witness is Mr. R. G. Zimmermann, assistant secretary, assistant treasurer, F. W. Woolworth Co., on behalf of the Chamber of Commerce of the United States, accompanied by Jan Peter Ozga, associate director, health care, Chamber of Commerce of the United States.

STATEMENT OF R. G. ZIMMERMANN, ASSISTANT SECRETARY, ASSISTANT TREASURER, F. W. WOOLWORTH CO., ON BEHALF OF THE CHAMBER OF COMMERCE OF THE UNITED STATES, ACCOMPANIED BY JAN PETER OZGA, ASSOCIATE DIRECTOR, HEALTH CARE

Mr. ZIMMERMANN. Thank you, Mr. Chairman.

Senator TALMADGE. Mr. Zimmermann, you may insert your full statement and summarize it for about 10 minutes, please. There are two more witnesses after you. This is one of those days when I am supposed to be at three different places at the same time.

Senator Baucus has kindly consented to chair the hearings until 12:30 p.m. I believe we can complete them by then with some cooperation on the part of all individuals. If not, Senator Baucus, if you will recess it when you have to leave and have the staff get me and I will try to come back to complete the hearings.

Mr. ZIMMERMANN. I would request our statement be inserted into the record.

Senator TALMADGE. It will be inserted into the record.

Mr. ZIMMERMANN. Thank you, Mr. Chairman. We will make it as brief as we can.

My name is Robert Zimmermann. I am an assistant secretary and assistant treasurer for the F. W. Woolworth Co. of New York. I am accompanied by Mr. Jan Peter Ozga, associate director for health care at the National Chamber of Commerce.

We are pleased to have this opportunity to express the National Chamber's views on S. 505, S. 570 and other proposals to help contain the rising cost of hospital and health care.

A full text of our comments has been submitted for the record. We will now attempt to summarize our comments.

S. 505 represents a significant step in the right direction toward containing spiralling health care costs but needs to be modified to be an effective weapon in the battle against health cost inflation.

Primarily, its reimbursement reforms should be applied to all third-party payers, not just medicare and medicaid, so that public savings are not made a private sector expense.

The national chamber would also like to go on record as opposing mandatory revenue controls on hospitals as are proposed in S. 570, the administration's hospital cost containment bill, by any other name, S. 570 is price control.

By their nature, price controls treat the symptoms not the causes of inflation. They reward inefficiency while penalizing efficiency, inhibit competition and innovation and create distorted consumer demand, all of which are counter to an effective cost containment strategy.

S. 570 has more flaws. First, it exempts federal hospitals, many of which are showing cost increases greater than those of private hospitals. It contains a wage pass through for nonsupervisory personnel yet one-half to two-thirds of hospital costs go for salaries.

Finally, S. 570 ignores the fact that regulation itself has accounted for a sizable part of health cost inflation. For example, New York State estimates that its hospitals spent over $1 billion, 25 percent of daily operating costs, complying with Government regulations.

The President promised there would be no mandatory wage price controls, yet S. 570 appears to be the first step in breaking that promise.

The question is, What is the next part of the economy which will be controlled?

Business is concerned about rising health and hospital costs because it is the largest private purchaser of health care in the country. In 1978, employers spent nearly $40 billion on group health insurance and perhaps an equal amount on items such as taxes to support medicare and medicaid, medical benefits in workers' compensation, inplant health services, corporate philanthropy for health programs, paid sick leave and compliance with safety and health regulations.

In my own company, we have experienced severe problems with rising costs. At the end of last year, the premiums on our medical coverage increased at a rate well in excess of what we would like to see them increase.

Business recognizes that hospital costs account for 40 percent of the Nation's health care dollar and that 75 percent of the cost of medicare and medicaid goes toward hospital expenses. Indeed, one of the major reasons for rising health care costs is the growth of these two public health programs.

The growth of medicare and medicaid has not been without its problems, some of which are cost overruns, fraud, abuse, and waste.

Recent efforts to detect and correct these problems, including Public Law 95-242, seem to be succeeding and should be continued as advocated in S. 505's administrative reforms.

The chamber supports these efforts and also urges the committee to consider the value of greater use of professional standards review organizations which are helping to contain rising medicare and medicaid costs.

The most important provision of S. 505 is its attempt to contain costs through a system of hospital classification and incentive reimbursement policies for routine daily hospital costs. This appears to be a form of prospective ratesetting, which the chamber supports.

The chamber is concerned that savings realized in medicare and medicaid may be perceived as losses by hospitals, which will then compensate by charging more to privately paying patients.

Language in last year's committee report on this bill charges the proposed health facilities cost commission to investigate charges of such action and recommend corrective action.

This may not be a sufficient safeguard. Thus, the chamber recommends that language in the bill itself require that incentive reimbursement procedures be established for all third-party payers to prevent a potential cost transfer.

This same commission is also empowered by S. 505 to consider extending the act's authority to include ancillary and other services. The chamber recommends that this extension occur as soon as

possible since ancillary services are among the most costly of hospital charges and because all services, even as all payers, should be included in the plan.

S. 505's approach to limiting hospital capital expenditures also receives chamber general approval since it relies on the existing and improved health planning system operating at the local and state level.

Health planning decisions, including those dealing with capital investment, should be locally determined, ideally by groups with business representation, to ensure that these decisions reflect the best health and economic interests of the community.

In summary, the chamber generally supports S. 505's approach to hospital cost containment through reimbursement reform, especially as an alternative to mandatory limits on cost increases imposed by the Federal Government or mandated state rate review commissions. This reform should apply to all payers so that an equitable cost savings program is imposed on hospitals.

The national chamber also calls your attention to the Chamber's health action program which I have before me. Each of you should have received a copy of this kit earlier this year.

A summary of information in this kit also was placed in the March 5 through March 13 issues of the Congressional Record by Congressman James Broyhill of North Carolina as a matter of public interest.

This kit is the basis for a nationwide community based program for applying voluntary efforts at the local level to contain costs and improve health. This program advocates that business use its clout and expertise to help improve health insurance, prepaid health plans, health education in the workplace and health planning.

The objective of the program is to instill competition, cost consciousness and individual responsibility for health into the health care system.

The success of this program would help obviate the need for more Government intervention into the health system, including a costly federally run national health insurance plan.

An outline of the health action recommendations and examples of where voluntary action on health costs are already working and are attached to the full text of our comments which we have submitted for the record.

We thank you for giving us the time and attention for this presentation.

Senator BAUCUS. Thank you very much, Mr. Zimmermann.

Senator Dole?

Senator DOLE. It is my understanding you recommend the bill apply to all payers.

Mr. OZGA. That is correct.

Senator DOLE. There was some discussion of that last year. I ~~can~~ understand the reason for that as you suggested in your statement. We did discuss it at some length last year and there was some support and a great deal of opposition. Beyond that, I share your concern and appreciate your statement.

Senator BAUCUS. Thank you very much, Mr. Zimmermann.

[The prepared statement of Mr. Zimmermann follows:]

STATEMENT OF R. G. ZIMMERMANN FOR THE CHAMBER OF COMMERCE OF THE UNITED STATES

Mr. Chairman, my name is R. G. Zimmermann. I am the Assistant Secretary and Assistant Treasurer for the F.W. Woolworth Company, New York. I am accompanied today by Mr. Jan Peter Ozga, Associate Director/Health Care for the Chamber of Commerce of the United States.

The National Chamber welcomes this opportunity to present its views on S. 505, the "Medicare-Medicaid Administrative and Reimbursement Reform Act of 1979," and S. 570, "The Hospital Cost Containment Act of 1979." Our membership of more than 80,000 business firms, trade and professional associations, and local and state chambers of commerce shares with the Congress a deep concern over the rising cost of hospital and other health services, which are paid by Medicare and Medicaid, by private health insurance plans and directly by patients.

Generally, the National Chamber favors S. 505's approach to the reimbursement and administrative reforms proposed for Medicare and Medicaid, as an an alternative to mandatory price controls on hospitals of S. 570, which we flatly oppose. The bill represents a significant step in the right direction; however, it requires certain modifications before it can be an important factor in helping to solve some of our health cost problems. Foremost among these is that the bill should be broadened to include all payors of health services, not just Medicare and Medicaid—so that public savings will not be made at private sector expense.

Before proceeding with our analysis of and positions on selected provisions of S. 505, we will present the employers' perspective on the health care system. After we have addressed S. 505, we will highlight the National Chamber's Health/Action program, including some examples of voluntary action by employers and communities to contain rising health care costs.

HEALTH CARE COSTS

In 1978, the nation's health bill was $183 billion. Over 40 percent of this amount went toward hospital bills. The average hospital stay now costs $1,300, up 1,000 percent since 1959 compared to a 236 percent increase in consumer prices as a whole. The two largest increases over the past quarter century occurred between 1966–71, after the implementation of Medicare and Medicaid, and between 1974 and 1975, soon after the Economic Stabilization program ended. These figures underscore the inflationary effect which governmental programs and price controls have had on health care.

In 1978, more than $38 billion was spent on Medicare and Medicaid, far exceeding the original estimates when these public health programs were enacted over a decade ago. Of this amount, $28.5 billion—over 75 percent—was for claims covering hospital charges. These figures are expected to increase to $43.6 billion and $32.7 billion respectively in 1979.

Over 90 percent of all hospital charges are paid by someone other than the patient, usually through public or private insurance programs. It is no wonder then that very few people feel the full impact of rising health care costs—increasing at annual rate of 13 percent—and that attempts to educate consumers to make more cost-saving decisions regarding their health care have not been successful.

There are a number of reasons for escalating health care costs, including overall inflation; the cost of complying with governmental regulations; the growth of our population, coupled with expanded health care benefits and increased demand for services; malpractice awards and protection (and related factors such as over-prescribing and overtesting); and heavy investment in new technology. However, accelerating the rise of health care costs are public health programs such as Medicare and Medicaid and a 30 percent rise in all health costs within two years when Phase IV of the wage and price controls were lifted from the health care industry in 1974.

BUSINESS ROLE IN HEALTH CARE

The cost of current health-related benefits to business is 25 times higher than it was a generation ago. In 1950, less than half of all wage and salary earners had hospitalization, surgical and regular medical coverage while the vast majority of workers now have such coverage.

Between 1967 and 1977, wages nearly doubled while health-related benefit costs increased over 284 percent. Approximately 80 percent of health insurance is purchased through the workplace, with employers paying an average of 70 percent of the cost, for a total 1978 bill of $40 billion. An equal amount was spent for Medicare and Medicaid taxes, workers' compensation medical benefits, paid sick leave, corporate philanthropy and in-plant health services.

Thus, business is the largest private purchaser of health services in the United States.

DEFECTS IN MANDATORY CONTROLS

These seemingly uncontrollable costs have prompted some health experts to advocate mandatory revenue controls, such as proposed in S. 570, "The Hospital Cost Containment Act of 1979." However, this approach merely treats the symptoms not the causes of inflation. Such controls, in fact, reward inefficiency while penalizing efficiency, inhibit competition and innovation, and distort consumer demand—all of which are counterproductive to an effective cost containment strategy.

The Chamber fails to understand why S.570 exempts federal hospitals from its controls, when many of these facilities are showing cost increases greater than those of private hospitals. S.570 also contains a wage pass through for non-supervisory personnel; yet one-half to two-thirds of hospital costs go for salaries. Finally, S.570 ignores the fact that government regulation accounts for a sizeable part of hospital cost inflation. For example, New York State estimates that in 1976 its hospitals spent over one billion dollars, or 25 percent of operating costs, complying with government regulation.

CHAMBER POSITION ON S. 505

The "Medicare and Medicaid Reimbursement and Administration Reform Act" represents a significant step in the right direction to help curb rising health care costs. The bill envisions instituting reform in reimbursing hospitals, physicians, nursing homes, and in the administration of Medicare and Medicaid and related public health programs. In fact, the bill attempts to specify reforms which are generally stated in Public Law 92-603, the "Medicare-Medicaid Amendments of 1972."

Hospital reimbursement reform

The National Chamber supports in general S. 505's cost-saving concept of establishing prospective limits on daily routine costs of hospitals, which would be classified according to size and type and other appropriate categories. This approach, which includes penalties, rewards and exemptions as incentives for performance, should help hospitals become more cost-efficient.

Indeed, all hospitals, extended care and nursing home facilities should accept reimbursement for services on a prospective, rather than on a retroactive ("cost-plus") basis, with budgets, financial statements, statistics and services to be reviewed by private and public payers.

It appears that S.505 accomplishes what we feel is necessary. However, without continuing, careful oversight by your committee, the bill could provide an opening for a centralized, federal rate-setting system.

Although S. 505's incentive reimbursement system is a better method of controlling costs than the price ceiling on inpatient charges proposed in S.570, we cannot entirely endorse this provision since, as drafted, it does not effectively include all third-party payors. Public interest cost-savings should not be made at private expense. Experience has shown that hospitals which incur losses in revenue resulting from public reimbursement policy compensate for such losses by increasing charges to private payors, such as Blue Cross, commercial insurers or patients.

The Chamber has long recognized the need for uniform reimbursement practices between public and private programs, whereby each hospital should charge the same prices for the same services, regardless of the kind of benefit protection of the patient.

When introducing S. 505, Senator Talmadge stated that he was "quite open to the idea" of broadening his proposal to reach beyond Medicare and Medicaid. This bill appears to reflect his intentions, with provisions such as Section 1127 which states that the Health Facilities Cost Commission will ensure that hospitals are "not to increase amounts due from any individual, organization, or agency in order to offset reductions made" by the proposed reimbursement reform program. Moreover, the Senate Finance Committee took special notice of the cost transfer problem when, on page 12 of its Report No. 95-1111, it stated: "The Committee expressed concern over the possibility that the new limits on reimbursement might lead to increased costs for other payors. The new Health Facilities Cost Commission should review the operation of the new Medicare-Medicaid hospital reimbursement system and report on the extent, if any, to which hospitals bill other payors to cover costs disallowed by Medicare and Medicaid."

However, the bill provides no clear method of preventing such cost transfers; therefore, the National Chamber recommends that S.505 be expanded to include

both public and private third party payors, so that public savings will not be made at private sector expense.

The Commission is also empowered to recommend extending S.505's reimbursement system to ancillary and other services. We recommend that this this extension occur as soon as possible since ancillary services are among the most costly and because all services, just as all payors, should be covered by S. 505.

The National Chamber also supports uniform cost reporting among hospitals to help establish a basis for cost-saving actions. However, because of the diversity among hospitals and other health care facilities, such reporting should allow sufficient flexibility to accomodate different management practices.

Capital expenditure reform

The National Chamber also supports S. 505's attempt to control capital expenditures by extending and expanding the authority of health planning statutes. These include responsible decisions made by project review under Section 1122 of Public Law 92-603 and Section 1526 of Public Law 93-641, as well as State Certificates of Need. We also favor the principle that decisions on capital expenditures in metropolitan areas which cross state lines should include input from states in which the metro area is located. Projects which are disallowed by local health planning authorities should not receive Medicare or Medicaid reimbursement for their costs. However, these decisions should be made at the local level and should not be overruled by state or federal authorities. If they are, local planners should be able to contest such decisions.

Alternative reforms

The National Chamber also urges the committee to consider including incentives for other cost-saving innovations in S. 505. Examples are group purchasing, consumer education, claims and utilization review (e.g., second opinion on surgery), prepaid health care plans (and other methods of instilling competition into the health system), and health care economic courses in medical schools and hospitals, so that physicians will become aware of the rising cost of health services and products. These are some of the basic recommendations which are included in our Health/Action program, an outline of which is shown on Attachment A.

Finally, the Chamber calls the committee's attention to voluntary prospective rate setting arrangements which are working in several states. For example, Indiana, which has such a program, has experienced total hospital cost savings of nearly $200 million from 1968 to 1973. The Chamber recommends that this voluntary approach, not mandated programs, be used to contain costs.

Administrative reform

The National Chamber supports S. 505's provision to reduce fraud and abuse in public health programs. These include the provision that claims will be denied to persons falsifying Medicaid eligibility by temporarily transferring their assets to relatives or friends. This provision is a logical extension of corrective action already begun through the "Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977," and earlier activity designed to achieve the same purpose. Between 1976 and 1977 over two and a half billion Medicaid dollars were recovered from administrative action and prosecution. This anti-fraud and abuse activity also resulted in 620 providers being terminated or suspended from the Medicaid program. We also support coordinated auditing between Medicare and Medicaid programs.

Review of medicare and medicaid care

The National Chamber has long held that business should encourage provision of peer and utilization review of all inpatient and outpatient health services. Also, all hospitals should establish arrangements to review and monitor the appropriateness of such items as hospital admissions, duration of stay, and treatment prescribed.

As mentioned earlier, S. 505's reforms are an extension of previous legislation designed to lay the foundation for reimbursement changes in Medicare and Medicaid Public Law 92-603. This same legislation also established a program of Professional Standards Review Organizations (PSRO's), which are beginning to show a positive cost/benefit ratio. PSRO's are physician groups designed initially to review hospital care provided to Medicare and Medicaid patients, assuring that such care is effective, efficient, appropriate and reasonably priced.

Thus, PSRO's should continue to be the watchdog of the Medicare and Medicaid programs, instilling accountability and integrity into these programs. For this reason we are encouraging businesses to contract with PSRO's and similar organizations to conduct claims and utilization review on private patients.

Moreover, more stringent review of claims by fiscal intermediaries for the Medicare and Medicaid programs, should be demanded by HEW. This would help ensure that over-utilization, fraud and abuse are not perpetrated by either providers and consumers of service.

The success of these efforts, coupled with better designed health insurance programs and prepaid health care, should increase the delivery of outpatient care where appropriate, thereby reducing unnecessary and more costly hospital care. This, in turn, will reduce the need for further government intervention into the health system, since these reforms can be implemented voluntarily.

NATIONAL CHAMBER'S HEALTH/ACTION PROGRAM

Because of business' vital stake in rising health care costs and the lack of effectiveness of most government control programs to solve this problem, the National Chamber has launched a nationwide, community based program called Health/Action. Material for this program is contained in a kit of six booklets which explains how business and community leaders can contain costs and improve health through voluntary efforts applied at the local level.

Each member of this panel has been sent a Health/Action kit. In addition, Rep. James T. Broyhill (R-NC) inserted a summary of this program as a series of installments in the Congressional Record from March 5 through March 13 of this year.

The recommendations in the National Chamber's Health/Action program are based on a comprehensive, year-long study of health and business conducted by InterStudy of Minneapolis and sponsored by the National Chamber Foundation. Funded by some 40 organizations, the study was guided by a 22-member steering committee, comprising representatives from business, labor, health providers, health insurers and academia.

In general, the Health/Action program recommend that a greater effort be made by business to instill competition, cost consciousness and individual responsibility for health into the health care system. For instance, the program recommends that employers:

Negotiate with insurance companies for more cost-effective policies which cover preventive, out-patient services and second surgical opinions. Self-insurance also may be appropriate for some firms.

Support the development of prepaid health plans (e.g. HMO's) which are demonstrating an ability to improve health and save money emphasizing preventive services and lower rates of hospitalizations.

Establish physical fitness, nutrition and screening programs for employees. Such programs should reduce medical claims, improve productivity and reduce absenteeism. Ultimately, lower health insurance premiums will result.

Serve on Health Systems Agencies (HSAs), hospital boards and other planning bodies, and participate in local health studies which identify problem areas and roles for business to play in solving these problems.

The Chamber's Health/Action kit also includes a leader's guide to help local businesses and chambers of commerce implement the program. This guide provides four case histories of local action programs on health (Attachment B).

The Chamber's Health/Action program recognizes that there is a variety of reasons for rising health care costs and that all of the contributors to the problem—government doctors, hospitals, insurers, unions, business and the general public—need to cooperate in finding solutions. The Council on Wage and Price Stability holds that these solutions should stress private efforts, not government intervention. "Cost control incentive proposed by the private sector promise to be more effective than those imposed by the multitude of government agencies * * *. The private sector is motivated by economic incentives which the government will simply never share * * * (These) incentive(s) * * * (have) been the missing factor(s) in health care * * * the key ingredient(s) in bringing about much needed change in the system * * *. In our opinion, the private sector is up to the challenge."

Our health action program is the National Chamber's way of accepting this challenge.

CONCLUSION

The National Chamber supports S. 505 as a significant but incomplete step toward controlling health care costs. The bill's administrative and reimbursement reforms appear to offer incentives to the health care industry to become more cost-efficient and effective. It is clearly a better approach than mandating controls on hospital revenues, as proposed in S. 570. However, we favor broadening the coverage of S. 505 to include both private and public third party payors, so that public savings will not be made at private sector expense. Also, Professional Standards Review-Organi-

zations, which are designed to monitor and evaluate care provided to Medicare and Medicaid patients, should be perceived as a major instrument for containing costs to public health programs.

The National Chamber holds that cost-saving proposals should encourage competition and provide well-designed incentives which allow the nation's health industry to operate at its optimum. We further recommend flexibility to allow for innovation. Finally, we recommend that maximum scope be given to voluntary efforts, such as the National Chamber's Health/Action program, to obviate the need for further government intervention into the health care system.

Attachment A

HOW BUSINESS CAN CONTAIN COSTS AND IMPROVE HEALTH

Below is an outline of recommended action business can take within their firms and their communities to help fight health care inflation. The source of information is the Appendix to Health/Action, one of six reports included in a kit by the same name. The titles in parentheses correspond to the five reports of the National Health Care Strategy, sponsored by the National Chamber Foundation and prepared by InterStudy, which are also included in the Health/Action kit.

1. COST CONTAINMENT ("How Business Can Use Specific Techniques to Control Health Care Costs"). Work with insurance carriers to develop policies and services which deal with the following areas:

Administrative
- Claims review
- Coordination of benefits and subrogation
- Self-insurance

Altering Utilization
- Cost-sharing
- Hospital utilization review
- Second surgical opinions
- Pre-admission testing
- Ambulatory surgery
- Home health care

Controlling Charges
- Prospective hospital reimbursement
- Prenegotiated physician fee schedules
- Volume purchasing of drugs and optical equipment

2. HEALTH MAINTENANCE ORGANIZATIONS ("How Business Can Stimulate a Competitive Health Care System"). Support the growth and development of these prepaid health plans in the following ways:

- Offer HMOs in a positive framework. Evaluate existing HMOs. Provide support to HMOs when they market their services.
- Endorse the HMO concept by reinforcing information provided by the HMO, explaining the advantages of HMO membership.
- Provide technical assistance to developing HMOs to help the plan realize its full potential. Monitor and evaluate the plan's operations.
- Help develop an HMO in your community, providing financing support and planning advice and making facilities available for clinics.

3. HEALTH PROMOTION ("How Business Can Promote Good Health for Employees and Their Families"). Establish programs which address the following health areas:

Healthful Lifestyles
- Nutrition
- Physical fitness
- Smoking cessation
- Alcohol chemical abuse
- Obesity control
- Detection and treatment of hypertension

Self-Help and Wiser Buying
- Stress management
- Medical self-help
- Understanding and using health insurance
- Selecting and using doctors
- Buying medicines more economically

4. HEALTH PLANNING ("How Business Can Improve Health Planning and Regulation"). Serve on the following types of health organizations:

- Hospital boards
- Health Systems Agencies
- Health Maintenance Organizations
- Nursing homes
- Community study groups
- Industry task forces

5. SMALL BUSINESS ("How Business Interacts with the Health Care System—With a Special Action Plan for the Smaller Business"). Improve your health benefit package by

- Purchasing health insurance coverage with cost-containment features.
- Enrolling employees in health maintenance organizations or other alternative health delivery systems (ADS).
- Offering both health insurance and ADS options to employees.
- Joining with other small firms to purchase benefits (insurance and/or ADS membership) as a larger group.

CONTACT: Jan Peter Ozga, U.S. Chamber of Commerce, (202) 659-6106

Attachment B

In the face of rapidly rising health care costs, some firms and business organizations, often working with their local health care planners and providers, have taken steps to reduce the rate of medical cost increases.

The nature, scope, and intensity of such efforts vary widely, illustrating that (1) there are many alternative courses for private health cost containment programs to follow and (2) measures that yield results for one company or community will not necessarily be successful for others. Local action must be tailored to deal with specific local problems.

The examples that follow present an overview of only a few private sector attempts to deal with escalating health care costs. The purpose of these case studies is by no means to describe comprehensively the only courses of action available. Rather, these reports present sketches of a few of the virtually limitless options available. These efforts are successful primarily because they are well-reasoned, carefully planned, and enthusiastically supported by the private sector. They are offered as examples to encourage similar action elsewhere.

The Greater Cincinnati Chamber's Health Care Committee was formed in May 1977 at the request of high-level executives of several member firms. These business people had previously been meeting informally to discuss the severe problems caused by rapidly increasing health care costs. They agreed their concern should be channeled to an existing business organization. They, therefore, approached the chamber with the proposal to establish a Health Care Committee.

The fact that chamber members brought the health care cost problem to the organization is regarded as critical to the committee's subsequent successful operation: These executives recognized that the problem was serious, their concern was genuine, and they knew decisive action was required.

Most committee members are either personnel benefits officers for area companies or are business executives who have an extensive knowledge of, and experience in, the health care system.

Primary Goal

The committee's primary goal is to explore, develop, and encourage means by which the area's business community can influence the decisions of individuals and organizations that control the utilization and cost of health care services. The overriding concern, of course, is to secure high-quality health care at the lowest reasonable cost. This requires continuing communication with physicians, medical review organizations, the area's Academy of Medicine, hospitals, planning agencies, and insurance carriers. It also involves helping the business community understand and influence employer-employee utilization of health care services. Through this ongoing communication, the committee works with the entire local health care system to ensure that all concerned are doing their jobs cost-effectively.

At the outset the committee attempted to establish a common frame of reference for its members. The full committee has since had educational sessions with organizations such as the Health Planning and Resource Development Association of the Central Ohio River Valley (CORVA) and the Midwest Medical Foundation.

Three subcommittees were formed to examine the organizational components of the local health care delivery system: hospitals, planning agencies, and third party payers. Reports by the subcommittees were completed in De-

Source: Health Action. Chapter III. Part of six-volume kit by the same name. Chamber of Commerce of the United States. January 1979.

cember 1977. This was considered an essential first step toward the committee's goal of influencing the individual and collective decisions of the system's components.

For example, the subcommittee on planning agencies submitted a report on CORVA, the Health Systems Agency for metropolitan Cincinnati.

The subcommittee concluded that the Health Care Committee should be involved in local health planning by participating actively in certain CORVA projects and by providing business representatives for the organization's task forces, committees, and board. The subcommittee maintained that the business community has a large stake in the health planning process embodied in CORVA: "If this process cannot be made to work, the federal government may intervene on a much greater, more direct scale, even though it has already made significant inroads into the local system through the policy linkage between Washington and CORVA."

Another subcommittee—on third party payers—concluded in its report that the Greater Cincinnati Chamber "should take a positive position supporting the role of third party payers who work with health care planning agencies in their efforts to restrain unnecessary expenditures by delivery agencies. Further, chamber members, as primary payers for the majority of health insurance plans, should be visible supporters of the efforts of the third party payers to control health care costs. They should adopt strong positions to pay *only* the types and levels of benefits specified in reimbursement plans for their employees." This subcommittee also recommended that the chamber support efforts of third party payers designed to encourage individual personal involvement in controlling health care costs.

Continuing Activities

Early in 1978, the Health Care Committee determined the following specific objectives.

1. Study the impact of specific health care costs on representative business operations in the area.

2. Develop and recommend to chamber members effective internal auditing systems to monitor and control the utilization of health care services.

3. List alternative health care benefit designs which will help chamber members improve the quality of health care and reduce the rate of increase in health care costs—and recommend strategies for their implementation. Examples could include

- Greater outpatient coverage and utilization of outpatient care.
- Home health care.
- Subscriptions to health maintenance organizations.
- Employee deductibles for medical treatment.
- Second and third opinions on surgery.
- Pre-admission testing.
- Employee education programs.
- Preventive care.

4. Maintain business representation and input in the activities of local planning agencies and government organizations.

5. Lobby for the business community's point of view on proposed local, state, and federal legislation/regulations that affect the quality of health care and health care costs.

Having determined an overall goal and method of operation, followed by reports that established recommended activities, the committee and its subcommittees are now pursuing a number of projects. Because the subcommittees only recently began their activities, tangible results in the management of health care expenditures and benefits for chamber members are not expected until late 1979. However, the committee has produced results in the other areas from the beginning of its operation:

1. The committee encouraged CORVA to "do its job" and make the appropriate decision on the issue of the number of beds in a new hospital proposed for Cincinnati. Hospital advocates had proposed installing more beds than may have been needed and had attempted to lobby their position through the CORVA board. A compromise was reached on the issue which resulted in a reduction in the number of beds for the proposed facility.

2. The committee recently evaluated a proposal for CORVA staff to establish a regional hospital cost ceiling in advance of federal legislation. The committee's response will have a significant impact on CORVA's decision on whether to proceed with the proposal.

3. The committee is monitoring significant state and federal health care legislation and adopting positions on them, in an attempt to urge sound concepts on legislators.

4. A member of the committee chaired a task force to evaluate the local tuberculosis control program. Other Health Care Committee members serve on CORVA committees and task forces.

Future Activities

The future course of action for the committee is being determined as members gain knowledge and experience and thereby better understand how to assist the business community to influence those who, by law or by their activity, control the future of health care in the area. Under study by several members is a project to provide personnel from the business community who can assist local hospitals with cost-saving projects and techniques. This proposal is being explored with CORVA, Blue Cross, and local hospitals that would benefit from the existence of the projects and techniques.

The Health Care Committee regards itself as a goad to ensure that health care organizations and businessmen make intelligent decisions on costs and quality of care and to see that the decisions are enforced. The committee feels that much of the policy and decision-making machinery is already in place in the community, and that many of the local health care system's components are already concerned about cost. The committee feels its challenge is to provide coordination and implementation—to increase business participation in the health care delivery system and to establish strong linkages among individual components.

For further information

Mr. Ed Wolking
Group Executive, Community Affairs
Greater Cincinnati Chamber of Commerce
120 West Fifth Street
Cincinnati, Ohio 45202
(513) 721-3300, ext. 50

Occupational health care for employees of Cummins and other area companies is delivered through the Columbus Occupational Health Association (COHA). It is a voluntary, not-for-profit association founded by seven Columbus companies which joined collectively to provide comprehensive occupational health services that each had previously sought, individually and less successfully, to secure from the private medical sector of the community. The facility in which these services are now delivered is known as the COHA Medical Center.

The founding companies include five manufacturing firms, a financial investment company, and a bank. To date, 126 additional companies have joined. They represent a total of more than 25,000 employees.

Each of the seven founding companies appoints one representative to serve on the association's board of directors. The COHA medical director is an ex-officio member. New member companies are not entitled to representation on the board.

As the governing body, the board oversees the operation of the association and its medical center within the limits and guidelines specified in the "Articles of Agreement," which each joining member must sign.

COHA membership is open to any company required by law to provide occupational health care or that elects to provide preventive medical services to employees.

Admission of new companies requires only a letter of application and approval by the board of directors. There is no entrance fee, but each member company must give 90 days advance notice of withdrawal from the association.

The medical director establishes, directs, and administers the occupational medical program. His decisions—by the terms of the Articles of Agreement—"shall be final," and are not subject to reversal by the board of directors. He is responsible for general administration of the medical center and implementation of policies and procedures deemed necessary for the proper conduct of the occupational health program, supervision of nonprofessional personnel, purchasing, financial planning, and public relations.

Scope of Operation

The association treats only the employees of member companies for injuries and illnesses arising out of and in the course of employment—but includes consultation services by staff physicians in environmental health problems of client companies and specific programs in preventive medicine. Temporary emergency medical care is provided for employees who become ill at work from nonoccupational causes until private medical care can be arranged.

The medical stations of member companies are not part of COHA or its Medical Center. These stations are maintained by individual companies and continue to treat most injured or ill employees. Cases requiring physician care or further diagnostic study are referred to the Medical Center.

Medical Center patients requiring hospitalization are usually not managed by COHA physicians. However, the COHA medical staff maintains contact with hospitalized patients until they are discharged and returned to work.

Dependents of employees are not eligible for care at the Medical Center. (Participating companies have continued to offer traditional forms of health insurance, such as Blue Cross Blue Shield, which covers employees and their dependents.)

The Medical Center operates on a regular 40-hour week, Monday through

Friday (8:00 a.m. to 5:00 p.m.), and is staffed by registered nurses for after-hour emergencies 24 hours a day, including weekends and holidays when member company employees are working. Physician's assistants rotate calls for emergency coverage after regular working hours.

Fee and Billing System

Charges for services rendered are on a fee-for-service basis. All procedures performed are assigned a numerical point value, the magnitude of which is determined in relation to some arbitrarily selected basic service. A simple office visit consultation serves as the baseline, with an assigned value of 1.0. (The physician's fee, for example, for a complete physical examination as a part of the annual physical is 10.0 points; a complete annual examination averages 34.8 points for men, 31.0 points for women.)

Services rendered with assigned point values are itemized for each patient at each visit. At the end of each month the total number of points accumulated by each member company is multiplied by a "dollar factor"—currently $7.00 for each full point. (This charge is determined annually and is firm from January through December.)

The 1978 dollar factor of $7.00 represents an increase of 27 percent over the initial dollar factor of $5.50 in 1972. For the same period—1972 to 1978—health care costs in the U.S. have increased 113 percent, indicating that COHA has significantly reduced increases in health care costs of participating companies.

The dollar factor was initially chosen to make fees comparable to similar services in the local medical community. However, detailed operating results over several years will allow this factor to be derived on a cost-analysis basis rather than by consideration of what is competitive in the community.

COHA sends each member company a monthly statement of the total amount due, with copies of all itemized bills. Member companies, including Cummins, then pay these monthly fees directly to the association.

In addition to savings realized through medical care fee increases that are far below the national and community norm, Cummins and other participating companies have benefitted from sharply reduced workers' compensation costs.

The Cummins Role

While enjoying the same privileges and obligations as any other member of the association, with no preferential treatment extended its employees, Cummins did assume certain commitments to the association beyond those of other founding members.

Cummins agreed to furnish all facilities, personnel, equipment, and operational funds necessary for conducting the medical program. The $2 million capital cost of the medical center was absorbed entirely by Cummins and has not been amortized directly by assessment nor indirectly through [illegible] service to member companies.

The Medical Center is staffed with Cummins employees [illegible] COHA, which has no employees of its own. Each month Cummins bills the association for the operating expenses of the medical center.

The company agreed at the outset to subsidize any initial deficit, which it did until January 1978, when COHA's income first exceeded expenses. Any income not needed to meet expenses is used to offset the initial deficit.

COHA and the Community

Surrounded by southern Indiana farmland, Columbus has a population of slightly over 30,000. The city has more than 110 manufacturing firms, ranging in size from two-man firms to the largest employer, Cummins, with 11,000 employees in the area.

Some 75 physicians, including a relatively large number of specialists, practice in the community. There is a single 325-bed county hospital, which is modern and well-equipped.

Several events of 1968 led to creation of COHA. Cummins realized that its existing medical facilities had not kept pace with the growth of the company, and expansion was immediately necessary. A local general practitioner and retired surgeon, who was handling most of the city's other companies, announced his intention to retire in 1970. Some of those companies, faced with losing their physician and aware of Cummins' plan to expand, approached Cummins to determine if a cooperative occupational health care arrangement was feasible. An organizational framework for such a joint venture was developed and the Kaiser International Consulting group was retained to conduct a feasibility study. The consultants not only concluded that the idea was sound, but enthusiastically urged Cummins to proceed with the project.

The association began operations in October 1970—quartered in the Cummins in-plant medical facilities until the COHA Medical Center building was completed in February 1974.

The Medical Center

The 20,000 square foot clinic houses a full range of modern medical equipment, and includes an X-ray department, cardio-pulmonary laboratory, physiotherapy department, and physicians' offices with adjoining examination rooms.

Medical Center staff now includes four physicians, four physician's assistants, five nurses, six technicians, and an administrative staff which performs reception duties, billings, and transcription of medical dictation—a total of 28 people on three shifts.

COHA offers a full range of occupational health services. The primary reason for its existence is to provide definitive diagnosis, treatment, and rehabilitation of occupational injuries and illnesses that occur on the job. Cases that are beyond clinic capabilities, in terms of equipment or skills, are referred by Medical Center physicians to appropriate outside specialists for treatment.

Another major service rendered consists of periodic examinations, of which there are several types. The pre-employment or pre-placement examination attempts to evaluate the worker's physical condition in an effort to ensure proper placement in a work environment that will not harm him or cause harm to other people. Other periodic physical examinations are performed on vehicle operators, every two years in most cases, to ensure that they are physically qualified to operate vehicles safely. Audiometric examinations are performed annually on all people who are constantly exposed to noise-hazard workplaces.

The preventive medicine service also includes an annual physical examination program. Next to the treatment of occupational injuries and illnesses, it is the largest single effort in terms of the number of participants, time consumed, and expense involved.

Another major program is the ready availability of staff physicians for in-plant environmental health and hygiene consultations and inspections on request of client companies. Prior to COHA this service was not available to smaller Columbus firms. The addition of a full-time industrial hygienist is planned for the near future.

Medical Community Relations

COHA, like most private clinics, maintains liaison with the local (Bartholomew County) hospital. Hospital laboratory facilities are available if needed and all COHA physicians are hospital staff members.

COHA physicians are also members of the county, state, and national medical associations.

From its inception, COHA has emphasized that its function is to treat only occupational injuries or illnesses of client companies, with no effort or plans to extend services to personal care of employees or dependents. Columbus area specialists are frequently consulted on patient care and procedures.

For further information:

Mr. Clinton J. Frank
Director of Medical Administration
Cummins Engine Company, Inc.
Columbus, Indiana 47201
(812) 379-8132

The PENJERDEL Greater Philadelphia Chamber of Commerce/Health Services Council Joint Health Cost Containment Program was initiated early in 1978. This effort was undertaken after many area businesses concluded that individual company actions to hold down health care costs could at best meet with limited success. In the face of alarming increases in medical benefits costs over the past five years, PENJERDEL Greater Philadelphia Chamber of Commerce and their affiliate, the Health Services Council (HSC), undertook to coalesce the business community into an effective force for developing and implementing reasonable cost containment techniques and strategies.

The PENJERDEL Corporation is the affiliated regional counterpart of the Greater Philadelphia Chamber of Commerce, covering 11 contiguous counties in an area frequently referred to as the Greater Delaware Valley. PENJERDEL is a nonprofit corporation with its own board of directors, contracting with the Greater Philadelphia Chamber for staff services and concerning itself with regional issues of significance to the area's business community.

The Health Services Council, a private nonprofit organization with 20 years experience in health planning and research, became affiliated with the Chamber/PENJERDEL in 1977. The HSC, previously known as the Hospital Survey Committee, has long been supported by business as its adviser on priorities for corporate philanthropy in support of health facilities capital needs. Prior to the advent of the Health Systems Agency of Southeastern Pennsylvania, HSC had also functioned under contract to Blue Cross to conduct triennial reviews of member health institutions. This affiliation provided the Chamber/PENJERDEL with a technical resource of experienced health planning and research expertise to supplement the business liaison function of their Health Care Department.

Launching the Program

A pilot inquiry was instituted by these three affiliates in early 1978 to determine the extent of business interest in and commitment to an effective health cost containment program. This inquiry consisted of a series of meetings at which the concept of the proposed program was presented to small groups of benefits managers from approximately 50 of the area's larger employers. The business community was eager to publicly endorse, finance, and lend its expertise to such a program.

It was suggested that participating industries provide 15¢ per employee per month in the PENJERDEL region, or 0.2 percent of their health benefits

costs, to finance the cost containment program's first year. This arrangement was seen by most businesses as a relatively small investment for a program which, if successful, could save their firms thousands of dollars in future benefits cost increases.

The basic premise of the joint program is that health care services should be purchased by the business community with the same prudence, shrewdness, and concern for receiving maximum value that is exercised in other purchases and investments. Other premises are: (a) that health costs can be contained without diminishing the scope of medical benefits to employees or the quality of professional care and (b) that cost containment techniques and action must be suited to the particular needs of the region and capable of rapid implementation without radically restructuring the health delivery system or the present administration of health benefits. The program is composed of four distinct, yet interdependent components:

1. A Health Cost Strategy Committee, currently composed of 15 experienced benefits officers and managers from major area businesses, charged with overseeing the development of specific cost containment methods and techniques.

2. The PENJERDEL Employee Benefits Association, being formed at this writing, which will be open to all benefits officers and managers in the region as an educational forum designed to address mutual problems and new ideas across the range of employee benefits.

3. A network of informed business executives who serve as trustees or directors of health care institutions.

4. An educational program designed to provide support for business representatives who serve on boards and committees of the several Health Systems Agencies in the PENJERDEL region.

Monitoring Project

One project currently being developed by the Health Cost Strategy Committee is a system for monitoring characteristics of employee hospitalizations. This will include accumulating and analyzing data on the average length of stay in each hospital in the region, by age group, for selected diagnoses most frequently encountered by business. From these regular reports, reasonable norms for length of stay can be developed. If an institution exceeds these norms consistently, the committee—through the region's insurance industry or individual businesses—can review the matter with the institution's administration or board and determine solutions.

The monitoring program will also disclose the degree to which providers are practicing the cost-saving technique of performing diagnostic tests for nonemergency hospitalizations on an outpatient basis. Although employee benefits plans would still pay for necessary tests, the high cost of occupancy of a hospital room for this purpose would be saved.

Length of stay is only one of the areas being studied by this committee. It is one, however, that shows some promise for immediate relief. The strategy committee is aware that the implementation of the monitoring program depends on the cooperation of Blue Cross-Blue Shield and the commercial insurance industry, and the committee relies on these carriers for computer data pertaining to claims paid for employee hospitalization.

Communications

The Employee Benefits Association is designed to deal with the full range of

employee benefits. The association is potentially a vehicle for disseminating the Joint Health Cost Containment Program's findings throughout the business community, and it can function as a forum for a constructive critique of the committee's projects and for exchange of new ideas and experiences. Members will be able to educate their company management on the critical cost containment issues that affect business profit-planning.

Network of Business Executives

In establishing the third component of the program, a network of informed business executives, lists of all trustees, and directors of general care hospitals were examined to determine which area firms have employees on hospitals' boards and committees. It was found that a number of businesses (perhaps to their surprise) have as many as 10 employees serving various hospitals.

By compiling this information, the program can selectively distribute pertinent monitoring data and other cost containment information and experiences. Individual firms can also coordinate their approaches to implementing methods that have been demonstrated as effective in restraining cost increases.

Health Systems Agency Service

The fourth component of the joint program, designed to assist executives serving on Health Systems Agencies, recognizes that HSAs have enormous potential for developing and implementing a rational and cost-effective health delivery system. The HSAs are responsible for regional health planning and implementation, and for review and approval of: (a) all expenditures in excess of $150,000 and (b) additions of services and changes in bed complements of individual institutions. The joint program will develop and disseminate specific information to help HSA business representatives keep attuned to the economic, medical, and community considerations that have an impact on each decision.

The Health Cost Strategy Committee has determined that the joint program's efforts will be limited to action on health care concerns of direct relevance to the business community. Implementation and effectiveness are paramount. There has been no promise that the actual cost of employee health benefits will be reduced, but rather that vigorous pursuit of effective cost containment measures will at least reduce the rate of benefits cost increases. Program participants are convinced that without sustained efforts there will be continued acceleration of health benefits costs.

For further information:

Ms. Brent W. Roehrs
Director—Health Care
Greater Philadelphia Chamber of Commerce
Suite 1960
1617 John F. Kennedy Blvd.
Philadelphia, Pennsylvania 19103
(215) 568-4040

Beginning in the summer of 1973, three separate HMO-type plans were offered simultaneously to selected companies in the Rochester area.

These plans represented three basic organizational models: (1) a multispecialty prepaid group practice utilizing a single large health center; (2) a decentralized network of neighborhood health centers; and (3) a foundation

for medical care. By agreement among the plans and Rochester Blue Cross and Blue Shield, which acted as their financial and business center, the benefits were nearly identical for all three plans. The benefits were based upon anticipated federal HMO benefit requirements and, in fact, with minor exceptions, equalled or exceeded these requirements as finally enacted into law. These three prepaid health care plans were:

1. The Genesee Valley Group Health Association (Group Health). Group Health is a multi-specialty prepaid group practice, organized and financed by Blue Cross and Blue Shield of the Rochester area, which provides services through the Joseph C. Wilson Health Center, a facility with capacity for serving 40,000 members. The health center includes offices for physicians and nurse clinicians, a laboratory, pharmacy, X-ray facilities able to accommodate extensive diagnostic tests, and a special procedures area with room for minor surgery and the setting of fractures. Group Health, from the beginning, assumed full financial obligation to pay for both its basic benefit package and its debts to Blue Cross/Blue Shield. A formal referral and approval process was developed for out-of-center services such as psychiatric care and physician specialty care (allergy, dermatology, orthopedic surgery, urology, etc.). Hospital inpatient and outpatient services required approval for payment by the medical staff, who carefully monitored and reviewed all admissions and stays.

2. The Rochester Health Network (RHN). RHN's existence began with the establishment of an Office of Economic Opportunity-funded neighborhood health center in the City of Rochester. These centers, historically funded by HEW, have primarily provided medical care to Medicaid patients residing in Rochester's inner city or adjacent areas. By 1974, RHN had increased the number of city locations to five and expanded to suburban Monroe County, where two affiliated sites are now located. Though initially limited to serving the poor, its basic objective was changed in response to changed federal regulations in 1973 to become an integrated system of medical care covering a broad range of socioeconomic groups. RHN is, then, a network of independent, multiple site group practices providing services on a fee-for-service and prepaid basis. One of the RHN centers is hospital-based; the other six vary considerably in terms of medical staff and ancillary service capability.

RHN assumed financial risk for primary care medical services provided within each of the network components. Blue Cross assumed the risk for hospital services; Blue Shield assumed the risk for costs incurred for RHN members referred to non-RHN physician specialists, including surgeons. Though RHN was not at risk for these services, it promised to repay Blue Cross/Blue Shield losses incurred under the contract. RHN physician referral was required for hospital admissions and for payment to outside physicians and nonemergency outpatient hospital services.

3. Health Watch. The Medical Society of Monroe County organized the foundation for medical care, an independent practice association-type HMO. After suffering increasing losses for two years, primarily caused by high hospital usage, Health Watch was dissolved in 1976.

About 700 of the 1,200 practicing physicians in Monroe County participated in the Health Watch program during the three years of operation. The plan did not assume any financial risk or make any agreement to pay losses for the comprehensive benefit package. Blue Cross and Blue Shield, as the [illegible] assumed all risk. Since 99 percent of the local physicians were [illegible] participating providers, it was deemed simply to expand the existing Blue Shield fee schedule to include doctor office and home visits for [illegible] Watch. The Blue Shield fee schedule or schedule of allowances is based on a relative value system. Health Watch, then, had some basic characteristics of a foundation for medical care but lacked the two elements of financial risk and a peer review process for inpatient hospital claims.

This case study will focus on the experience of the federally qualified HMO—

the Genesee Valley Group Health Association. Group Health, operational since August 1, 1973, became New York State's first federally qualified HMO in January 1976. With five years experience and a current enrollment of more than 36,000 members, Group Health experience may be more similar to the experiences of other, newly formed group practice HMOs which have all of the essential elements of an HMO in place and functioning.

Group Health has been extensively monitored and studied by a multidisciplinary team based at the University of Rochester School of Medicine's Department of Preventive Medicine and Community Health. During the last five years, a substantial body of literature has been accumulated on the enrollment and utilization experience of Group Health and the other prepaid plans in Rochester.

Benefits and Premiums

The services covered in the basic benefit package for each of the prepaid plans were considerably broader in scope than those covered by the traditional Blue Cross and Blue Shield plans. They provided full coverage for 120 days of inpatient hospital care for medical, surgical, obstetrical, or psychiatric conditions. Full maternity coverage was offered by the prepaid alternative plans compared with very limited coverage for most of the basic Blue Cross and Blue Shield contract types.

The most significant departure from the traditional Blue Cross and Blue Shield benefit package is the coverage for almost unlimited ambulatory care. Physician office visits for illness or injuries, physical examinations, well-baby or well-child care, immunizations, injections, X-rays, laboratory tests, psychiatric care in an outpatient department of a hospital or community mental health center, and limited psychiatric care in a private psychiatrist's office were all covered. Prenatal and postnatal care were also included. Every effort was made to anticipate federal HMO benefit requirements. The emphasis was on preventive care and early disease detection health services, health maintenance, and out-of-hospital care.

The monthly premiums for all three plans were initially set for two years, assuming full operational levels with hospital days fixed at 500 per thousand members per year. After the first two years, premiums were to be recalculated based upon the actual experience and prospective budgets for each plan.

Competitors Give Aid

From 1973 to 1976, Group Health was marketed under very unusual circumstances, to say the least. Two other prepaid plans were offered, neither of which had originally been anticipated, in addition to Blue Cross Blue Shield. In essence, employees were offered not just "dual choice," but "quadruple choice." Since one of the plans has ceased operation, the primary competition for the two remaining prepaid plans is Blue Cross Blue Shield of the Rochester Area. Blue Cross Blue Shield provides health insurance for 80-85 percent of the 750,000 residents of Rochester and Monroe County, New York. The executives of Blue Cross Blue Shield and their boards of directors have been extremely supportive of the development of Group Health and actually provided, from reserve funds, the $3.2 million needed to construct the [illegible] Wilson Health Center—the primary delivery site rented by Group Health—and another $3 million in loans.

Evaluation of the performance of Group Health—or any other HMO—obviously involves much more than studying the impact of the HMO on inpatient utilization. However, during the first few years of an HMO's operation, the inpatient experience can have a dramatic impact upon costs and,

ultimately, the premium the HMO must charge. It is for this reason that the impact of Group Health upon inpatient hospital use will be discussed.

The statistics below have been taken from several recently prepared reports. The reports are of a highly technical nature, containing extensive detail about the performance of Group Health from its beginning in 1973. The basic comparison is between Group Health and Blue Cross, because the latter represents the community norm (and the primary competition). Nearly all persons enrolling in Group Health were formerly covered by Blue Cross.

From its beginning, statistical analysis of inpatient utilization revealed consistently lower rates for Group Health than for Blue Cross. Perhaps the most important differences were for medical and surgical days per 1,000. The combined medical/surgical days for Group Health were 47 percent lower than for Blue Cross. Admissions were 38 percent lower. The birth rate for Group Health was 24 births per 1,000 people per year—considerably higher than for Blue Cross; the obstetrical and nursery days were correspondingly higher. In spite of these high maternity-related rates, the overall rates for Group Health were still 29 percent below Blue Cross.

Reducing "Doubtful" Surgery

The lower hospital utilization rates for Group Health are consistent with the experience of many established prepaid group practice plans across the nation. The substantial reduction of surgical days and admissions is particularly significant since prepaid group practices can exercise the greatest control over hospitalization for surgical procedures. Prepaid group practices can reduce inpatient hospital surgery by reducing "doubtful" surgery through careful review of surgical referrals, by providing an alternative surgical site—the health center—and by changing the financial incentives for the physicians to emphasize alternate courses of treatment, where medically possible.

Group Health's age-adjusted medical/surgical rates were the lowest of the three prepaid plans and one-third below the Blue Cross experience of 1972 (the last full year before the prepaid plans were introduced).

The availability of its own center, as an alternative site for providing services otherwise provided in a hospital, may be a factor in controlling medical surgical hospital admissions and days. It seems that this centralized, comprehensive health center, part of an integrated system of health care, can play a significant role in controlling hospital utilization.

To describe differences in hospital utilization is relatively easy. To explain the findings is far more difficult. There is evidence that Group Health experienced some degree of favorable selection. Members were younger than those in Blue Cross and very likely healthier. Since inpatient rates of utilization are highly correlated with age, the utilization rates of Group Health were adjusted to compensate for these age differences. After this step, Group Health's medical-surgical rates are still substantially below those of Blue Cross. Age, then, does *not* appear to be the prime reason Group Health has rates of medical-surgical utilization below those of Blue Cross.

There is another possible explanation: Were persons who joined Group Health healthier than persons who remained in Blue Cross? Perhaps one of the most significant studies released to date addresses this very issue.

Using a different technique than earlier reports on the Rochester experience, the study involved following groups of people over a period of years.

In 1972, the medical-surgical admission rate for the Blue Cross subscribers was 72 (per 1,000 per year). The rate for this group varied only slightly

between 1972 and 1975. The same pattern was found for hospital days. For the Group Health sample, the 1972 admission rate and hospital days, age-adjusted, were significantly lower than for the Blue Cross sample. These results indicate that those joining Group Health had lower prior rate of hospital utilization—suggesting that possibly those who joined Group Health were healthier than those remaining in Blue Cross.

However, even if healthier, compared to 1972, those who joined Group Health experienced even lower rates of inpatient hospital utilization during 1974 and 1975. Both admissions and days declined substantially, while rates for the Blue Cross sample remained nearly the same.

For further information:

Mr. Richard P. Wersinger
Research Coordinator
Blue Cross/Blue Shield of the Rochester Area
41 Chestnut Street
Rochester, New York 14647
(716) 454-1700

Senator BAUCUS. Our next witness is Dr. Edward S. Hyman, founder, vice president, Private Doctors of America.

STATEMENT OF DR. EDWARD S. HYMAN, FOUNDER, VICE PRESIDENT, PRIVATE DOCTORS OF AMERICA

Dr. HYMAN. Thank you, Mr. Chairman.

I am Dr. Edward S. Hyman of New Orleans, a practicing physician and founder, vice president of Private Doctors of America. With me is Dr. José García Oller, the president and Dr. Wesley Segre, another founder, vice president.

Senators, in the past decade, the cost of medical care has risen less than the cost of living and less than other services in the Consumer Price Index. Of the cost of medical care, only the hospital component has risen slightly more than the cost of inflation.

As representatives of 42,000 privately practicing physicians who have attended the sick in hospitals before and since medicare, we must tell you that the Government itself is the major cause of the abnormal rise in the cost of hospitals.

S. 505 will fail to stem this rise because it does not deal with the fundamental problem of the hospital costs, the huge and expensive bureaucracy spawned by Federal regulations. By adding regulations, S. 505 will increase costs, and by reducing payments to hospitals, S. 505 will restrict and ration services to our patients, the American public.

Government run hospitals have always been more expensive than private hospitals. Before medicare the cost per patient stay in a community hospital in the United States rose 7.4 percent per year, but since medicare, with the introduction of government methods into private hospitals, the cost has risen 70 percent faster at 12.6 percent per year. The shaded area of our poster—between a continued 7.4 percent rise and the actual 12.6 rise is the cost of the Federal bureaucracy. This is the problem.

After 10 years of such a discrepancy, the mathematical difference is about 40 percent of the cost per stay.

On poster two, for those who are scientifically oriented, who would question whether there are actually two curves, a log plot of the compound interest data shows two distinct straight lines intersecting at 1966, the year the bureaucratic cancer entered our hospitals.

The practicing physician has absolutely no control over this government caused inflation in hospital costs.

Since medicare, every department within the hospital has become burdened with featherbedding, job descriptions, paperwork, redundant audits, new typewriters, typewriter jockeys, copying machines, et cetera.

This is what raised the cost of hospitals, and this is what appears on the patient's bill under such inappropriate items as "room charge," "laboratory charge," "pharmacy charge," "operating room charge," et cetera.

The cost of deadheads and paperwork is distributed throughout every department in the hospital and there is no item in the budget which describes this expense.

There is no item on the patient's bill which tells him that he has supported four to six employees during his stay. Most of the new

and expensive employees have nothing to do with the care of sick patients.

S. 505 will create more sick paper, will require more audits, will require more personnel to do more nonmedical tasks and will inevitably raise the cost. The actual thrust of S. 505 is to ration medical services to sick people.

Poster 3; although statewide cost control commissions have been lauded as successes, our review of the actual cost for a patient stay in the hospital clearly shows that hospitals in Massachusetts, New York, Maryland, and Connecticut, those States with cost control commissions for 5 or more years, are the most expensive in the country and their costs are rising more dollars per year than in the other States.

They are well above the national average, which is in red on the poster, and Massachusetts is about twice as expensive as Louisiana, Georgia, Kansas, and North Carolina. Hawaii, Wisconsin, and Minnesota are just below the national average. Highly industrialized Pennsylvania is only slightly above the national average without a cost control commission.

Any national cost control commission based upon the misrepresented successes of prototype statewide cost control commissions would also fail. This would add one more inflationary bureaucratic program to the growing list of failures such as PSRO's, HSA's, and HMO's, which themselves were based upon misrepresented successes.

More of the cause is not the cure. We need less bureaucracy not more. We must deregulate medical care and hospitals and we must excise the bureaucratic cancer. If the Government is alarmed by the inflation in the cost of hospitals, it should stop causing the inflation.

Thank you.

Dr. Garcia?

Dr. GARCIA. In the next 5 minutes, I would like to make a brief list of our recommendations as follows.

One, PSRO's are a failure. For 7 years, after the enactment of PSRO's, nine consecutive Government studies costing millions of dollars have shown that PSRO's are a failure and a waste of the taxpayers' money. We urge immediate repeal of PSRO to stop this abuse—in spite of HEW's last minute attempt to pump credibility into PSRO by selective statistics and by urging a selective 1 percent increase in rationing of services, as a substitute. We urge the committee to get back to the reasonable utilization review "Option Three" of their S. 1861K of medicare. As the Senate Finance Committee staff had reported and recommended years ago, "Option Three" should be made an equally available option within the regulations prior to 1974.

Two, we agree that HIBAC, in section 18, which endorses the PSRO, should be terminated.

Three, we agree with the courts that PSRO's are Federal agencies. They do have the authority to deny Federal payments for our patients and therefore must be open to public scrutiny.

We believe that the section to cloak PSRO's in secrecy should be eliminated. We are for confidentiality but not for those Federal agencies that deny payment for the sick.

Health service agencies and PSRO's are a failure as cost-effectiveness mechanisms. With the money saved in PSRO's, one can provide every hospital in this country a free CAT scanner. We can do that every year and increase life-saving advances' availability to our patients instead of to a select few.

We believe direct billing should be the proper orientation of your bill. A patient who is in a direct billing contract with the doctor gets personal, individualized attention. We believe hospital based physicians should be treated like all other doctors as consultants and should not be treated as hospital employees.

We specifically urge the committee to consider this important determination: Will you allow the doctors to directly bill the medicaid patient, the poor patient, the rural patient? We can directly bill them so we can treat them with dignity instead of as second-rate patients. That is the problem with nonparticipation of doctors. It is not the level of reimbursement, but it is the fact that we are required to accept Government money and Government regulations.

Relative value scales in our view are price fixing in their general effect and should be rejected.

We have another fundamental question of your Committee. It is true, is it not, that medicare premiums and Social Security payments by the taxpayers are uniform nationwide?

Should we not then have medicare payment also uniform instead of differing by State? Why should Massachusetts receive twice as much money as Louisiana, Kansas, Georgia, and Alabama, Wisconsin, et cetera?

PDA also recommends that Medicare benefits no longer cover all hospitalization but that it cover that amount that you, the Congress, believe is consistent with fiscal responsibility—but make it uniform throughout the country. We then have cost-containment. We control what the Congress is spending instead of making an open-end, cost-plus reasonable and customary payment.

The Federal court injunction with which we, PDA, have stopped the disclosure of medicare lists by Secretary Califano of physicians, dentists and surgeons with the amount of money paid, agrees with your section to prohibit the Secretary from disclosure of these lists with faulty data.

Dr. HYMAN. Mr. Chairman, we would ask that our full statement be inserted into the record.

Senator BAUCUS. Your full statement will be inserted into the record.

Senator Dole?

Senator DOLE. I do not believe I have any questions. Do you have any preference? Sometimes you have to take one dose or another of medicine. Which do you like the best, S. 505 or S. 570?

Dr. GARCIA. There is no question that we oppose the Administration bill whole heartedly because if one places medical care in a closed box, hospital care in a closed box with any kind of ceiling, the bureaucracy is going to swallow and smother the medical care. Everywhere in the world where there is government payment and there is a fixed level of payment, the bureaucracy goes out escalating with more typewriters, more computers, more audits; and multiplying job descriptions and featherbedding so that we cannot have

the nurse take care of the patient because they are taking care of the sick paper.

Our choice is we are certainly against the hospital cap. We do commend the committee for these hearings and all of your very careful attempts to study this.

Our effort is at the fundamentals. We know as we visit hospitals, we have deadheads upon deadheads lining our walls like some sort of a Federal hiring hall.

As soon as the government issues a new regulation, the job descriptions multiply and we have more deadheads per bed. We are trying to impress this committee that the cost of hospitalization is due to this law, what we call our PDA law, "The ratio of deadheads per patient bed."

One can close 100 beds in a 200 bed hospital. Secretary Califano says we have too many empty beds, let's close them. But, if we do not get rid of the payroll and the deadheads and these regulations, the same exact dollar amount is going to be expended.

This is what is ridiculous to us, to say, let's close hospital beds, let's cut routine admission costs. Senator, that is nothing compared with the huge expanding payroll.

As the gentlemen from the AFL-CIO were saying, it is not the increase of the salary of the employee that we are worrying about, it is the number of employees.

I would say if the administration puts a cap or if we put too much pressure on the industry, we will be witnessing a tragedy in hospitals, the reduplication of deadheads like a cancer. So we are suggesting that you put a true cap, pay them so much and do not try to pay for everything.

Medicare pays for 90 days but really the PSRO cuts it down to 7 days. It is deceptive, done with mirrors.

We are saying let's stop playing around with dollars and have the Congress say, "this amount" is fiscally responsible. We are going to spend $20 billion in medicare this year and this is the amounts available. We will make no judgments of what is proper or improper and stop this charade of medical necessity.

Let's say this is what the Nation can afford under the concept of fiscal responsibility. Then we will have competition among the expensive hospitals with the ones that use that money best, as they do in our Southern and Central States.

Thank you.

Senator DOLE. I do not quarrel with your statement. I believe there are other choices that we should consider. I think sooner or later we are going to be voting on one of the other or some blend of the two.

My question was if you had to vote, would you vote on one or the other or just be absent?

Dr. GARCIA. The lesser of two evils is certainly the good Senators' bill. We are suggesting that you seriously consider discontinuing these deadhead organizations like PSRO's and HSA's that are spending billions.

Senator DOLE. There are deadheads everywhere.

Dr. GARCIA. Correct.

Dr. HYMAN. Senator, you are asking the question whether the antidote for arsenic is better than that for lead. If you have these

fixed costs, if you deny laboratory tests, that is only one source of revenue for the hospital that the administrator is going to have to assign somewhere else. It has happened in Maryland and these other wonderful States where they did it with mirrors and came out with higher costs. They did not have any success.

If you keep patients out of the hospital, then the cost for the individual patient must go up to pay, again, those fixed costs. You are not going to touch the problem because the fixed costs have gone up 70 percent faster than they went up before medicare.

We have photographed these for you in our formal testimony.

Senator DOLE. Do you have medicare and medicaid patients?

Dr. HYMAN. Yes, sir. I have several in the hospital right now.

Dr. GARCIA. Senator, we have been in practice for about 30 years. We treat every patient that comes to our front door.

Dr. HYMAN. We have seen these changes in hospitals. We have photographed it for you. These persons do not perform any useful tasks. Actually, they get in the way of useful medical care. They are required. They are required by audits. They are required by a new regulation concerning pharmacies, and a new regulation concerning the billing.

The entry for this does not appear on any patient's bill. When U.S. News talked about the emergency room charge, they are really talking about the overhead which has been arbitrarily assigned to the emergency room.

Senator DOLE. We have GAO looking at that problem and they are supposed to report this summer so hopefully some of these things you suggest will be covered.

Dr. HYMAN. The vicarious experts have been through hospitals and expressed their opinions, and it is astounding. We suggest some physician input would be valuable to know which is helpful and which is a mess.

Senator DOLE. Thank you.

Dr. GARCIA. I have one suggestion that will take a second. There are many questions on how can we increase the level of cost consciousness among physicians? I would like to suggest if *a.* copy of the hospital bill for each patient be sent to the attending physician, that is one way to raise the cost consciousness.

Senator DOLE. The problem is the patient does not care because they do not pay the bill.

Dr. GARCIA. I was just saying if the doctor gets to see the patient's bill as he sends that patient home, I think this level of cost consciousness will increase.

Most private doctors, Mr. Chairman, are very conscious of costs of what we prescribe each day because they are our private patients. The problem is that very often interns and residents and educational institutions, because of their interest in education and research, do order batteries of tests. The problem is this approach to batteries of diagnostic tests.

That does not equally exist in the private sector because most of us, when we order a CAT scan, we have to find out whether that patient can pay for it.

Dr. HYMAN. Senator, there is yet one other aspect. Medicare and medicaid do not actually pay their own way. Our private patients, who are not medicare and not medicaid, must pay the remainder of

the Government sponsored patient. Those patients will bring that bill into our office and ask why an electrocardigraph in the emergency room costs three times as much as it does in your office.

When you bring the report of the staff of the Finance Committee to the hospital administrator, he looks at one section of your proposed changes and says: "There is no way we can perform those services at only twice the cost of the doctor's office. Think of our overhead." He is talking about that group of AFL-CIO workers in the hallway, sitting there having coffee.

Senator BAUCUS. Thank you, Doctors.

[The prepared statements of the preceding panel follow:]

STATEMENT OF PRIVATE DOCTORS OF AMERICA

SUMMARY

In 10 years: CPI Rose 100.9%, Medical Care Rose 89%

In the past decade the cost of medical care has risen less (89%) than the cost of living (100.9%), and less than other services in the Index. Of the cost of medical care, only the hospital component has risen slightly more than the present cost of inflation (11.8 to 12.7%).

Sec. 32: The Federal Bureaucratic Cancer in our Hospitals

As privately practicing physicians who have attended the sick in hospitals before and since Medicare we testify that the government itself is the major cause of the abnormal rise in the cost of hospitals. S. 505 will fail to stem the rise because it does not deal with the fundamental problem of hospital costs, the huge and expensive bureaucracy spawned by Federal Regulations. By adding bureaucracy S. 505 will increase costs, and by reducing payment to hospitals it will restrict and ration services to our patients, the American Public.

Pre-Medicare 7.4% per year, Post-Medicare 12.8% per year

Government run hospitals have always been more expensive than private hospitals. Before Medicare the cost per patient stay in a community hospital rose 7.41% per year, but since Medicare, with the introduction of government methods into private hospitals, the cost has risen 70% faster, at 12.6% per year. This is the problem. After 10 years of such a discrepancy the difference is about 40% of the cost-per-stay. The practicing physician has absolutely no control over this government caused inflation of hospital costs.

Featherbedding in Medicare

Since Medicare, every department within the hospital has been burdened with featherbedding, job descriptions, paperwork, reduntant audits, new typewriters, typewriter jockeys, copying machines, etc. This is what has raised the cost of hospitals, and this is what appears on the patient's bill under such inappropriate items as "room charge", "laboratory charge", "pharmacy charge", "operating room charge", "emergency room charge", etc. The cost of deadheads and paperwork is distributed throughout every department in the hospital; and there is no item in the budget which describes this expense. Also there is no item on the patient's bill which tells him that he has supported 4 to 6 employees during his stay. Most of the new and expensive employees have nothing to do with the actual care of the sick patients. S. 505 will create more sick paper, will require more audits, will require more personnel to do more non-medical tasks, and will inevitably increase the cost. The actual thrust of S. 505 is to ration medical services to sick people.

Sec. 2(c): Hospital Cost Control or Rate Review Commissions (RRC) Have Not Lowered Costs

Although statewide cost-control-commissions have been lauded as successes, our review of the actual costs for a patient-stay in the hospital clearly shows that hospitals in Massachusetts, New York, Maryland, and Connecticut, those states with cost-control-commissions for five or mmore years, are the most expensive in the country, and their costs are rising more dollars-per-year than in other states. They are well above the national average, and Massachusetts is about twice as expensive as Louisiana, Georgia, Kansas, and North Carolina. Hawaii, Minnesota, and Wisconsin are just below the national average.

Any national Cost Control Commission based upon the misrepresented successes of prototype statewide Cost Control Commissions would also fail. This would add one more inflationary bureaucratic program to

the growing list of failures (e.g. PSRO, HSA, HMO, etc.) which themselves were based upon misrepresented successes.

HEW's Fraud Leads to PSRO's

Born of HEW's Certification Fraud, of further deceit, of cover-up, and of the failure of its prototypes, PSRO's have failed. S. 505 would assign further functions to PSRO's which would increase their failure. We agree with Section 18 that HIBAC (which endorsed the fraud) should be terminated.

Sec. 28: PSRO Cover-up – The Confidentiality Veil

We agree with the courts that PSRO's are Federal agencies with the authority to deny Federal payment for services, and therefore must be open to public scrutiny. Section 28, designed to clock PSRO's in secrecy, should be eliminated. Seven years after the enactment of PSRO's, nine government studies costing millions of dollars have shown that PSRO is a failure and a waste of taxpayer's money. We urge immediate repeal of PSRO to stop this abuse. We abhor HEW's last minute attempt to pump credibility into PSRO by selective statistics and by urging a 1% increase in rationing of services.

CAT Scanners: Every Hospital Should Have One

Health Service Agencies (HSA's) are charged with the responsibility of rationing equipment such as CAT Scanners, but it would be cheaper to allow reduplication of equipment than fund the HSA's. The cancerous growth of these non-medical bureaucracies have unnecessarily inflated health care costs and impaired medical care. The cost of fully implemented PSRO's could buy a CAT Scanner for every hospital in America in one year, and could make that very important lifesaving advance available to every American citizen, and not to only a selected few.

Sec. 5 & 6: Direct Billing Preserves Good Medical Care

We urge the Committee to delete Sections 5 and 6, and to reorient its attitude in favor of direct billing, because direct billing encourages doctors to provide personal and individual attention to the patient who pays the bill instead of looking to the government for payment. Our recommendations extend to "hospital-associated physicians" since they too should be encouraged to direct bill. They should perform personalized services as true consultants, and not as "hospital employees" with nameless, faceless patients. Medicaid should also provide the option for Direct Billing. Direct billing physicians should not be required to use government forms for private medical care.

Sec. 7: Relative Value Schedules

Relative Value schedules are pricefixing and should be rejected.

Sec. 10(4)(e): Uniform Benefits Nationwide

Medicare payments differ by state. Medicare premiums and Social Security payments by taxpayers, however, are uniform nationwide. PDA recommends that Medicare "Benefits" also be made uniform nationwide to terminate this inequity.

Sec. 23: Disclosure of Payments to Doctors

The Federal court injunction obtained by PDA has stopped "disclosure" of Medicare and Medicaid payments to physicians, dentists and oral surgeons. We urge adoption of Section 23, to prohibit nationwide Secretary Califano (or his successors) from further needless injury of professional reputations by willful use of faulty data to defame individuals and the profession in general.

Conclusions

More of the cause is not the cure. We need less bureaucracy, not more. If we are to effect true cost containment, S505 should be rewritten towards a deregulation of medical care and of hospitals, and towards the excision of the bureaucratic cancer. If the Government is alarmed by the inflation in cost of hospitals, it should stop causing the inflation.

* * *

TESTIMONY BY PRIVATE DOCTORS OF AMERICA ON S. 505
THE MEDICARE-MEDICAID ADMINISTRATIVE REFORM ACT OF 1979
AND ON HOSPITAL COST CONTAINMENT ALTERNATIVES TO THE
HEARINGS OF THE SUBCOMMITTEE ON HEALTH OF THE SENATE FINANCE COMMITTEE
WEDNESDAY, MARCH 14, 1979

Mr. Chairman and Members of the Subcommittee:

I am Dr. Edward S. Hyman, Vice President of Private Doctors of America. With me is Dr. José García Oller, President of PDA. We testify in behalf of Private Doctors of America, the nation's largest association representing only privately practicing doctors. PDA was founded in 1968 as the Council of Medical Staffs, and our current voting membership is 43,000 doctors (Appendix D) in 49 states, Puerto Rico and the Virgin Islands. I have been a privately practicing specialist in Internal Medicine for 25 years. Dr. García Oller has practiced neurosurgery in Louisiana for 29 years. Also with us is Dr. Wesley Segre, Vice President, a practicing pediatrician for 40 years and past-president of the Louisiana Medical Society, the black physicians in Louisiana.

It is necessary that public policy in the field of medical care be responsive to the needs of our patients, the American public. It is they who will suffer any denials or limitations of services by HSAs, or the rationing of medical care by PSROs, and it is they who bear the cost of the huge bureaucracy that is strangling our hospitals under Medicare and Medicaid. That is why we are presenting this testimony.

CPI 10 yrs. — 100%. Medical Care — 89%

In his remarks to the Senate on March 1, 1979, introducing the proposed S. 505, the Medicare and Medicaid Administration and Reimbursement Reform Act of 1979, Senator Talmadge noted the explosive rise in the cost of Medicare and Medicaid to be from $37 billion for fiscal 1977 to $44 billion in fiscal 1978 to a projected $55 billion in fiscal 1980. Thus the rise in fiscal 1978 was 12.8%, and the projected rise for the following two years would be 11.8% per year. The projected rise is thus only slightly above the current rate of inflation, which for January 1979 was 11.4% (Figure A). Moreover it is nearly the same as the 11.6% per year rise in personal income over the past three years (The Wall Street Journal, February 9, 1979) (Figure B). During the past ten years the consumer price index has risen slightly over 100% for all goods and services, but only 89% for medical care. Although this rise in the cost of health care trailed costs in general, it also included the cost of hospitals and of Federal health programs. This means that other elements within health care have risen even less.

We view the content of S. 505 largely as a matter of readjustment or fine tuning to redirect the disbursement programs in Titles 18 and 19 of the Social Security Act in the hope of gaining for the government a less inefficient expenditure of Federal health dollars. It is another patch-up of the administration of the delivery of medical care that has been made worse by government intervention and previous patch-ups. But what would be less payout by the government is less income for hospitals, a clear restriction or rationing of pay for a system which has been seriously

burdened both financially and operationally by the previous Federal "remedies". Thus the net effect for any proposed federal saving will be the constriction of services while adding yet more commissions and further administrative overkill which will cause further aggravation of the shortages in the care of the sick. Recognition of this problem,
Sec. 32 along with an attempt in theory to correct it, is made in Section 32 of S. 505 under the title "Coordinated Audits under the Social Security Act". In that Section, the Bill recognizes that the audits which have plagued all hospitals are redundant. We are encouraged that government has recognized the problem but we are hardly encouraged by the proposed
Sec. 1134 cure called "coordinated audits" in Section 1134. Upon witnessing twelve years of progressive Federal intervention into hospitals, we anticipate that coordinated audits will result in the same audits plus a superimposed audit to coordinate them. That is the nature of the autonomous, ever-expanding bureaucracy, a bureaucracy spawned by the government, a bureaucracy which is indeed the cause of our problems.

Senators: as privately practicing physicians who have attended sick people in and out of hospitals, both before and after Medicare and Medicaid, we are obliged to testify that the government itself is the major cause of the rise in costs of medical care, and in particular the government is the cause of the abnormal rise in costs of hospitals.

CPI for Medical Care Misrepresented

Figure 1 is the popular graph of the Consumer Price Index (CPI) for the decade 1959 to 1969. The public has been told and retold by a non-inquiring press that physicians' fees and the cost of all medical care have risen twice as fast as the CPI. This graph originated with the United Auto Workers' Committee for National Health Insurance (CNHI). They wittingly omitted the cost of other services (the plumber, the repairman, the lawyer, etc.) which rose identically with the rise in physicians' services and the rise in medical care services. Thus the uninquisitive press has perpetuated this miscomparison and has fostered the goals of the CNHI. In that same graph you will notice the striking rise in the hospital per diem. This curve was obviously introduced to startle the reader without advising him that the hospital per diem is one component of "all medical care". Since it is high, other components of medical care services must have risen less than "all services" in order that "all medical care" service would equal other services. Since hospital cost is certainly that component which has risen the most, since it is a major component of health care costs, and since it is the subject of S. 505 as well as of Senator Kennedy's cost-containment bill in the last Congress and a similar bill in this Congress, we would like to bring to this Committee a view of the changes in hospitals as seen in the front lines, so that you may consider what changes the government has caused rather than limit your deliberations to administrative overviews and to day-to-day cures of the problems created by yesterdays' cures. In this way we would like to reorient you to the nature of the problem itself. But first note that the hospital per diem rose even more rapidly after 1966, the year the government entered the hospitals.

Pre-Medicare 7.4% per yr.; Post-Medicare 12.6%

I have plotted (Figure C) not the hospital per diem, but a more im-

portant number, the cost for a patient stay in the hospital. This is the bill that the patient pays. The data in this graph are derived from the Guide Issue of the American Hospital Association. The curves are fitted by a statistical least-squares-best-fit on an electronic calculator. The coefficient of correlation of each curve is about 0.95. Here again there is a distinct break in the curvature at 1966 when the government methods entered our hospitals. Between 1946 and 1966 the cost for a patient stay rose 7.41% per year. Between 1966 and the present, the cost per stay has risen 70% faster, at a rate of 12.6% per year. This is the problem. For those who are scientifically oriented and realize that it is difficult for the mind's eye to be sure of a change in the curvature of a curve, I have replotted that same data as the logarithm of the cost per stay vs. the year, because a compound interest rise in such a plot will result in a straight line. Thus (Figure D) there are two unequivocal straight lines intersecting at the year 1966, the year the bureaucratic cancer virus infected the hospitals. As clearly shown in this graph, the annual Federal legislative patch-up remedies enacted have been ineffective against the bureaucratic cancer virus. The difference between a continued 7.41% rise per year and the realized 12.6% rise per year, the shaded area in the Figure, is the cost of the bureaucracy. Mathematically, after eleven years, that difference in the rate of rise alone would account for 40% of the total cost of a patient stay in the hospital. That estimate may be compared to a recent estimate in the State of New York which assigned 25% of the cost of the hospital stay to added regulations. In spite of the well managed propaganda, the physicians have no control over this escalation of cost. These regulations begin with Congress, and this Committee has the power to reverse the regulations and reverse the escalation.

Hospital Rate Review or Cost Control Commissions (RRC) Have Not Lowered Costs

We have been told that there is a cure for the escalation of hospital costs thru Hospital Rate Review Commissions which began in 1972. Their
Sec. 2(c) "successes" have been widely touted by Aetna, by The Travelers, and by the Health Insurance Association of America, as well as by the Rate Review Commissions themselves (Figure E). To assess the effect of such Commissions, the cost per patient stay was plotted (Figure F) by States.

Massachusetts, New York, Maryland and Connecticut, those states which have had Rate Review Commissions since 1972, not only have the highest cost per patient stay, but also the highest dollar rise in the cost per patient stay. Yet, by careful wording, these RRC states are reporting "successes" in cost containment in the face of such failures!

The State of Pennsylvania is included because it is a highly industrialized and unionized state, and it did not have a Rate Review Comission. Yet, in Pennsylvania the cost per patient stay and the dollar rise in the cost per stay have been less than the States with the Rate Review Commissions.

The cost for a patient to go to the hospital in the States of Louisiana, Wyoming, North Carolina, Georgia, Kansas, Hawaii, Wisconsin, Minnesota

and many others has remained well below the national average without a Rate Review Commission and without a federal grant of taxpayers' money to create the deadhead bureaucracy of that Commission.

Because hospitalization is twice as expensive in Massachusetts, a 12% rise in costs for Massachusetts is the dollar equivalent of a 24% rise in Louisiana, Georgia, Kansas and others states. Thus if hospitals in all states are allowed the same percent rise, a hospital in Massachusetts will be able to buy twice as much equipment, or increase salaries twice as much as a hospital in a more frugal state.

Rate Review Commissions claim to have controlled the room rate and other specific charges of hospitals, but not all the charges, nor the total cost. Hospital administrators in the Rate Review states were obliged to meet their financial obligations by raising the cost of goods or services that were not controlled, or by inventing new services. Thus, as noted in the Connecticut Commission Report, (Figure G) (kindly supplied us by The Travelers) that Commission was surprised to find that the total cost of hospitalization had gone up 15.8% in 1975 instead of the projected 8.3%. A similar discrepancy appeared in 1976. The national average rise is 12.6% per year.

This is like the hypothetical Federal Automobile Rate Control Experiment (FARCE) which demanded that the sticker price of a Chrevolet increase no more than 5%, but which allowed General Motors to make the steering wheel an option at an extra cost. That FARCE also obtained cost containment at a higher price.

Aetna and The Travelers and the HIAA have spent millions of dollars of the shareholders' money advertising the misinformation that statewide Rate Review Commissions lower hospital costs. We do not know why they have done so, but the Indiana Hospital Association has suggested that private insurance companies are using the RRC as a device to offset the Blue Cross discount from hospitals, a discount which private insurers consider an unfair market practice (Figure H).

PDA and the CMS-ESR Foundation will refer the apparent false advertising by these insurors to the FTC with a plea for corrective advertising. We hope that the Congress does not act on the false and misleading claims of the bureaucracy of State Rate Review Commissions.

A national Rate Review Commission would not only fail, but would also cause further escalation of hospital costs. We suggest that Section 1127 "HFCC" would easily become the National RRC, and we therefore recommend that this precancerous lesion be excised as preventive fiscal medicine.

The Federal Bureaucratic Cancer in our Hospitals

In spite of the information repeated in the popular press, hospitalization in the government's "System" of hospitals is much more expensive than in the private, so called "Non-System" of hospitals. As an example, before Medicare, the cost of hospitalization in U.S. Veteran's Administration Hospitals was more than three times as high as in a private hospital (Figure 2). Public Health Hospitals were about the same price (Figure 3).

Not only does it have a much higher cost per stay, but the U.S. Public Health Hospital in New Orleans has been unable to keep up with the times, as shown in the photograph (Figure 4).

That hospital would not qualify for Medicare because there are more than four in a room. That hospital could not pass inspection by the New Orleans Fire Department. It is not air-conditioned, but every less expensive private hospital in our deep-South city is air-conditioned. When we visited it was nearly empty. Of the 363 patients in the hospital log book, there were only about 50 warm bodies on the wards. Six out of seven patients were not there. Some lived as far away as 1,000 miles. They lent their names to the hospital log. They required no food, no medicines, no linens, no nursing, and no other service. One out of seven patients was there. Thus, the two employees per patient touted by the AFL-CIO's spokesman in New Orleans was fourteen employees per patient who actually lived there. Perhaps that is why they had enough personnel to wash disposable syringes during our visit. Like any Federal Hospital, the floors were highly polished (Figure 4), as if no one walked on them.

In spite of being more expensive for a patient stay, these government hospitals, like those in England, or Russia (Figure 5) are not capable of using their large revenues for change; for updating; for installing modern plumbing and air-conditioning; or even for partitioning wards into rooms. This is the picture of a mature or overripe "system of hospitals" full of government methodology.

Now, as HEW imposes the methodology of a government hospital onto a private hospital, we may expect the cost of the private hospital to rise and to approach that of a government hospital, and the quality of care in the private hospital to decay to that of a governemnt hospital. This is the real explanation of the abnormal rise in cost of our private hospitals. Let us witness the change.

Medicare Featherbedding

The abnormal rise in the cost of private hospitals began with the feather-bedding of personnel and the extra accounting required by Medicare. A hospital which has 12 technicians in the Biochemistry Laboratory to serve sick patients, now has another 12 in the Personnel Office (Figure 6) and 27 more employees in the catacombs of this Medicare Office (Figure 7) to serve sick paper. Each is paid a salary by the hospital using patient revenues. Hospitals now have superfluous personnel at desks (Figure 8) and in the hallways. Healthy young nurses (Figure 9) are taught to sit at a desk and fill out pages of useless paper to expand a chart at the demand of some government agency, or some government-controlled agency such as the Joint Commission on Accreditation of Hospitals. Large amounts of physicians' time once devoted to patient care and to scientific medicine, is now necessarily devoted to pointless committees, reviews and meetings to discuss federal regulations which threaten to engulf all medical care.

This costs the patient money, and this interferes with good medical care. While the nurse treats sick paper, an untrained aide attends the sick patient. There are nursing plans and nursing audits which will never be used. But, when the nurse becomes insulated from the patient

by untrained assistants, patient care deteriorates. Instead of an old-fashioned, interested nurse, there is a "patient representative (Figure 10). One half of the rack (Figure 11) for patient's charts is now devoted to a file for rules and regulations. With Medicare, accountants have proliferated. Unplanned administrative cubicles had to be built in the lobby of a hospital recently built (Figure 12).

A small hospital where all the doctors and one administrator once parked under the oak tree now has four parking lots and they are all full, even when the hospital census is low. The versatile employee who knew what to do was replaced by several untrained employees, each with a job description to limit any potential versatility or usefulness. Then, as problems arose between two job descriptions, another job description was created. The hospital became a "hiring hall". Clearly, these expenses are also not controlled by the doctors' orders as has been claimed by labor and by HEW.

A Pharmacist for each Pill

Then at the urging of the vicarious experts of the health-care-cult (whose principal temple is in Washington) there as been a proliferation of pharmacists in the hospital pharmacy. These extra pharmacists are classifying drugs, and are writing rules and regulations to create and to solve problems so aptly described in televised hearings of another Senate Subcommittee. But, as the number of registered pharmacists increases, the availability of an urgently needed drug in a ward 100 yards away is further delayed because of the extra accounting necessary and because that drug must now be delivered by the "courier service". In the meantime, these registered pharmacists are paid to create "therapeutic notes" for physicians, a useless task for which they have never been trained. Some of their information is blatantly contradictory to the facts of science as shown (Figure I). In this bulletin the expert in the pharmacy advises physicians that a vial of sodium phosphate contains 20 milliequivalents of sodium and 30 milliequivalents of phosphate in every milliliter. Since the count in milliequivalents is literally a count of electrical charges, his expertise has erroneously proclaimed that for every 20 positive charges there are 30 negative ones. Such a vial would send a bolt of lightning to the nearest water pipe!

We used to call these extra employees "deadheads on the payroll". Now you, the Senate, are considering limiting medical care by regulations which would require more deadheads to oversee your present deadheads. This process is recommended by the National Association of Professional Bureaucratics.

To compound this tragedy, a study was done in San Francisco and perhaps elsewhere, to determine the benefits of a "satellite pharmacy", a small pharmacy which would serve as a "drug warehouse" for only one hospital. Here in this photograph (SLIDE) the hospital hired two more registered pharmacists for that ward. Whereas before Medicare a nurse responsible for a patient would take a pill from a bottle and would hand that pill to a patient with a glass of water, now we have an "improved system". One of these two pharmacists takes a single pill from a patient's bin in the satellite pharmacy, and delivers that pill to the top end of a chain

of persons on that ward. The pharmacist repeats this walk three or four times a day for each medicine that is prescribed. Hopefully at the bottom end of the chain the patient will receive each pill. In this system it is inconceivable that four persons doing the work of one will cost less. In actual practice the number of errors in giving pills goes up and not down. But more horrible, it may take an extra day for a new medication to reach the patient. Unfortunately, I can find no recorded success of the San Francisco pilot program in "satellite pharmacies".

You are told that new medical equipment like this heart monitor (Figure 16) is so expensive that it makes hospitalization expensive. But, an IBM typewriter costs as much as a heart monitor, and the typewriter service contract costs more, and there are many more new typewriters than heart monitors, and each typewriter is equipped with a jockey. You are also told that "expensive and unnecessary heart surgery units lay unused and increase costs". But, the decried open heart surgery units exist in less than 10% of all hospitals, and all hospitals are suffering nearly alike from the escalating costs of bureaucracy. Obviously, these heart surgery units are only a small part of the problem. Further PDA comment on heart surgery units by Dr. Charles Pearce, and the PDA policy Book on HSAs, is provided to the Subcommittee for the written record.

In the extensively itemized hospital bills, widely advertised in the popular press, there is no entry for these deadheads. Their costs inflate every item in the hospital bill.

A hospital pharmacy buys a pill for ten cents and charges one dollar for it. The ninety cent markup is necessary to pay the deadhead and the new typewriter jockeys imposed by HEW throught the hospital. Won't you in this room join with us to lower the cost of that drug by getting rid of the deadhead and the typewriter jockeys, and not by cheapening the drugs or by cheapening the medical care?

Shortening Stays, Closing Beds Does Not Save Costs

The cost of the bureaucracy, of the paper, and of the deadheads is a fixed hospital cost, to be divided by the patient days. Shortening a patient's stay will reduce the patient-days, and will thereby increase the per diem cost. There is no saving. Keeping patients out of the hospital reduces the number of patients who will pay for these fixed costs, and the cost per patient-stay will rise. Again, there is no saving. Thus, shortening of hospitals stays, of weekend stays, or of pre-surgical hospital stays cited in your published "alternative" (Press Release 104 of March 1, 1979), and Sec.3 of the Bill, while maintaining the bureaucracy, will simply increase the per diem. No savings will be had without reducing the bureaucracy. Therefore we must challenge the estimates by the Staff of the Finance Committee of savings of hundreds of millions of dollars by the suggested "alternative number 7".

Cost-Control alternative 7

Sec. 3

From 1 to 67 Audits a Year

In 1969, when the three doctors in Hinesville, Georgia noted that the business office of their 17 patient hospital had expanded from two to eleven persons since Medicare, that the cost of pharmacy had soared, and

that the flood of paperwork and audits had raised hospital costs 20% in three years of Medicare, they asked HEW to turn back the clock, to reduce the featherbedding, and to cut the cost (Figures 13 & 14). Federal, state and insurance audits had increased from one a year to 57 audits a year!

Of course, HEW said, "No" (Figure 15): "Audits, as you know, are important management tools we need in order to meet our responsibility to the public we serve". This is signed by the Chief of the Program Experimentation Branch, of the Division of Special Operations, of the Bureau of Health Insurance, of the Social Security Administration, of the HEW. What a pedigree! This letter raises the question as to whether HEW is actually interested in lowering hospital costs.

Note that no "open heart surgery" is done in that hospital. The expenses soared not because of expensive technology, but because 57 audits had diverted all personnel away from patient care.

Length-of-Stay Reviews Not Cost Effective

PDA is grateful to Dr. Charles McSherry who found in his New York-Cornell Hospital that the Utilization Review Committee, designed by the bureaucracy to save costs by reducing hospital stays, had only discovered six patients overstays per 9,500 charts reviewed for the 30,000 admissions in a year; and that it cost $34,212 per patient identified by the Utilization Review process. He projected the nationwide cost of the failure of Bureaucratic Utilization Review that year to exceed the research budget of any one of the National Institutes of Health as follows:

UTILIZATION REVIEW COSTS vs. NIH RESEARCH FUNDS

Utilization Review (McSherry)	$356 million
National Cancer Institute	$222 "
N.I. Alcohol, Drug Abuse, Mental Health	$189 "
National Heart & Lung Institute	$179 "
N.I. Arthritis, Metabolism & Digestive	$117 "
N.I. General Medical Sciences	$113 "

Fraud Leads to PSRO

In 1969, when the "featherbedding" of hospitals had already exhausted the Medicare money, the heads of Social Security wittingly misrepresented data in a fraudulent press release, and told the press that doctors had overutilized hospital stays.

This fraud was endorsed and re-endorsed by the Health Insurance Benefits Advisory Council (HIBAC) over a period of three years. We support Sec.18 of your bill for termination of HIBAC. It serves no useful purpose. But this sequence of fraud and coverups by HIBAC and by the Social Security Medicare Bureau of the Department of HEW, resulted in a euphemism called Professional Standards Review, or PSRO. In brief, a PSRO is but another set of catacombs housing a bureaucratic office, full of deadheads and typewriters, reviewing more paper (Figure 17). The very same paper has already been reviewed in the catacombs I showed you in the hospital, and will again be reviewed at the desk of the Blue

Cross (Figure 18). PSRO is currently a $148 million failure, born of fraud and nurtured by deceit. Rather than adorn PSRO with additional patches, duties, or authority, PSRO should be abolished as a bad mistake.

Sec. 28: PSRO Coverup – Confidentiality Veil

Sec. 28

No coverups should be tolerated. PSROs are government agencies making final decisions as to billions of federal dollars. They should not be provided with a cover of confidentiality or immunity against suits. If they deny care to patients, PSROs should be responsible in the Courts. Otherwise, PSROs will become witch-hunts. We believe that true Peer Review in hospitals by private doctors should be confidential and not related to hospital payment or government control. PSRO is not peer review, but fiscal review by government-agent doctors. PSRO is a gross invasion of privacy, but government agents must operate without secrecy. Already PSROs are denying the availability of a list of their own membership although they are government-paid employees. The HEW PSRO office is sponsoring this secrecy of lists of PSRO government employees under the ruse that they are "private contract Foundations"!

We urge that Section 28 be eliminated. Seven years after the PSRO law has been enacted, 10 exhaustive multimillion-dollar government studies have established PSRO as a failure and a waste of taxpayers funds. This Senate Finance Subcommittee should move to repeal PSRO (Title XI, Section 249F; P.L. 92-603) and stop waste and abuse of taxpayers funds, in spite of HEW's last minute attempt to save credibility by selective statistics and warnings to PSRO's to become cost effective by increasing denials.

CAT Scanners: Every Hospital Can Now Afford One

The most important advance in X-Ray studies in at least 30 years is the Computerized Axial Tomography, the CAT scanner. The apparatus initially was very expensive, but like all other computers, the cost for a fixed-state-of-the-art scanner is falling radically, from $500,000 to $85,000 (see PDA "HSA" Policy Book). Rationing of CAT Scanners has been assigned to another deadhead bureaucracy called Health Systems Agencies (HSA's).

But, by any reasonable estimate, the additional money to be spent on fully implemented PSROs in one year would buy a CAT scanner for every private hospital in America. Let's not deny our patients the wonderful advances such as the CAT Scanner, which would shorten hospital stays and help sick people (New York Times, 3/4/79) (Figure J). Let's reduce the cost by getting rid of deadheads, and sick paper, the PSROs and the HSAs and then let every hospital in the nation provide this life-saving CAT scanner service.

Sec. 5: Assignment will Decrease Doctor Participation

Sec. 5

Under Section 5 of the bill, doctors are urged to become "participating physicians" by accepting "assignment", i.e, payment by the government to the doctor, not to the patient. A $1.00 per claim "cost-saving allowance" is used as inducement for the doctor.

The basic reason doctors do participate in Medicare but shun Medicaid

is not income - "60 Minutes" has documented large incomes in Medicaid - but the forced assignment required by Medicaid. Assignment makes a doctor a de facto employee of government, subject to numerous restrictive regulations. The move to assignment of bills, "bulk billing", "patient lists" provided in this bill tracks the British socialized medicine system of capitation lists, and will have the same sad results.

We urge the Committee to delete Section 5 and to reorient its attitude in favor of direct billing, which encourages doctors to provide personal individual attention to patients who pay the bills themselves, instead of looking to government payment.

Sec. 6

Sec. 6 Our recommendations extend also to any part of your bill relating to "hospital-associated physicians", since they too should be encouraged to bill directly and perform more personalized services as true consultants, instead of as hospital "employees" with nameless, faceless patients.

Sec. 7: Relative Value Schedules are Price Fixing

Sec. 7 Relative value schedules may be regarded as a form of price fixing, and should be rejected.

Sec. 10(4)(E): Benefits Uniform, Nationwide

Sec. 10(4)(E) We see no reason why Medicare payments should continue to differ by State. Medicare premiums and Social Security payments by taxpayers are uniform nationwide. PDA recommends that all Social Security Medicare "Benefits" payments also be uniform nationwide, for similar services.

Sec. 21: Regional Pediatric Pulmonary Centers

Sec. 21 PDA deplores the government bias towards regionalization of medical care. Better care and less costly care is usually rendered close to where patients, their families and their work reside. The enormous cost to patients and families of dislocation to "centers" has been disregarded. The "$5 million" initial grant for teaching pulmonary centers under this Section 21 will certainly be "billions" soon. We recommend deletion of this Section.

Sec. 23: Disclosure of Payments to Doctors

Sec. 23 In April 1978, PDA obtained a nationwide injuction to stop Secretary Califano from capriciously publishing lists of Medicare-Medicaid payments to doctors. The AMA, much later, followed our lead and obtained similar injunction. We agree with comments by Senator Talmadge on Section 23, that there is no justification for the deliberate, callous publication of lists riddled with errors causing needless harm and embarrassment to doctors and their families.

We also recommend Section 23 be adopted, and amended to include dentists and oral maxillofacial surgeons.

Sec. 1133(a): Uniform Claims Form

Sec. 1133(a) PDA recommends that Section 1133(a) be amended to clearly state that this will apply only to doctors on assignment of bills, and not to doctors who are not being paid by government, i.e. on direct billing to

patients. Direct billing physicians should not be required to use government forms for private medical care.

PSRO Repeal

The following PSRO activities should cease immediately and the enabling authority in Title XI, Part B, Section 249F, P.L. 92-603, terminated:

1. Preadmission Certification - a failure (Sec. 1155(a)(2)(A)).
2. Ambulatory care review (Sec. 1155 (b)(4)).
3. Invasion of physicians' offices and records (Sec. 1155(b)(1) to (4)).
4. Concurrent review - an expensive failure.
5. Repeal the "fine" (Sec. 1160 (b)(3)) or doctor payment of bill (Sec. 1160 (b)(3)).
6. Certification by private attending physician (Sec. 1156 (d)(1)(A), (B)).
7. Physician and patient profiles (Sec. 1155 (a)(4)), dossiers constituting gross invasion of privacy.
8. Criteria, norms & standards (Sec. 1156) as statistically meaningless when applied to a given patient.

It is obvious that PSRO, an expensive boondoggle is a very serious invasion of fundamental liberties, and must be repealed now.

Conclusion

If the Carter-Califano ceiling of 9.7% cost rise per year is imposed on hospitals, Medical Care will be sealed in a closed container along with the expanding cancerous bureaucracy. The bureaucracy malignancy will smother medical care.

In summary, more of the cause is not the cure. We need less bureaucracy, not more. If we are to effect true cost containment, S. 505 should be rewritten towards a deregulation of medical care and hospitals and the excision of the bureaucratic cancer. If the Government is alarmed by the inflation in cost of hospitals, it should stop causing the inflation.

* * *

TABLE OF FIGURES

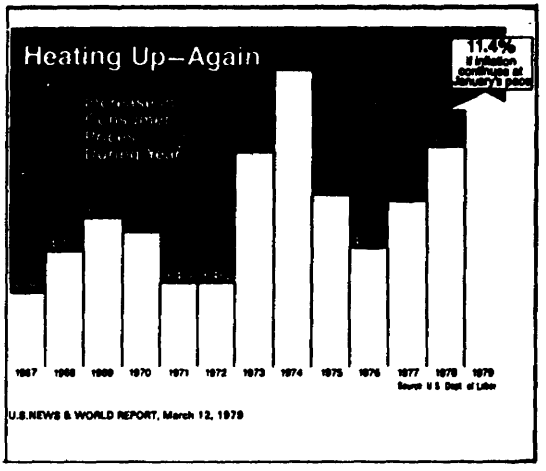


Figure A

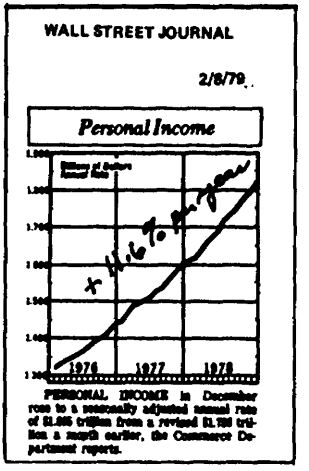


Figure B

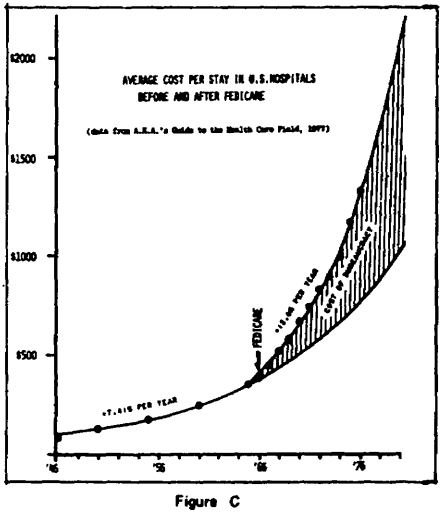


Figure C

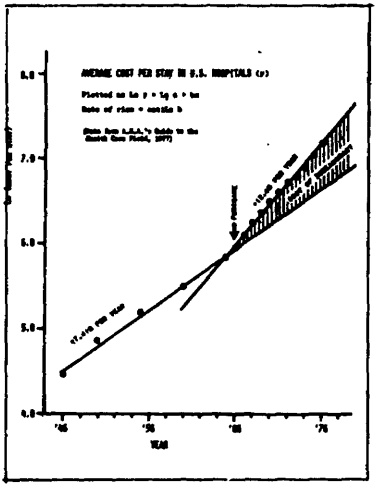
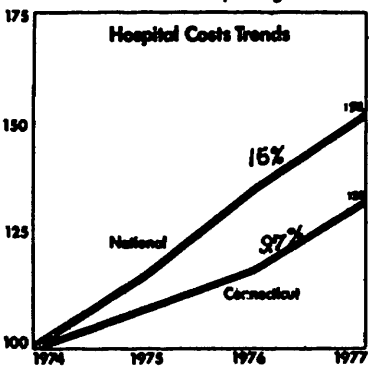


Figure D

THE TIDE IS TURNING.

For a long time, continuous, large increases in hospital costs have been looked at as inevitable.

But, a few years ago, Connecticut established a state commission to try to control these costs. It has succeeded so well, as you can see from the graph, that hospital costs in Connecticut are increasing at a much lower rate than the national average.



And as costs are brought under control, the insurance premiums that pay most of these costs can reflect the improvement. We have adjusted our rates in Connecticut in response to the improved costs records of Connecticut hospitals.

Insurance rates are, in a sense, a mirror of society. Its economics; its technology; even its morality.

And when society takes effective action to solve problems, it shows up in our rates.

For a copy of the annual report of the Connecticut Commission on Hospitals and Health Care, write The Travelers Office of Consumer Information, One Tower Square, Hartford, Connecticut 06115. Or dial, toll-free, weekdays from 9 to 5 Eastern Time, 800-243-0191. In Connecticut, call collect, 277-6565.

PDA NOTE: The right hand margin's "152 and 132" and "15% and 9.8%" added by PDA. Source: U.S.N.W.R., Feb. 13, 1978

THE TRAVELERS
Raising our voice, not just our rates.

The Travelers Insurance Company, The Travelers Indemnity Company, and Affiliated Companies, Hartford, Conn. 06115

Figure E

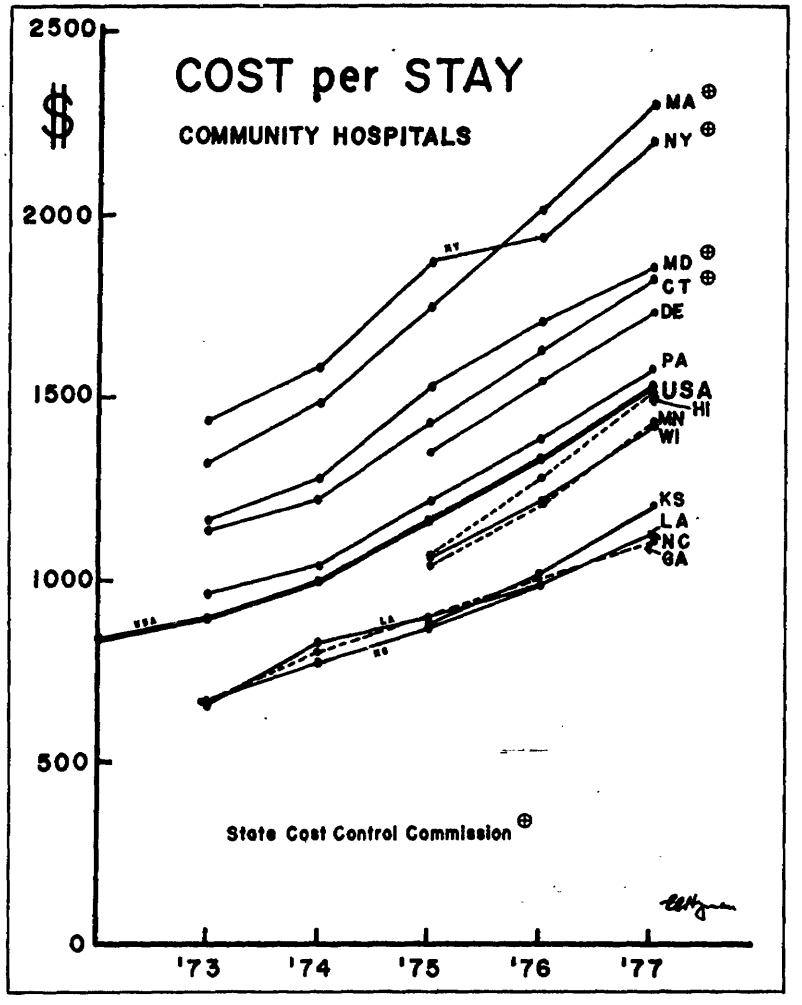

2500
$
COST per STAY
COMMUNITY HOSPITALS
2000
1500
1000
500
0
MA
NY
MD
CT
DE
PA
USA
HI
MN
WI
KS
LA
NC
GA
State Cost Control Commission
'73
'74
'75
'76
'77

Figure F

REVIEW OF HOSPITAL BUDGETS

Pursuant to its responsibilities under Chapter 334a of the Connecticut Statutes, the commission has reviewed the budgets of the state's voluntary, acute care hospitals for the past three years. During the first two years of budget review, the commission concentrated on reviewing increases in charges to patients, and it appeared initially that these charges were being held to levels considerably below the national average. For example, in fiscal 1975, the increase was only 8.3 percent rising to 9.6 percent in fiscal 1976.

Charge increases alone do not accurately reflect the cost to the public for hospital services. This fact became obvious both in 1975 and 1976 when Connecticut Blue Cross filed rate increases with the state insurance commissioner averaging 15 to 25 percent per year.

The question was how could Blue Cross need such large premium increases if hospital charges were going up less than 10 percent? The answer came in the spring of 1976 after the hospitals had filed their audited statements for fiscal 1975. *The fiscal 1975 audits showed that total patient revenues from hospitals increased 15.8 percent--almost twice the level of charge increases approved by the commission. In addition, a startling fact emerged. The hospitals had generated $17 million in excess revenue which they had neither requested nor been authorized by the commission to generate. Preliminary findings of fiscal 1976 data showed that another 15 to 16 percent increase was likely--again well in excess of the charge increase approved by the commission.*

From THIRD ANNUAL REPORT TO THE GOVERNOR AND GENERAL ASSEMBLY, State of Connecticut Commission of Hospitals and Health Care, January 1, 1977, page 7. Underlining by PDA.

Figure G

From: HEALTH CARE WEEK, September 11,1978

"MANDATORY RATE REVIEW CAN BE COSTLY"

commission approach; although, they have never complained about the extensive benefits that they have received in Indiana. I mention this because one of the hidden agenda items could well be that HIAA members have a special problem in many states because of a Blue Cross discount. One way to eliminate the discount is to move to a cost commission or a public utility concept which they favor. Frankly, I think that is kind of a drastic measure to impose upon our industry by some other industry which doesn't particularly like to have controls imposed upon them. In addition, it appears that the mandatory approach is very costly from the standpoint of the amounts of money that are necessary to run a state commission system. For example, figures I've seen from Massachusetts indicate something between a 2½ to 3 million dollar budget. In contrast, our approach has about a $250,000 expenditure and the savings may well be in the neighborhood of $400 to every dollar spent.

I think these are some of the other factors that ought to be considered before we give too much emphasis to throwing the hospital industry under rigid state controls.

-9-8-78 ELTON TEKOLSTE
President
Indiana Hospital Association

Figure H

THERAPEUTIC BULLETIN

of the DEPARTMENT OF PHARMACY SERVICES

"Issued to further liaison between the Medical, Nursing, and Pharmacy Staffs

PHOSPHATE

Volume X, Number 1 February, 1979

Potassium phosphate injection is a combination of potassium phosphate monobasic and potassium phosphate dibasic. The label states that each milliliter contains:

4.4 mEq. K^+ AND 3 mM P

Note: Milli-equivalents of Potassium but Milli-moles of Phosphorous. The 3 mM of Phosphorous are equal to 9 mEq. $PO_4^=$. Since the last dissociation does not take place at the pH of the solution, each milliliter actually contains 6 mEq. of $HPO_4^=$. This is the figure the pharmacy uses in calculating the amount of additives in a T.P.N. solution where a definite number of mEq. of Phosphate is ordered.

A problem arises when the pharmacy receives an order to add 20 mEq. Potassium Phosphate to an I.V. solution. Does the physician want 20 mEq. of Potassium or 20 mEq. of Phosphate? In this instance the pharmacy considers the order to be 20 mEq. of Potassium and adds an appropriate amount of the injection to the I.V. solution. The patient will then receive:

20 mEq. K^+ AND 27.3 mEq. $HPO_4^=$

A similar problem exists with Sodium Phosphate Injection, which contains:

4 mEq. Na^+/ml. AND 6 mEq.

An order for 20 mEq. Sodium Phosphate will give the patient:

20 mEq. Na^+ AND 30 mEq. $HPO_4^=$

Remember, if the order is for a definite number of mEq. of Phosphate, the pharmacy will add that number of mEq. of $HPO_4^=$

Figure I

Italian Skier Critically Injured

By MICHAEL STRAUSS

Special to The New York Times

WILMINGTON, N.Y., March 3 — Leonardo David, a promising 18-year-old Alpine ski racer from Italy, suffered a severe head injury today during the World Cup downhill competition on Whiteface Mountain.

The teen-age star, seventh in the overall World Cup standing before the start of this morning's competition, was hurt early in the race, which was won by Peter Wirnsberger of Austria. He was rushed by helicopter to the Burlington (Vt.) Medical Center Hospital where he underwent surgery.

Late in the afternoon his condition was reported as critical by the hospital. At the hospital, he was examined by a "cat scanner" and then taken to surgery.

In today's competition, the 21-year-old Wirnsberger, who is from Austria's eastern mountain area, became the only performer this season to win two World Cup downhill events. He has not scored a point in slalom or giant slalom.

Figure J

TABLE OF FIGURES

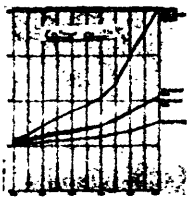


Figure 1

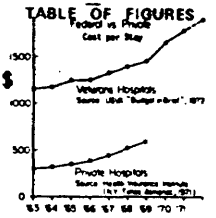


Figure 2

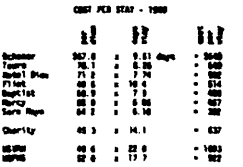


Figure 3

Figure 4

Figure 5

Figure 6

Figure 7

Figure 8

Figure 9

Figure 10

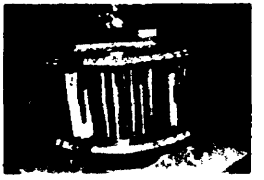


Figure 11

Figure 12

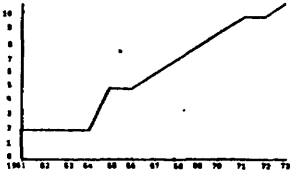


Figure 13

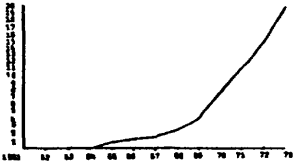


Figure 14

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BALTIMORE, MARYLAND 21235

REFER TO

IHI-632

JUL 0 3 1974

Frank T. Robbins, M.D.
Masonic Building
Hinesville, Georgia 31313

Dear Dr. Robbins:

After studying your perceptive report about administrative requirements in small hospitals, such as Liberty Memorial, we are very empathetic about the administrative demands our complex society makes on its institutions.

Yet, we do not see how we can possibly meet your request to waive the audits to make life simplier. Audits, as you know, are important management tools we need in order to meet our responsibility to the public we serve.

For example, reimbursement on the basis of cost requires assurance that the amount of cost is correct, that there has been a proper distribution of overhead and other costs, and that the utilization data are not in error. To verify accuracy of the cost reports requires proper audits of the hospitals and other providers. Such audits are necessary to assure equity to both the purchaser and provider of service and in general would contribute to sound management of the program.

But I can well understand that, sometimes, there may be an excess of a good thing. After we read your statement about the large number of audits done at Liberty Memorial, we have asked our Atlanta office to be in touch with you to make sure that we in Medicare, at least, do not trouble you with any more audits than are absolutely needed. We have also asked our Atlanta office to see if they can do something in an operational way that would ease the admin'strative burden you so well describe.

On the personal side, I thought your report was an exceptionally lucid and nicely organized document that well illustrated your point.

We do regret that, in this instance, we cannot be more helpful.

Sincerely yours,

Glenn J. Martin

Glenn J. Martin, Chief
Program Experimentation Branch
Division of Special Operations
Bureau of Health Insurance

Figure 15

TABLE OF FIGURES

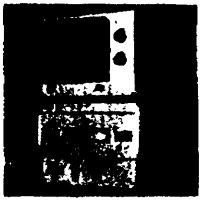


Figure 16

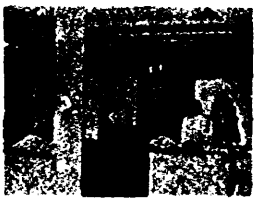


Figure 17

Figure 18

APPENDIX A

Views of Readers

THE NEW ORLEANS TIMES PICAYUNE
SUNDAY, MAY 15, 1977

Bureaucracy Blows Up Hospital Costs

New Orleans.
Editor, The Times-Picayune:

Carl T. Rowan's column (May 8) entitled "Public Hospitals are Cutting Back" gives hard information but faulty conclusions. He summarizes, "Reports from around the country tell of lives endangered and even lost, of patients waiting hours to get prescriptions filled and months to get X-rays, of bureaucratic bungling and hospital entanglements in politics and patronage." That distress is the status of any ripe government-run hospital, and that "bungling bureaucracy and politics" is the cause of the distress, not only in this country but in virtually every country in the world.

Ironically, the cost per patient stay in a public hospital greatly exceeds that in a private hospital. Yet as Mr. Rowan says, "well-to-do go to more comfortable and prestigious private hospitals." And the rise in cost of private hospitals since Medicare in 1966 is closely related to introduction of the government's bureaucracy and politics, and to bungling by the same government methods which paralyze the government hospitals.

But rather than shackle private hospitals with the extra burden of increased bureaucracy, bungling, and politics of some government kind of "cooperative effort" as in Rowan's thesis, or with the expensive bureaucracy necessary to impose President Carter's 5 per cent ceiling on the rise (caused by prior bureaucracy), we should go exactly the other way. We should allow private hospitals to go back to their older, less expensive ways which produced the more desirable medical care, and we should see what we can do to liberate the downtrodden public hospitals from the malignancy of paperwork and politics.

EDWARD S. HYMAN, M.D.

THE WALL STREET JOURNAL, Monday, June 2, 1975 9

Letters to the Editor of the Journal

Strangling the Hospitals

Editor, The Wall Street Journal:

Regarding I. D. Robbins' article "Health Costs—A One-Way Street" (May 5):

Mr. Robbins should be reminded that the cost of running New York City rose about four times as much as the cost of the nation's medical care in the past decade, and that New York City leads the country in medical indigence, and does so with a Medicaid system subsidized by other states where the per capita income is lower. New York's hospitals are probably the nation's most distressed, but perhaps not for the reasons he cited.

Should he compare his cited 180% rise in "wages in the health industry" (from 1968 to 1973 (only 4.3% per year) to the 149% rise in per capita income nationwide or to the 180% rise in New York State during the same period, then there would be no need for his derogatory explanations of the "health industry."

He should also be enlightened that his cited 30% increase in hospital personnel, or the 79% rise in a decade reported recently in U.S. News & World Report, is primarily an increase in persons who do not attend the sick, but instead are assistant administrators, insurance clerks, other clerks, personnel officers, quality assurance persons, couriers, typists, auditors, etc. These extra employes are spawned by civic minded businessmen who do not understand medicine but who seem determined to improve and expand the paperwork they think they understand. The same is done by agencies of the government, by agencies controlled by the government such as the Joint Commission on Accreditation of Hospitals, and by "health planners."

The physician or surgeon has no control over this featherbedding and often finds that it interferes with good medical care. The doctor has lost the help of a good nurse because she is now doing a sham called "Quality Assurance." She is replaced by two or more persons each with a Job Description to limit his versatility or usefulness. The physician is limited by a businessman's accounting system which makes it expensive for a patient to sleep in one more night. Thus a patient must have walk-in surgery and leave before nightfall, or perhaps have his appendicitis treated with "ice packs and penicillin."

This cost accounting system is responsible for many square pegs in round holes. If a physician needs a simple hemostat he must open a whole suture tray; if he needs a few pills he must order a unit package; and on and on. But the use of a drug or the extra blood test must be compromised to pay the salary of a typewriter jockey in the Madisaro (Papercare) office. Then some civic leader on CBS or NBC discovers that drugs can be purchased cheaper outside the hospital, and he wants to cheapen the quality of drugs to lower the price instead of sequestering the typewriter jockey. As this bureaucracy strangles a hospital, civic leaders delight in employing more administrative personnel to limit admissions, to do "utilization review," or to replace a technologist with two untrained refugees from the welfare system.

All of this destruction is done by "experts" with the opening prayer that this will "lower the cost while raising the quality of medical care." We need less advice from these vicarious virgins describing labor pains and more input from the physicians in the front line.

EDWARD S. HYMAN M.D.
Secretary
American Council of Medical Staffs

New Orleans

Treating Appendicitis

Editor, The Wall Street Journal:

Mr. Robbins certainly did not pick a very convincing example to bolster his position when he spoke of patients getting "... surgery instead of ice packs and penicillin for an appendicitis." (This being intended to illustrate the greed of surgeons.)

The potentially lethal, peritonitis-causing bacteria in appendicitis are almost always E. coli and other gram-negative organisms, against which penicillin is ineffective. The ice packs do not deserve discussion. Appendicitis would kill many young and otherwise healthy people; surgery is a simple and effective means of treatment.

The article is an eloquent, albeit unintentional, argument in favor of letting the experts in health care make the decisions.

W. LAWRENCE WILES M.D.

Belmont, Mass.

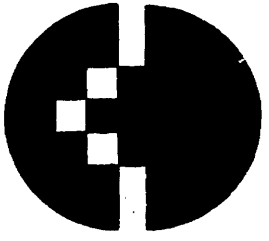
PRIVATE DOCTORS OF AMERICA MEMBERSHIP - MARCH 1979 APPENDIX D

	CHAPTER	NO. OF STAFFS	VOTING MEMBERS
I	ALABAMA		
	1 Northern Alabama	1	93
II	ARIZONA		
	2 Central Arizona	1	458
III	ARKANSAS (See Gr.Memphis)		
IV	CALIFORNIA (V-7194)		
	3 San Diego Imperial	2	205
	4 Southern California	50	6,989
V	COLORADO		
	5 San Luis Valley Area	1	18
VI	FLORIDA (V-3608)		
	6 Florida West Coast	6	641
	7 Ft.Lauderdale Area	2	436
	8 Mid East Florida Area	6	684
	9 South Florida Area	12	1,847
VII	GEORGIA (V-579)		
	10 Ctl.Savannah River	2	242
	11 Northeast Georgia Area	1	11
	12 Northern Georgia Area	1	326
VIII	ILLINOIS		
	13 Northern Illinois Area	9	1,210
XIX	INDIANA (V-241)		
	14 Northeast Indiana Area	2	85
	15 South Ctl.Indiana Area	1	43
	16 Southern Indiana Area	2	113
X	IOWA		
	17 Black Hawk Area	2	61
XI	KANSAS		
XII	KENTUCKY (V-273)		
	18 Bluegrass Area	1	19
	19 Green River Area	2	108
	20 Northern Kentucky Area	2	140
	21 Pennyrile	0	6
XIII	LOUISIANA (V-2957)		
	22 Acadiana Area	4	81
	23 Baton Rouge Area	3	234
	24 Ctl.Louisiana Area	1	30
	25 Greater Monroe Area	3	184
	26 Lake Charles Area	5	210
	27 New Orleans Area	37	1,960
	28 Shreveport Area	1	258
XIV	MASSACHUSETTS		
	29 Merrimack Valley Area	7	642
XV	MICHIGAN (V-5697)		
	30 Albion Area	1	42
	31 Greater Detroit Area	49	5,347
	32 Jackson/Hillsdl/Lenawee	7	292
	33 Northern Michigan	1	16
XVI	MINNESOTA		
	34 South Ctl.Minnesota	1	9
XVII	MISSISSIPPI (V-424)		
	35 Central Mississippi	2	273
	36 Northern Mississippi	1	9
	37 Northwest Mississippi	1	22
	38 Southeast Mississippi	3	120
XVIII	MISSOURI		
	39 Greater St.Louis (Illinois)	9	1,296
	40 Mid America KS	2	493
XIX	MONTANA		
	41 Montana Area 2	3	152
XX	NEW HAMPSHIRE		
	42 New Hampshire Area	1	172
XXI	NEW JERSEY (V-1243)		
	43 Northern New Jersey	7	994
	44 Southern New Jersey	2	249
XXII	NEW MEXICO		
	45 New Mexico Area	4	78
XXIII	NEW YORK		
	46 Nassau-Suffolk	6	1,113
XXIV	NORTH CAROLINA (V-627)		
	47 Clinton-Fayetteville	1	29
	48 Kinston Area	1	71
	49 Rocky Mount Area	2	98
	50 Winston-Salem	2	479
XXV	OHIO (V-4301)		
	51 Eastern Ohio Area	6	767
	52 Mid Ohio Area	17	1,338
	53 North Central Ohio	2	145
	54 Northeast Ohio	12	1,135
	55 Northwest Ohio	10	762
	56 Southwest Ctl.Ohio	1	154
XXVI	OKLAHOMA		
	57 Oklahoma City	0	8
XXVII	OREGON		
	58 Portland Area	1	82
XXVIII	PENNSYLVANIA (V-5795)		
	59 Allegheny Valley Area	10	1,304
	60 Central Penn. Area	1	87
	61 Delaware Valley Area	25	3,889
	62 Northeast Penn. Area	3	342
	63 Northwest Penn. Area	2	57
	64 South Central Penn.Area	2	116
XXIX	RHODE ISLAND		
	65 Rhode Island	2	215
XXX	TENNESSEE (ARK & MISS)(V-842)		
	66 East Tennessee Area	1	31
	67 Greater Memphis Area	2	811
XXXI	TEXAS (V-2559)		
	68 Alamo Area	0	2
	69 Gr.Houston/Galveston	11	1,203
	70 Lower Rio Grande Area	0	17
	71 North Ctl.Texas Area	18	1,101
	72 South East Texas Area	1	236
XXXII	VIRGINIA		
	73 Southwest Area	1	20
XXXIII	INDIVIDUAL MEMBERS		641
	TOTAL	402	43,151

A POLICY BOOK...

NATIONAL HEALTH PLANNING

HSA's



PRIVATE DOCTORS OF AMERICA T.M.

Est. 1968 CMS

- RATIONING OF MEDICAL TECHNOLOGY
- CERTIFICATE OF NEED FOR DOCTORS' OFFICE EQUIPMENT

Private Doctors of America, founded in 1968, is the national organization representing privately practicing doctors thru a grassroots vote where all members of all medical staffs are entitled to vote.

PDA is engaged in research on socio-economic issues vital to better medical care. These studies are published in the interest of an informed doctor and an enlightened citizen.

In 1979, PDA is the largest organization presenting only private doctors, with a voting membership of 43,000 in 49 states.

Edited by: José L. Garcia Oller, M.D.
Founder and President

PDA

This is a PDA POLICY BOOK, designed to provide the necessary factual information for an informed vote or position on the issues.

3422 BIENVILLE STREET • NEW ORLEANS, LOUISIANA 70119 • TEL. 504-486-5891

CONTENTS

PDA PRIVATE DOCTORS OF AMERICA T.M.

José L. García Oller, M.D.
President and Editor

NEWSRELEASE

FOR IMMEDIATE RELEASE
Sunday, January 21, 1979

Contact: Sue Molaison
504-486-5891

HSAs & NHI: NATIONAL HEALTH RATIONING

Private Doctors of America, the nation's largest association representing only private practicing doctors (42,000 doctors in 49 states) challenged today the conclusions of federal Health Service Agencies - such as the New Orleans Area - Bayou River HSA against duplication of hospital services published in the AP newsrelease yesterday.

"The people should know that the federal government is now rationing health care in a massive scale, denying or limiting hospital services to patients: new technology (CAT scanners), specialty surgery (heart surgery), specialty diagnosis and care (neonatal units) and treatment (cobalt x-rays treatment), and last week even good drugs (Califano generics). The HSAs are using their federal power to turn the clock back 30 years by creating monopolies in health care, forcing patients away from their local hospitals and into "centers". This will cause massive increase in health costs, not decrease, as we create shortages and monopolies. Patients will get treatment by interns and residents in the center, not by specialists in their local hospitals as they now receive."

"The money spent in the New Orleans HSAs alone ($600,000 this year) is enough to buy a CAT scanner for six hospitals in New Orleans every year; or cobalt x-ray machines, or Kidney dialysis ... and by duplication lower the cost of equipment and make it available to all hospitals. The CAT Scanner cost has been reduced from $500,000 to $85,000 - by duplication. Any hospital can now afford one. This is the American dream," said Dr. José L. García Oller, President of Private Doctors of America (PDA), "to equip all our hospitals with CAT Scanners, Cobalt x-ray for cancer, kidney dialysis for poisoning, cardiac surgery facilities. We can afford it by closing the HSAs nationwide. Also, by repealing other federal rationing (PSROs) which cost $1 billion a year to limit services."

Medical progress now has made available treatment by nearly all specialties close to our patients' homes: plastic surgery, neurosurgery, vascular surgery, cardiac surgery can now be done without transporting and disrupting the family which would cause great additional cost to our families in loss of hours of work, etc. HSAs would turn back the clock and transport to a "center".

The suggestion that we should close all heart surgery units "except Ochsner" - close Charity, Baptist, Touro, Tulane, Hotel Dieu; or all x-ray Cobalt units except Mercy, Gulf South, Dr. Duhe and Dr. Schlosser; or cardiac catheterization or neonatal unit, is preposterous and dangerous.

That "Quality" of treatment depends on the number of procedures done in our hospitals is ridiculous. It is only true of "centers" where new interns and residents teams have to be trained every few months and where the surgery is done by doctors undergoing education. In private hospitals surgery is done by trained, experienced specialists with proven skills. A few operations by the skilled and experienced specialist are far superior in results to the hundreds of operations done as training and teaching exercises in the "centers". It is the training and expertise of the doctor that counts, not "the hospital numbers game".

"Bureaucratic overregulation is strangling our hospitals, adding $40 a day to costs. HSAs planning agencies are applying a defunct, unworkable and expensive "crystal ball" process.

(M O R E)

10 years ago the planning agencies were crying "crisis" over the bed shortage in New Orleans, with full sections in our newspapers carrying the stories. Now health planners say "we have too many beds". 20 years ago planners said we need more OB beds - today, that we need to "close OB" because the planners did not foresee "the birth control pill". "Iron lungs" wards recommended by planners were closed by the polio vaccine - but may be needed for the federal planners' Guillian Barré paralysis from their swine flu vaccine fiasco.

"Those who say 'restrict progress to the health center' are regressing 30 years, leading us to a bankrupt system of anticompetitive socialized, monopoly medicine, as in foreign countries. But the Carter, Califano, Kennedy policy is to ration and deny care - so they may be able to 'afford' NHI. NHI will be National Health Rationing," said the PDA spokesman, "and we'll all be like England or Russia: 5 years wait for your hernia operation for the worker, or for the hip surgery for the senior citizen, or tonsillectomy for the child. Let's close the HSAs instead as was recently done in Los Angeles and Puerto Rico. Let the goal of the American medical system be: let every hospital share in our miracles of technology, and make available the best surgery and medicine in hospitals close to where our patients live. Duplication, competition and availability is the key to higher standards of health Care.""

* * *

High Health Costs Tied to Duplications

Times Picayune, New Orleans, January 21, 1979

By The Associated Press

Higher medical costs and lower quality care are two potential problems in New Orleans hospitals that have duplicated equipment and such services as open heart surgery, neonatal care, certain cancer treatment and diagnostic procedures for heart disease.

The conclusion was contained in a report by the New Orleans Area - Bayou River Health Systems Agency, a regional health planning group under the state Department of Health, Education and Welfare. The planning agency serves 11 parishes.

In its report, the agency said only Ochsner Foundation Hospital meets the minimum number of 200 open heart surgeries annually, which is the medical standard of proper use.

The other area hospitals which perform open heart surgery are Charity, Southern Baptist, Touro Infirmary and Tulane Medical Center. An agency spokesman said all five hospitals also perform pediatric open-heart surgery, but at a rate lower than the accepted annual number for such operations. The report said infrequent performance of a surgical procedure may mean that medical skills do not stay honed. Expensive equipment may stand idle or be used when not medically necessary.

It recommended that hospitals which perform less than a standard number of procedures in a specific field — within three years after such services have begun — should stop the practices.

The report is a series of proposed additions to the agency's 1978 health plan covering problems and priorities in the 11-parish area.

Times Picayune, New Orleans, January 22, 1979

Doctors Dispute Agency Report

By THERESE L. MITCHELL

Private Doctors of America Sunday challenged the local health systems agency's conclusion that duplication of hospital services is driving up medical costs.

"It is a hoax to tell people that duplication is expensive and rationing will lower costs," Dr. Jose L. Garcia Ofler, president of the national organization, said of the New Orleans Area-Bayou River Health Systems Agency report.

"The HSA is using their federal power to turn the clock back 30 years by creating monopolies on health care," Dr. Ofler said in an interview with The Times-Picayune.

"This will cause a massive increase in health costs, not a decrease," he added.

The report, which was released last week, concluded that local hospitals are overly equipped for the needs of the patients. It also recommended that hospitals which perform less than a standard number of procedures in a specific field — within three years after such services have begun — should stop the practices.

Because a specific number of procedures are not performed, the report concluded, the medical skills of the physicians do not stay honed.

Dr. Ofler said for the HSA to conclude that "quality depends on the number of procedures done is ridiculous."

He added that the HSA recommendation for the development of health care centers would probably mean the surgery patient would be cared for by interns and residents who "have to be trained every few months.

"In private hospitals, surgery is done by trained, experienced specialists with proven skills. It is the doctor that counts, not the hospital numbers game," Dr. Ofler said.

Dr. Ofler, representing 48,000 doctors from 48 states, also took issue with the HSA's charge that duplication of such equipment as the CAT scanner or Cobalt X-ray is driving up costs.

"The CAT scanner cost has dropped from $500,000 in 1976 to $85,000 in 1978," he said. "The money spent by the local HSA alone is enough to buy a CAT scanner for six hospitals, a Cobalt X-ray, or a kidney dialysis unit every year.

"By duplication, the cost has lowered and the CAT scanner service is available to patients in eight local hospitals."

Dr. Ofler claims that "bureaucratic overregulation is strangling our hospitals, adding $40 a day to costs. Planning agencies are applying a defunct, unworkable, expensive and crystal ball process to medicine."

The New Orleans Area-Bayou River HSA is a regional health planning group under the aegis of the state Department of Health, Education and Welfare. It serves an 11-parish area.

STATEMENT BY THE AMERICAN COUNCIL OF MEDICAL STAFFS ON THE PROPOSED NATIONAL GUIDELINES FOR HEALTH PLANNING

FR 42, no. 186, 9-23-77
FR 42, no. 226, 11-22-77

December 8, 1977

Dear Mr. Secretary:

I. There appears to be no such thing as a failure of a Federal program in Washington. When a program does not work, we change its name, we double the personnel and double the budget. Such is the history of the failure of Health Planning.

A. In 1946, Congress decided we needed to build more hospitals. The Hill-Burton program for hospital construction was instituted and hundreds of hospitals built.

The Congress now finds that we have "too many hospital beds".

The Congress found, in 1970, a doctor shortage. Never mind that government's own publication showed we had more doctors per capita than the European countries, except Austria (and Israel). Expansion of our medical schools was demanded and imposed by federal financing regulations.

Today we are told we have too many doctors.

Government planners said we had a postwar baby boom, we needed to build more obstetrics and pediatrics wards. Planners and social engineers did not foresee the development of "the pill". Today the Secretary of HEW decrees we must close OB and Pediatric wards.

Planners didn't visualize the medical breakthrough of the polio vaccine, and demanded more "iron lungs" and rehabilitation centers. Today, polio is nearly a disease of the past, the centers closed.

The point, Mr. Secretary, is that interventional Health Planners have been an expensive failure, because bureaucracy's solutions come too late, and are soon made obsolete by medical progress by doctors working for a cure of the problem.

B. If a "voluntary" government program fails, we tend to make it compulsory and to override the power of the states.

1. The Comprehensive Health Planning Program (CHP) of 1966 was a failure. The money misspent in planning could have paid for the expensive technology it purported to ration, - enough money to buy all the Cobalt machines, instead of denying those services. In our own experience in the New Orleans Area Health Planning Council since 1968, nothing was accomplished in eight years other than an astronomical waste of physicians' and community leaders' time. We know of no accomplishment during those years, except "to comply" in order to obtain more "federal dollars".

AMERICAN COUNCIL OF MEDICAL STAFFS
3422 BIENVILLE STREET, NEW ORLEANS, LA 70119 504-486-5891

2. The Regional Medical Program of 1965 was designed to create Regional Centers for Heart Disease, Cancer and Stroke. With few worthwhile exceptions (stimulating availability of intensive care and dialysis units, etc.) the RMP failed.

3. Because CHP and RMP failed, Congress created a compulsory, huge health rationing device which overrides the proper regulatory powers and authority of states, and eliminates the power and authority of hospital boards in our communities: "The National Health Planning and Resources Development Act of 1975", Public Law 93-641, which was enacted against the unanimous opposition of the medical profession.

C. The National Guidelines provide for Rationing of Hospitals and Medical Services. The Health Planning Act gives HEW the power to ration and dismantle the best hospital system in the world, and to deny access to quality medical care to those most in need, the poor and the rural areas. In the opinion of the Council of Medical Staffs, the proposed National Guidelines would not only deny services, but are incompatible with high quality and compassionate care delivered at the point of need.

There are four forms of rationing now used, requisite for political imposition of socialized medicine (national health insurance):

1. Close Hospital Beds - no more hospitals to be built. No more beds added. This system is exemplified by the British National Health Service. The public suffers by a long waiting line for care: 2 1/2 years for a hip operation in a senior citizen, years for a tonsillectomy in a child, or a hernia in a worker. We do save "excess beds" - "money is saved" - but the patients suffer denial of services.

   Empty beds, Mr. Secretary, are essential for prompt, quality medical care. If the firemen in the Firehouse are idle most of the day, do we then fire the firemen, to call them only when there's a fire? Government planners "foresee" a swine flu epidemic, yet want to close hospitals. Where are we going to admit the patients in an epidemic, in a disaster?

   No hospital can function efficiently at 80% occupancy - it's simply overloaded, and quality suffers.

2. Deny services as "unnecessary", by creating the artificial concept of "medical necessity". Medical care is a service aimed at improving the quality of life. It is "desirable", but not a "necessity" service. It is provided therefore when the suffering patient seeks it as an individual decision. The guidelines propose that a physician delivering under 500 babies a year in a rural area should be obsoleted. Yet excellent care can be provided if only 100 are delivered, and it's all "necessary", from the rural mother and doctor's standpoint.

3. Deny equipment: the "reduplication" rationing. This country's leadership was built and is daily surviving by our ability

to "reduplicate". Expensive technology becomes cheap only when it it becomes reduplicated. The $100,000 automobile prototype becomes the $5,000 family car. The $500,000 CAT Scanner can now be had for $95,000 - a miracle of "reduplication" - in just one year! While the politicians were busy arguing the guidelines to obstruct availability, free enterprise has solved the problem once again.

The intensive care unit, once esoteric technology, is now available, in rural areas, thanks to reduplication.

What is expensive and is not fruitful is the reduplication of the planning agencies and bureaucrats, which stultify progress in technology and in delivery of care. What we need is a law and guidelines to prohibit reduplication of bureaucratic failures. We also need guidelines for the accountability for the cover-ups of the planners.

4. Geographical Rationing: "Regionalized care" which takes doctors and hospital facilities away from where patients and their families live and work. The "less expensive treatment" at a "regional center" is in fact a great expense to the patient. He is away from his loved ones, the family assumes additional travel expenses, plus the cost of having someone to attend home and the children. The loss to patients, and to their families, their finances, their work - this is never mentioned in the Guidelines, Mr. Secretary, but that is what illness is all about, and what we, as doctors, care most about: individualized patient care.

The CMS recommends, therefore, that the current proposed Guidelines be withdrawn, and a new set of guidelines be issued on the concept of patient and the family as the geographical center of planning and the benchmark of access and quality - not the convenience of the "health center" or of the health bureaucrat. That should be the basic reference standard against which to issue the guidelines as required by S. 1501 (b)(1) of P.L. 93-641, "standards respecting the appropriate supply, distribution and organization of health resources".

The proposed Guidelines, Mr. Secretary, are further subject to the following criticisms.

1. They set raw numbers as the answer to problems. A central computer can now do the entire national planning, relocate all hospitals and services.

2. State planning and Health Service Agencies are rendered obsolete by the guidelines.

3. The Guidelines give HSA's and the federal government the power to regulate and control the entire private health and medical industry. This is not "planning". This is control.

4. Rural services by doctors and hospitals will be seriously diminished.

5. Relocation and referral patterns of doctors practices would be drastic-

ally changed by federal edict, instead of by evolutionary response to the needs of the sick.

6. Federal hospitals, public health service hospitals should be the primary testing areas for all "health planning". Only if they work in "federal" hospitals, should the experiment be cautiously expanded.

7. The Guidelines represent a clear incentive for overutilization. "Heart units" will obviously strive to attain their "200 operations" "to stay alive". Patients will be shuttled accordingly, for the convenience of the quota. When the quota of "200" is reached, the patients' operation may then be conveniently postponed to the following year's quota. Is this, we ask you, quality - producing guidelines?

8. The "quota" system for babies, for children, and for technology, etc. disregards the central fact that quality is not responsive to numbers. Generally, quality suffers as quotas for utilization lead to assembly line treatment, losing out in patient observation and care, because the "efficiency" engineer is watching. Medical care is an art. One heart operation can be a masterpiece; 200 may all be second-rate. Medical care and surgery is not just technology. The design of that care, the gentleness and after-care and dedication and timeliness of every facet of pre and postsurgical care will produce a brilliant result when tailored for an individual. Patients will be lost, however, if we substitute the quest for quotas and efficiency engineering. These national quota guidelines for medical services are a plague visited upon medicine and must be withdrawn, and identified as bureaucratic meddling, not "planning".

9. If we are to encourage medical services to small communities the CMS recommends:

   a. exempt doctors from income tax for three years if they work in underserved areas;

   b. encourage, not restrict, full availability of services: OB, pediatrics, etc.

10. An "80%" average occupancy rate standard will increase costs, not lower them. It becomes an incentive to the hospitals to:

    a. Keep patients longer - just like the Public Health Service hospitals, whose attention to their bed occupancy leads to lengths of stay up to 15 years (see CMS monograph on the New Orleans PHS Hospital).

    b. Admit patients who may be treated as outpatients - as the PHS hospitals and Veterans hospitals admit patients just for "Barium Enemas", just to keep up their occupancy rates and justify their existence.

11. These Guidelines, by eliminating the smaller and the rural hospitals, will create a Health Monopoly under the Secretary of HEW Health Czar.

    The majority of this country's hospitals have 100 beds or less, yet give excellent care. The guidelines would have many of these fine hospitals eliminated or taken over by large hospitals.

12. Because of HSA rationing of beds, already large hospitals are seeking out Pediatric "Children's Hospitals" or OB Hospitals to take over - as the Planners in HSA's do not allow hospitals to expand. By incorporating these other specialty hospitals, more general beds are freed in the institution. But this is not progress, this is a forced relocation of services without regard to better care for the patients in the smaller specialty hospitals.

The community and patients suffer when the goals of the large general hospital overshadows those best for the patients of the specialty hospital.

13. The HSA Guidelines create health monopolies and abolish competition. Competition is essential to progress, yes - especially in hospitals, regardless of what "planners" pontify.

14. The larger the hospital, in general, the less its efficiency. My 13 years experience as a neurosurgeon at a then 3000 bed hospital (Charity Hospital of Louisiana) showed the huge odds against efficiency in large hospitals. 200-300 bed size hospitals should be encouraged for better patient care, because patient care depends on personal care and attention, hardly the landmark of bureaucratized hospitals.

15. If doctors decide to practice in rural area hospitals, according to the Guidelines - without obstetrics, pediatrics, intensive care, adequate x-ray - the doctor will deteriorate to the level of technicians, the "barefoot doctors" in China and "feldschers" in Russia. Is this "quality"? Today, many rural hospitals give care equal or better than university hospitals.

The central fact, Mr. Secretary, is that modern medicine cannot be practiced without hospitals, and we need more rural and more suburban hospitals to help our sick, not mammoth academic health monopolies in the cities.

16. It is government regulation and inept planning that is pushing up costs: Utilization review regulations, at $34,000 to find a single patient who overstays a few days; millions of doctor hours wasted on paper review; the cost of HSA's and PSRO implementation is sufficient to provide all hospitals with a free CAT Scanner each year. (See OMS Testimony on Hospital Cost "CAP" Legislation.) As OMS has stated, "more of the cause is not the cure". The central crisis in health care today is a crisis of bureaucratic overregulation, which will be multiplied by the HSA's and the guidelines.

17. The miracle of modern medical technology is the true saver of money and of priceless lives. A CAT Scanner will now save 27% of patients from operations no longer needed after the CAT's diagnosis. The CAT Scanner will again pay for itself in patients not hospitalized, thanks to the CT diagnosis. As a neurosurgeon, I received last week an offer for a high quality new scanner for $95,000. Compare this to the $500,000 it cost just one year ago!

18. The Guidelines quotes per hospital per unit for service - 200 cases for heart surgery, etc. - ignore the central fact that the expertise is in

the physician or surgeon, not in the "hospital heart unit", albeit recognition of "team experience."

A heart surgeon or a neurosurgeon working in several hospitals may do "x" operations a year. The guidelines will now force him to do all these operations in one hospital. Good for the hospital! Convenient to the doctor! But, is the forced travel, inconvenience and disruption better for the patient and the family? No! And as the "units" work to capacity and "occupancy" goals, lives will again be lost in the waiting list. Recall the 700,000 patients in the waiting lists each year in England and all socialized countries, whose beds are "always full" at the "centers" which are "well planned".

19. Planning by the "local" HSAs can never succeed. Only with the full knowledge within a given institution's board and medical staff, with appropriate consultation, can reasonable planning decisions be made. The "Planning Boards" are essentially political bodies where the needs of patients are soon lost to "statistics". Just compare the empty beds of the VA and PHS hospital, despite the long length of stay of the political hospitals.

    As an example, hospitals were "denied" cobalt units by the planning agency in many areas. The hospital that built them anyway soon had more work than they could handle. A second cobalt unit was then needed.

    That is the story of area planning in Louisiana. Furthermore, when HSA's are successful in initially denying hospital expansion, they end up in huge escalation of the cost when the facility is constructed later due to the delays of the HSA.

20. How can we reconcile the rationing and reduction of services resulting from the guidelines, (fewer beds, fewer services, fewer diagnostic and treatment units) with the avowed aims of HEW and Congress towards "preventive medicine"?

21. The current high cost of hospitalization is partially a result of the patients' demand to return to work with as short a hospitalization as possible. Diagnostic tests are therefore done with great efficiency in a very short time, but this does drive up costs per diem. But this is not due to "increasing costs of hospitalization" - it is a deliberate artifact of "intensive services per day" - efficiency! Yet, doctors and hospitals are being penalized by punitive regulations which disrupt our hospitals, because of the "higher costs". It's less cost to the patient!

22. Ambulatory care is not necessarily more desirable from the patient's standpoint. Numerous tests in a short hospitalization can result in quicker diagnosis and prompter treatment - at savings to the patient's health, family, finances, and job security. This is important to the patient.

23. The miracle of modern drugs have emptied thousands of beds. Tranquilizers emptied mental hospitals; antibiotics and chemotherapy, tuberculosis hospitals etc. Therefore, in planning to reduce the costs of

hospitalization by planning guidelines, the use of high quality and effective drugs is essential. The Guidelines should require that drugs be available as prescribed by the physician, not second-rate generic drugs, not drugs rejected by the military, not drugs limited by a hospital administrator's list, or a Medicaid state list. Patients who do not recover because of poor quality generic drugs become long-stay patients, at huge and yet unmeasured costs in lives and dollars.

24. Guidelines should include the revaluation of cost-effectiveness of many government imposed services and financial practices in hospitals, which have driven up costs and artificially created huge new industries. Hospital's actively pursue, at government prodding, much superfluous home health care, rehabilitation, inhalation therapy, expanded pharmacy services, public relations departments, leasing practices; use of loans to use government money instead of hospital capital; all these government inducements have escalated costs.

25. As an example of the "obstetrics guidelines" application, there are only five hospitals in the entire state of Louisiana which deliver 2000 babies. Should all other "SMSA" hospitals close their OB units?

26. These Guidelines make regulators out of the HSA's - not planners; they establish "top-down" planning, not "grassroots" community input.

27. The National Planning Act aims to force the medical profession and our hospitals into becoming "regulated public utilities" - an euphemism for socialization and state control. The National Guidelines confirm the intent of central regulation by the Secretary of HEW, the antithesis of local health planning.

Our hospitals will sink into mediocrity, and our citizens will suffer second class assembly line medical care, as they await their turn to be bused to the distant approved regional center hospital emerging from these Guidelines.

Sincerely,

FOR AMERICAN CMS,

José L. García Oller, M.D., President

Robert J. Meade, M.D., Vice President

Wesley N. Segre, M.D., Vice President

December 8, 1977

Letter to Congress from PDA

HSA'S WAR AGAINST PATIENTS

MAY 12, 1978

Dear Congressman:

"CMS - Private Doctors of America" represents 42,000 doctors from 48 states. Our "Letter to Congress" program is a Fact Sheet from our socioeconomic research on issues vital to our member doctors in your state.

Last month in our first letter, we extensively documented how the government's cost-control program for medical care, "PSRO" (P.L. 92-603), will cost $1.24 billion when fully implemented, yet not saved a penny since 1972. We asked that you vote not to fund PSRO in the budget bill now in Congress.

This month's Letter spotlights the colossal error we believe the Dept. HEW-PHS have made in declaring war against technology thru the local HSA's (Health Service Agencies) under the aegis of "cost control" and "certificate of need". I will give you a precise example of how disastrous this certificate of need policy is for your constituents. I will demonstrate how the free market has made a phenomenal breakthrough in cost control, making rationing by HSA's moot. The example is the "CAT Scan" – which I am sure you have seen on TV and other media – that remarkable marriage of computer to x-ray which provides cross section views of the human body without risk. And we hope that you will vote against the Rogers bills (H.R. 6575 & H.R. 11488) or the Kennedy bills (S. 1391 & S. 2416) sections requiring such "certificates of need".

As a private neurosurgeon with subspecialty in x-ray studies for the past 25 years, I realized instantly when it was invented in 1972, that "CAT Scan" was the most revolutionary breakthrough since x-ray was introduced. Its promise has now been fulfilled: many thousands of lives are saved, unnecessary surgery avoided, suffering alleviated. Today it is indispensable to the daily practice of neurosurgery. It has saved millions of dollars in unnecessary hospitalization, truly lowering the cost and increasing quality of medical care thru technology, not rationing.

One would think that after this dramatic scientific advance, government would have promptly assisted to expand access to every corner of our land. Instead, Mr. Califano, the HSA's, the PHS and Mr. Nader have waged war against the Scanner, as a "too expensive technology" that must be rationed and denied thru "certificate of need". The FTC should take note that HSA's, in denying this equipment except to a "few Hospitals", are restraining trade, establishing monopolies and engaging in price fixing!

In England, where the CAT Scanner was invented, the national health insurance (NHS) system has allowed only a few scanners for all Britain!

In the U.S. 470 scanners were sold in 1976, 240 in 77 – but government now wants to stop the free market. Let's look at the economic miracle performed by a free industry: in the past three years, while HEW, HSA'S and Congress were trying to stop the scanner to lower costs by prohibition, the cost of the Scanner has fallen from $500,000 to $95,000. The problem has been solved by free enterprise, competition, and duplication. When PDA testifed before the Kennedy Subcommittee on Hospital Costs last year, we remarked that the cost of the PSRO program would pay for a free CAT scan to every hospital every 3 years – that same week the cost went down to $225,000 – enough for 5556 hospitals of the 5,977 private hospitals in the U.S. (of total 7,174). Last week in New Orleans at the neurosurgical convention, I was offered a total body scanner for $85,000!

MIRACLE OF FREE MARKET: CAT SCAN COSTS

A. Head Scanner			B. Total Body Scanner		
1976	$500,000		1976	$500,000	
1977 May	$250,000				
1977 June	$225,000		1977 Sept.	$150,000	(reconditioned)
1978 Feb.	$130,000	(new)			
1978 April	$ 95,000	(new)	1978 April	$ 85,000	(reconditioned)

Would you rather see every hospital and radiologist be thus equipped to save lives, than denied? If you agree, please vote against the Rogers – Kennedy planning bill amendments which require a "certificate of need" for scanners for either hospitals or doctors. Mr. Congressman, the Scanner story again merely restates the caveat: Freedom in medicine saves lives, lowers costs.

Please share with me, if your time allows, your questions or comments, and any suggestions that could make this Letter to Congress effort more helpful to you.

Sincerely,

José L. Garcia Oller, M.D.
President, CMS-PDA

cc: Members of Congress; Major Media outlets, U.S.
PDA Doctors in each Congressman's State

Secs. 110, 122

DORNAN AMENDMENTS

AMENDMENT TO H.R. 11488

OFFERED BY MR. ROBERT K. DORNAN

[LOBBYING]

Page 89, insert after line 16 the following:

(e) Section 1513(a) is amended by adding after the first sentence the following: "A health systems agency may not use any funds provided under this title or title XVI to, directly or indirectly, influence the issuance, amendment, or revocation of any Executive order or similar promulgation by any Federal, State, or local agency or to influence the passage, amendment, or defeat of any legislation by the Congress or by any State or local legislative body, except that this sentence does not apply to the use of such funds by a health systems agency in making its views known on any matter upon the request of any Member of Congress, committee of Congress, or any other Federal, State, or local governmental authority."

Page 119, insert after line 8 the following:

(g) Section 1523 is amended by adding at the end the following: "(d) No funds made available under a grant under section 1525 may be used by a State Agency to, directly or indirectly, influence the issuance, amendment, or revocation of any Executive order or similar promulgation by any Federal, State, or local agency or to influence the passage, amendment, or defeat of any legislation by the Congress or by any State or local legislative body, except that this subsection does not apply to the use of such funds by a State Agency in making its views known on any matter upon the request of any Member of Congress, committee of Congress, or any other Federal, State, or local governmental authority."

Sec. 115

AMENDMENT TO H.R. 11488, AS REPORTED

OFFERED BY MR. ROBERT K. DORNAN

[HIPPOCRATES]

Page 97, insert after line 24 the following:

(1) Section 1513(b) is amended by adding at the end the following: "(5) The HSP of a health systems agency shall include a statement of the effect that achievement of the goals of the HSP will have on the requirements placed on the practice of medicine by the Oath of Hippocrates (as restated in Geneva, Switzerland, in 1948 by the World Medical Association), and the AIP of a health systems agency shall include a statement of the effect that achievement of the objectives in the AIP will have on such requirements."

PDA

Est 1966 CMS

MAIL TO: Private Doctors of America, 3422 Bienville Street, New Orleans, LA 70119

PRIVATE DOCTORS
OF AMERICA"

MEDICAL STAFF RESOLUTION ON HEALTH PLANNING AGENCIES

WHEREAS, PDA has, since 1969, favored voluntary planning as an advisory and cooperative activity among all medical and health care facilities and resources; but opposed "fiscal control" planning wherein the independent authority of each institution is superseded by withdrawal of funds as a result of imposition of central planning, resulting in monopolies and anti-competitive practices as is now represented in the HSA's (Health Systems Agencies) of the National Health Planning Act, which law expired as of December 1978; whereas this PDA policy of non-participation in "fiscal control" HSAs, as a society, has also been adopted by the Louisiana State Medical Society,

IT IS THEREFORE RESOLVED THAT this Medical Staff:

1. opposes the National Health Planning Act of 1979 (H.R. 11488) because it creates agencies (HSAs) which supersede and control the authority of private hospitals' boards of trustees and rations and controls the practice of medicine; and
2. opposes the HSA numerical guidelines for hospital beds for specialty care units (neonatal, cardiac surgery and diagnosis, and cancer therapy) inasmuch as the U.S. has fewer beds per thousand than Great Britain, Sweden, Germany, France and Italy; and therefore
3. opposes the Certificate of Need for hospital expansion; and
4. opposes any HSA control by a Certificate of Need of expenditures by private physicians of their own capital resources for their medical equipment or office facility; and
5. supports Representative Dornan's Amendments to H.R. 11488 to prohibit the use by HSA's of planning funds for lobbying of legislation; and
6. supports the Dornan Amendment to evaluate the impact of HSA goals and actions on the requirements placed on the practice of medicine by the Oath of Hippocrates; and
7. that copies of this Resolution be sent to: Private Doctors of America, the State's Congressional Delegation, Members of the Interstate and Foreign Commerce Subcommittee on Health and the Environment, Congressman Robert K. Dornan and the local Health Systems Agency.

ACTION: ( ) Motion Approved ( ) Motion Not Approved

FROM: _____ Medical Staff. Date Voted: _____, '79

BY: _____, ( ) Chief of Staff ( ) Secretary

ADDRESSES

The Honorable _____
United States Senate
Washington, DC 20510

The Honorable _____
House of Representatives
Washington, DC 20515

HOUSE OF REPRESENTATIVES Committee on Interstate and Foreign Commerce, Subcommittee on Health and the Environment – Members.

Democrats		Republicans
Henry A. Waxman, (CA) Chairman		Tim Lee Carter (KY)
Richard C. Shelby (AL)	Barbara A. Mikulski (MD	William E. Dannemeyer (CA)
Andrew Maguire (NJ)	John M. Murphy (NY)	Edward R. Madigan (IL)
Richardson Preyer (NC)	Thomas A. Luken (OH)	Dave Stockman (MI)
Doug Walgren (PA)	William Phillip Gramm (TX)	Gary A. Lee (NY)
G. T. (Billlahay) Leland (TX)	David Butterfield (VA)	Samuel L. Devine (OH) Ex-Officio
Harley O. Staggers (WV) Ex-Officio		

STATEMENT OF CHARLES W. PEARCE, M.D., OF DRS. PEARCE, GIBSON, WEICHERT & BERTHEA ON THE NEW ORLEANS/BAYOU RIVER HSA PROPOSED GUIDELINES DRAFT ADDITIONS

The Health Systems Agency (HSA) has stated that a minimum of 350 cardiac catheterizations and 200 open heart surgical procedures should be performed annually to utilize hospital facilities properly and to maintain fine honing of medical skills.

During the past year my associates and I performed more than 300 open heart surgical procedures and will perform close to 400 during 1979. The medical cardiologist with whom we work performed more than 1,200 cardiac catheterizations during this past year and will perform even more during 1979. These operation and catheterizations are performed at three hospitals, the Southern Baptist Hospital, the Touro Infirmary, and the Hotel Dieu Hospital.

The HSA, as reported in the States-Item and Times Picayune, said death and complications rates appear related to the number of "previous and continuing experience." I would like to point out that in our own experience deaths and complications rates are lower than in most hospitals and centers over the country performing more than 200 open heart operations annually. Our mortality rate for patients undergoing coronary bypass operation for stable angina pectoris is 1 percent, as low as any in the country.

The HSA report was also quoted as saying that "costs and risks associated with underuse of open-heart surgery resources are sizable for residents of the area." As to costs I am willing to state that hospital costs for patients in this area are below the national average.

The HSA report spoke of "hospitals in the area performing open heart surgery." I would like to point out that operations are performed by doctors, not by hospitals. To imply otherwise is to dehumanize the care of patients, to interpret medical care as a cold, impersonal relationship between patient X and hospital Y.

The HSA report spoke of hospitals unnecessarily duplicating services. The word "duplication" carries a critical connotation. It implies something exists that does not need to exist. Facilities are available and doctors and personnel work at a number of hospitals in this area to provide quality care to patients with heart disease.

Availability of sophisticated services at area hospitals gives better service to more patients, provides the fine honing of medical and surgical competence fostered by competition, and brings in to play the critical eye of fellow cardiologists, surgeons, other doctors, and patients. There is no substitute for healthy competition.

This is part of the American tradition, a tradition of healthy competition that has made this country foremost in the world. I would hate to be counted among those who would destroy this tradition.

Secondary benefits of open heart surgery programs are also important. Personnel in the intensive care units are experienced in management of open-heart surgical patients, and are expert in the use of cardiac and arterial pressure monitoring, respiratory support, use of cardiac assist devices, cardiac resusciation and many other aspects of modern intensive care support. Time and again lives are saved and difficulties treated promptly and efficiently. Countless patients with acute myocardial infarcts, ruptured appendices, or intestinal obstruction, to name but a few, owe their lives and recovery to this expertise.

Although my associates and I perform a large number of operations, I would like to point out that numbers of operations performed does not equate with quality. We are all familiar with the shoddy second-rate products of mass production. Simply contrast these with the superb products of master machinists, created with quality, not quantity, in mind. So it is with open heart surgery.

The attempt to set standards of minimum numbers of catheterizations and operations also creates two potential adverse effects.

Hospitals may encourage and doctors may be tempted to liberalize indications for these procedures in order to satisfy the numbers. Patients may than be subjected to ill advised or unnecessary procedures. Secondly, the cost of health care will be increased to pay for such procedures.

It would be tragic, indeed, to see the high ethical standards which now exist eroded by a numbers game.

More than 1,200 heart catheterizations were performed this past year by the cardiologists with whom we work, yet we operated upon only 300 of these patients. By using liberal indications for operations we could have operated upon more patients. However, we chose not to recommend operation to those patients, using our judgement of what was best for the patient. It is interesting, and also a little

amusing, to note that heart surgeons have been critized by some for doing too many operations. Now the HSA comes along and critizes us for doing too few.

Isn't it odd that the HSA survey made no attempt to determine the quality of care rendered patients. No information was requested from area hospitals regarding deaths, complications or long term results. No information was requested on training, certification, experience, or reputation of the cardiologists or surgeons. No information on patient satisfaction was requested. Yet the report, without any facts to support it, clearly implies these surgeons and cardiologists are rusty, that hospital personnel are inexperienced, that patients suffer dire consequences.

These statements in the HSA report represent at best, speculation, and at worst, blatant propaganda of a libelous nature.

The irresponsible misleading statements of HSA represent the most evil form of propaganda, intended to influence and mold the minds of our citizens, and is comparable to statements by a ministry of propaganda, A retraction of these statements is the least one can demand of HSA, and I hope this will be published by our leading newspapers on their front page.

MEDICARE COSTS DATA

There has been widespread concern about rising health care costs, encouraged by those who claim to be experts in medical economics. Indeed these experts have been the jockeys with electrical prods and silver spurs driving the medical steed to near exhaustion and hallucinations.

They have urged the Congress to appropriate money to expand medical and nursing schools, subsidize students, both undergraduate and graduate post graduate to correct the doctor and nurse shortages. These same now complain that there are too many doctors who order too many tests, do too many operations, prescribe too many drugs. For years they exhorted medical schools and laboratories to expand research to extend life, reduce suffering and mend the disabled. Tremendous advances have been made in all these fields. But the costs are advancing apace. Those who demanded the expansion are the loudest complainers of the cost.

These same iconoclasts encouraged the building of hospitals through support of Hill-Burton funds. Through public and private effort the greatest facilities for care of the sick have been erected. The experts have decided that we have too many hospital beds and have devised methods and laws such as health service areas, compulsory planning, PSRO, Utilization Review and criteria and standards compendia to ration the use of facilities by the people whose labor has provided them.

Through deceptive and dishonest public criticism of medical practitioners and hospitals the medical mass production advocates have attempted to destroy the confidence of the public in physician and medical institutions. They have failed. It is little consolation that all other professions and institutions have also suffered losses in public confidence of much greater degrees than medicine. The truth is that to retain a level of confidence medicine has instituted and implemented programs that are tremendously expensive and often counterproductive.

The measures taken by the professions, voluntary and under legislative duress, to document accountability have inordinately increased cost and reduced productivity. Medicare demands cost accounting and the expense of processing the charge is frequently greater than the price of the item. Aspirins which cost 0.1 cent are provided to the hospital patients at 25 cents each.

Yet this cost is trivial compared to the diagnostic procedures ordered to satisfy third parties and to document conditions so that the physician may be able to defend himself in court. Much of this is waste made necessary by the erosion of patients' trust of physicians.

This is not a denial that there are not physicians who are not worthy of the confidence placed in them. Rather it is a reminder that doctors are men and medicine is not an infallible science. The dishonest and the fraudulent physician is uncommon. Most of these were handled well by the profession through hospital staffs, medical societies and licensing board. The sanctions employed by the above methods have largely been voided by civil rights laws and legal procedures. Their replacement by regulation, codification and litigation has been less effective and inestimably expensive.

Some measure of this cost can be read in the comparison of Medicare costs in the various states. The data is rather old. The latest available in 1976 was for 1972. Does it not seem strange that with the employment of computers, and modern equipment that simple data such as expenditures by States is obtainable by non governmental taxpayers only after four years? The table lists the medical expenditure for each enrollee in Medicare. The sum of the amounts spent for Part A and

Part B do not equal the total expenditures. This is not due to mathematical errors but to the official data provided by HEW.

It is interesting that there are 16 states in which expenditures exceed the national average and 34 below. The 16 states represent 39 percent of enrollee and 48 percent of payments. The cost per enrollee in New York was double that for Arkansas. Cost per enrollee in Louisiana is 55 percent of that in New York. Florida expenditure per enrollee are only 75 percent of those in New York. The costs in California are only about $15 less than New York. The data for 1975, received in 1977, is attached. Massachusetts has passed New York and California in expenditures per enrollee. Louisiana had dropped from 42d to 43d.

Since the payments and taxes are the same in all the States it appears that the population of the poorer states are being forced to subsidize the residents' of the wealthy states.

Is it not a strange insurance tha penalizes the poorer states and subsidizes the wealthy one?

Ref: "Medicare" DHEW

MEDICARE EXPENDITURES BY STATE, 1975

	H.I. and S.M.I.	H.I.	S.M.I.	U.I.	U.N.
Nat'l Average	582.90*(595.40)+	426.90	168.56	100	72.5
1. MASS.	804.36 (816.56)	633.38	183.18 (10)	138	100
2. CALIF	759.69 (774.75)	515.07	259.66 (3)	130	94.5
3. N.Y.	757.90 (770.23)	551.08	219.15 (6)	130	94.2
4. NEV.	745.00 (762.42)	517.63	244.79 (4)	128	93.0
5. D.C.	710.71 (762.57)	499.75	262.82 (2)	123	89.1
6. MICH.	706.42 (714.43)	539.50	174.93 (14)	121	87.8
7. CONN.	704.71 (713.35)	533.53	179.82 (11)	121	87.6
8. R.I.	654.70 (664.58)	471.53	193.15 (9)	112	81.4
9. ALAS.	643.46 (668.20)	446.11	242.09 (5)	110	80.0
10. N.J.	641.47 (649.43)	475.19	174.24 (15)	110	79.7
11. ILA.	639.46 (654.15)	437.99	216.16 (7)	110	79.5
12. PT.	628.30 (642.79)	469.13	173.66 (16)	108	78.0
13. ILL.	624.09 (633.76)	484.50	149.26 (22)	107	77.6
14. ARIZ.	618.52 (630.05)	421.07	208.89 (8)	106	76.9
15. MINN.	595.66 (602.26)	456.48	151.78 (21)	102	74.1
*16. DEL.	582.72 (590.46)	438.20	152.28 (20)	100	72.4
17. VT.	579.86 (582.66)	441.07	140.99 (30)	100	72.0
18.HAWAII	575.88 (578.99)	258.99	320.00 (1)	99	71.6
19. N.D.	575.11 (583.03)	453.90	129.13 (37)	99	71.5
20. COLO.	565.00 (597.03)	417.87	179.16 (12)	97	70.2
21. WIS.	552.83 (558.30)	415.90	142.40 (27)	95	68.7
22. OHIO	549.26 (559.94)	418.34	141.60 (28)	94	68.3
23. IA.	546.06 (553.73)	399.68	154.10 (18)	94	67.9
24. WIX.	544.36 (555.77)	377.00	178.77 (13)	93	67.7
25. MO.	535.83 (544.43)	417.09	127.34 (38)	92	66.9

(cont.)	HOSP. and S.N.I.	HOSP.	S.N.I.	N.A.	MAX.
26. ONT.	534.24 (542.31)	388.52	153.79 (19)	92	66.4
27. KAN.	522.54 (534.26)	390.15	144.11 (25)	91	65.6
28. MI.	515.20 (522.61)	386.87	135.74 (33)	88	64.0
29. N.H.	508.34 (515.51)	382.06	133.45 (34)	87	63.2
30. IND.	507.27 (512.78)	388.63	124.15 (39)	87	63.0
31. WASH.	505.14 (513.24)	349.03	164.21 (17)	86	62.8
32. OKLA.	496.34 (507.54)	364.00	143.54 (26)	85	61.7
33. VA.	488.29 (500.49)	360.18	140.31 (31)	84	60.7
34. IOWA	487.42 (492.14)	377.77	114.37 (47)	84	60.6
35. N.M.	480.13 (493.65)	342.28	151.37 (23)	82	59.7
36. IDAHO	475.29 (484.57)	352.57	132.00 (34)	82	59.1
37. NEB.	475.20 (480.76)	358.19	122.57 (43)	82	59.1
38. GA.	471.29 (483.61)	336.56	147.05 (24)	81	58.6
39. S.D.	461.82 (467.89)	365.39	102.50 (49)	79	57.4
40. MONT.	451.29 (457.50)	321.64	136.46 (32)	77	56.1
41. N.C.	446.40 (457.16)	335.13	122.05 (44)	77	55.8
42. ALA.	443.07 (454.44)	323.22	131.22 (36)	76	55.1
43. LA.	437.41 (451.51)	328.30	123.21 (42)	75	54.4
44. WY.	429.80 (435.66)	318.76	116.90 (45)	74	53.4
45. TENN.	428.97 (437.87)	322.68	115.19 (46)	74	53.3
46. MISS.	419.40 (432.12	308.00	124.12 (40)	72	52.1
47. KY.	417.20 (425.68)	333.85	91.83 (50)	72	51.9
48. S.C.	410.76 (421.39)	312.56	108.83 (48)	71	51.1
49. UTAH	408.38 (417.27)	275.98	141.29 (29)	70	50.8
50. W.VA.	393.54 (399.95)	308.43	91.52 (51)	68	49.0
51. ARK.	377.52 (385.65)	262.07	123.78 (41)	65	47.0

* Total amount quoted in HEW Report.
\+ Parts A and B added separately.

NOTE: 1975 is the last year for which HEW can supply this data.

MEDICARE EXPENDITURES BY STATE, 1972

Ref: "Medicare" DHEW

STATE	TOTAL EXPENSE PER ENROLLEE		HOSPITALIZATION		PART B	
United States	358.00*	381.48+	276.36	310.00	107.64	99
1. NEW YORK	$485.59	519.24	410.40	$344.95	1170	$135.12
2. CALIFORNIA	$470.96	504.42	358.16	$327.55	1422	$150.70
3. MASSACHUSETTS	$451.86	519.84	410.40	$346.19	1170	$111.64
4. RHODE ISLAND	$434.08	463.68	340.20	$320.95	122.64	$118.44
5. District of Columbia	$424.70	442.76	316.20	$326.07	126.72	$124.13
6. NEVADA	$420.51	432.08	304.56	$304.97	161.28	$123.96
7. CONNECTICUT	$414.19	449.76	346.80	$319.72	102.96	98.77
8. MICHIGAN	$389.54	442.09	343.92	$296.84	104.88	$ 96.96
9. MINNESOTA	$387.37	394.92	303.12	$303.50	102.72	$ 87.97
10. VERMONT	$382.11	388.20	294.72	$299.70	99.60	$ 87.20
11. COLORADO	$374.65	382.12	271.36	$270.11	111.60	$110.75
12. NEW JERSEY	$371.50	387.84	261.60	$256.40	131.28	$119.58
13. ARIZONA	$370.19	377.52	266.52	$263.15	124.80	$113.93
14. Florida	$364.54	393.36	257.04	$239.30	142.68	$130.45
15. MARYLAND	$357.93	360.00	294.24	$275.81	165.12	$ 91.20
16. DELAWARE	$354.27	365.64	296.24	$271.40	94.32	$ 83.32
17. WISCONSIN	$346.02	367.08	288.72	$269.28	81.80	$ 79.93
18. TEXAS	$345.65	373.92	277.68	$241.94	103.44	$110.70
19. ILLINOIS	$344.76	387.84	320.16	$252.18	88.56	$ 87.42
20. N. DAKOTA	$338.29	357.12	282.48	$267.50	79.20	$ 74.60
21. MISSOURI	$331.80	337.36	248.64	$253.60	84.24	$ 83.24
22. OREGON	$331.68	320.16	233.76	$235.34	91.92	$80.71
23. OHIO	$325.36	341.48	271.68	$259.01	85.92	$ 70.85
24. PENNSYLVANIA	$325.05	348.44	255.48	$236.08	99.48	$ 93.99
25. KANSAS	$324.33	339.96	259.68	$243.26	85.44	$ 85.25
26. MONTANA	$323.85	327.36	243.12	$245.89	91.68	$ 82.92
27. OKLAHOMA	$319.54	316.68	237.48	$226.06	96.60	$ 99.59
28. HAWAII	$319.44	310.68	210.24	$224.13	106.32	$101.94

CONTINUED:

29.	NEW HAMPSHIRE	$306.86	324.32	148.12	$235.17	28.82	$ 75.10
30.	IOWA	$305.72	316.46	249.22	$238.09	74.98	$ 70.56
31.	ALASKA	$303.09	393.12	350.16	$209.98	134.98	$117.47
32.	NEBRASKA	$302.57	318.24	155.68	$223.40	83.04	$ 82.92
33.	WASHINGTON	$302.17	342.96	246.00	$209.65	101.88	$ 96.72
34.	S. DAKOTA	$300.56	308.28	245.54	$233.90	68.40	$ 64.10
35.	INDIANA	$300.55	318.24	243.00	$240.08	79.20	$ 76.01
36.	MAINE	$299.49	334.20	251.64	$231.24	83.28	$ 72.11
37.	NEW MEXICO	$289.92	322.16	218.28	$207.26	124.80	$ 91.10
38.	IDAHO	$288.81	306.72	229.68	$214.65	93.48	$ 77.81
39.	WYOMING	$285.28	284.20	218.16	$217.85	75.24	$ 71.35
40.	GEORGIA	$275.27	272.24	202.32	$186.05	90.72	$ 86.11
41.	ALABAMA	$270.38	268.32	192.24	$194.23	80.16	$ 82.03
42.	LOUISIANA	$269.00	282.24	217.08	$200.29	75.84	$ 77.84
43.	VIRGINIA	$264.26	256.20	208.44	$204.18	93.36	$ 65.90
44.	KENTUCKY	$261.44	265.92	209.76	$202.85	63.24	$ 63.08
45.	N. CAROLINA	$262.20	274.24	205.20	$203.28	86.04	$ 63.05
46.	MISSISSIPPI	$259.39	240.36	198.24	$192.95	95.40	$ 72.85
47.	TENNESSEE	$258.80	270.48	208.32	$191.99	67.32	$ 71.64
48.	ARKANSAS	$241.20	266.64	217.08	$174.53	75.24	$ 71.56
49.	UTAH	$238.30	286.08	207.60	$164.89	73.32	$ 77.55
50.	W. VIRGINIA	$238.13	261.12	203.28	$191.91	62.16	$ 49.47
51.	S. CAROLINA	$202.14	226.56	173.64	$142.50	59.88	$ 64.59
52.	PUERTO RICO	$135.66	131.28	90.36	$ 91.93	79.08	$ 81.29

* Total amount quoted in HEW Report
\+ Parts A and B added separately

NOTE: 1975 is the last year for which HEW can supply this data

Ref: Hospitals "Guide" 1975, AHA

SELECTED HOSPITAL COSTS PARAMETERS

HOSPITALS	LENGTH OF STAY	COST PER DIEM	EMPLOYEES PER PATIENT
Louisiana:			
CHARITY	no information		
HOTEL DIEU	8.46 days	173.64	3.79
MERCY	6.95	161.11	3.58
OCHSNER	8.95	179.84	3.73
BAPTIST	9.27	117.40	3.04
TOURO	9.91	151.53	3.82
PUBLIC HEALTH	13.75	133.75	2.57
VETERANS	16.67	144.24	2.74
SARA MAYO	no information		
METHODIST	6.95	173.93	3.71
Massachusettes:			
AFFILIATED HOSPITAL CENTER	7.05	340.20	6.60
BETH ISRAEL	8.70	292.42	6.26
R.C.CARNEY	10.66	194.04	4.05
BOSTON CITY	8.14	457.48	7.79
MASSACHUSETTES GENERAL	11.78	412.52	7.00
NEW ENGLAND BAPTIST	11.84	127.75	2.05
NEW ENGLAND DEACONESS	11.68	230.74	4.85
NEW ENGLAND MEDICAL CENTER	10.11	406.21	8.63
ST. ELIZABETH	9.47	219.97	4.52
U.S.P.H.S.	13.67	196.32	4.0
UNIVERSITY	17.96	312.64	5.07
VETERANS	19.81	116.82	2.21

(2)

HOSPITALS	LENGTH OF STAY	COST PER DIEM	EMPLOYEES PER PATIENT
New York:			
LOGAN MEMORIAL	13.3	215.14	3.84
BEEKMAN	14.57	183.69	2.71
BETH ISREAL	12.44	217.04	3.57
BRONX	12.10	320.95	5.09
BROOKDALE	10.98	260.83	4.20
CABRINI	22.30	159.29	2.88
CALEDONIA	9.65	119.94	2.57
CATHOLIC MEDICAL CENTER	10.57	200.80	3.81
DOCTORS	9.19	189.26	3.85
COMM. H BROOKLYN	10.39	114.75	2.16

LOUISIANA PARISHES

PARISH	COST /ENROLEE IN MEDICARE
JEFFERSON	514.55
ORLEANS	404.87
CADDO	298.69
CALCASIEU	404.64
BOSSIER	269.16
LA FOUCHE	308.70

Senator BAUCUS. We will now hear from Dr. Jay Dobkin, President of Physicians National Housestaff Association.

STATEMENT OF DR. JAY F. DOBKIN, PRESIDENT, PHYSICIANS NATIONAL HOUSESTAFF ASSOCIATION

Dr. DOBKIN. I have a brief statement and I will summarize it even more briefly.

I would like to point out at the outset that I think there is really one major point for me to make today and it comes from a different direction than what you have heard this morning and in the past.

It is from the interns and residents who work within the hospital system and provide the great bulk of patient care in many of the biggest and busiest hospitals across the country.

The message that I relay from them is they, too, are feeling the cost crunch. The increases in cost, the inflation and the dislocations that are produced are not just impacting on the economy in general but on hospital employees and health care consumers.

Increases in costs and the reactions to them have taken the flexibility out of the system, making needed adjustments for better patient care very difficult in many hospitals.

Some of the reactions to increasing costs have also had a damaging impact both medically and economically and have been counterproductive.

Particular efforts as represented in the legislation and in the committee's staff report, are important steps in dealing with these problems.

Unlike the previous witnesses, I do not think throwing out the baby with the bath water is the answer. I think we in fact have serious issues to deal with and they must be dealt with soon.

I think both cost and quality controls are necessary to maintain and improve U.S. medical care. Either alone can be ineffective or even counterproductive.

The very important concept from our point of view working in large urban hospitals is that a guarantee of maintenance of important services must be included. Otherwise, the various forces in different directions may result in elimination of the most important kinds of services, the services for the disabled, the public health services, early diagnostic and screening services and so forth.

There are a number of cases in which efforts by hospitals to tighten up on costs and react to inflationary pressures have been counterproductive. I have cited a few. One in particular of a limited nature but I think an example of what we see all across the country, is the case where a hospital in trimming its staff closed its X-ray file room during the 12 p.m. to 8 a.m. shift. This may have been a good economy from the point of view of the administrator. It turned out that the residents were unable to obtain X-ray films that were necessary. This sometimes interferred with good patient care and frequently necessitated repeat X-rays at increased costs and obviously increased exposure to radiation.

On a larger scale, many public jurisdictions across the country have reacted to the overall squeeze, the added medicaid budgets that they have to carry by cutting back on what is most easily

controllable. These services frequently are the public health services, the health centers, the veneral disease and tuberculosis screening programs and so forth.

Obviously again, it is a false economy.

Several features of S. 505 and the committee's staff alternatives show how cost and quality objectives can be jointly pursued.

Addressing the matter of excess beds, unnecessary days in the hospital and the channeling of patient care funds into other activities is an important step.

The debate over section 227 of the medicaid regulations is a good example of an area that needs to be addressed.

The team approach to medical care involving attending physicians, interns, and residents, is one that we certainly think produces good care and cost-effective care. This should not be a license fc · what has been termed "backdoor financing" of other kinds of activities of medical schools.

We think the committee's efforts to correct this are laudable.

Another example of dislocations and counterproductive kinds of approaches which can result from a piecemeal sort of system is also referred to in the committee staff's report: the phenomenon of weekending where patients will be brought in a couple of days before any actual procedures will be begun, simply to fill empty beds. This is wasting resources and wasting the patient's time. This again is a problem that I think is amenable to a comprehensive sort of approach, a look at hospital beds, at hospital procedures, and an effort to establish 7-day-a-week service in many areas.

I think the current fragmented approach to financing and regulating health care has produced significant problems. True costs frequently are unrelated to charges and institutional self-interest may frequently dominate public interest.

Implementation of planning and other current regulations, we think is necessary, along with any broad based new reforms.

Thank you.

Senator BAUCUS. Thank you very much, Dr. Dobkin.

You referred to a basic message from resident doctors concerning waste and inefficiency in hospitals. You mentioned weekending as apparently one practice that is wasteful.

I wonder if you could more fully explain and give us examples of other kinds of waste and inefficiency that residents are finding in hospitals?

Dr. DOBKIN. One of the difficulties is each individual patient or provider usually only sees the part of the system they are involved with. There are many kinds of economies suggested by the reduplication of equipment and services and procedures in many hospitals in a given area. The duplicated facilities are perhaps desirable from the point of view of the individual institution or the medical school, but there is certainly plenty of room to regionalize highly complicated and highly expensive procedures, both diagnostic and therapeudic, that would not interfere, in our judgment, with training or patient care and would enhance the cost effectiveness of medical care.

We think all three would be better served by addressing some of these kind of programs on a regional basis rather than having them fragmented and splintered in half a dozen institutions.

Senator BAUCUS. What else besides duplication of equipment?

Dr. DOBKIN. The larger question of hospitalization where outpatient treatment would suffice is an important example. Because of the nature of the reimbursement system in many cases, patients are put in the hospital or kept in a hospital when they could just as easily or perhaps better be treated on an outpatient basis.

I think this again is an area where a modification would both improve patient care and be cost effective.

Senator BAUCUS. As you probably know, this committee several years ago with the General Accounting Office found substantial abuse in billing for services by so-called teaching physicians where virtually all the care was in fact rendered by house staff.

In your statement you say that medicare payments for phantom attending physicians not only will increase costs but reduce the quality of care.

I wonder if you could describe what you mean by "phantom attending physicians" and how widespread is this problem?

Dr. DOBKIN. I alluded to this and I can explain it in more detail. The nature of physician care in many of the largest hospitals, the so-called teaching hospitals, across the country is a team kind of effort. In fact, the care that is available would not be if not for this kind of team approach in which there will be interns, residents, medical fellows all in training programs doing the 24 hour a day, 7 day a week care at the bedside, supervised by attending physicians with various subspecialists as backups.

This is an effective system that allows for a type of care which probably would not be possible, certainly not without greatly increased costs otherwise.

We think and we have direct experience in many cases that there is abuse of the system and abuse of the phenomenon whereby the services that the interns and residents render are then billed for as private services provided by an individual attending physician. In some cases, the attending physician is not present when these services are rendered and in many cases, they are rendered routinely by housestaff doctors. We feel these services should be paid for on a cost basis rather than on a charge basis since that is the mechanism that has been set up to pay for the costs of the residents.

It in effect amounts to double billing or double dipping to rebill as a private service.

The worst problem is that the patient is shortchanged in these cases since the financing that is coming out of patient care programs, like medicare, is going into other activities of medical schools or hospitals that are not related to direct patient care.

We think if charges are going to be provided for attending physicians, those physicians should be present and participating in the care of the patient.

We have a number of examples where there are no-show attending physicians that hospitals are paying for. There are affiliation arrangements between various hospitals under which subspecialists are supposed to be available or make rounds at the affiliated hospital and they do not show up or they are not there as frequently as they should be.

We consider this both an abuse economically and an abuse medically because the patient for whose care these services are being paid, is not getting them or not getting them as fully as they should.

Senator BAUCUS. How widespread is it? Is this a recurring problem? Is it an occasional problem?

Dr. DOBKIN. We have not been able to do an exhaustive survey to quantify the problem. It seems to be fairly widespread. We have reports of this sort from many of our local groups all around the country. It seems to be a particular problem in cases where there are affiliations between private hospitals and public hospitals or medical schools and public hospitals in which there are professional services provided under contract with specific arrangements being left to the school.

It also seems to be a problem in some Veterans' Administration Hospitals where there are similar kinds of affiliations and in fact the services that are expected are not provided.

Senator BAUCUS. Thank you very much, Dr. Dobkin. We appreciate your testimony.

[The prepared statement of Dr. Dobkin follows:]

STATEMENT OF JAY DOBKIN, M.D., PRESIDENT, PHYSICIANS NATIONAL HOUSESTAFF ASSOCIATION

The need for re-structuring our hospital financing system is perceived not only by the patient, the 3rd party payer or the government. It is also quite apparent to those who work providing the bulk of direct patient care services in many hospitals—the intern and resident physicians. As president of the Physicians National Housestaff Association and as a doctor recently finished with 5 years of residency, I would like to report on this perspective on hospital costs.

There are 65,000 young doctors working as interns and residents in the major hospitals in this country. These doctors work in emergency outpatient and inpatient activities, with round the clock work-days and 80 to 100 hour work weeks. They are in a unique position to observe the impact of costs, cost controls and related phenomena.

The basic message we get from resident doctors on the cost issue is that waste and inefficiency in hospitals not only cost the American people a great deal of money but also prevent necessary expenditures in important areas. Paradoxically, as our health care system spends more in general, pressures mount to cut back on some of the most important but least defended services and institutions. A national policy on health care costs is clearly necessary but also needed are implementation of national policies on health care quality and perhaps most important, health care priorities.

Resident physicians active in PNHA have cited instances where cost-related measures lost sight of the larger picture and became unproductive or counterproductive.

A Los Angeles hospital, cutting its clerical staff, became unable to process millions of dollars of outpatient 3rd party bills leading to an apparent crisis in support for vital outpatient early diagnostic and preventive services.

A New York hospital, trimming its staff, eliminated the X-ray file room clerk on midnight to 8 a.m. shift. Unable to obtain X-rays resident physicians were deprived of important patient care data and forced in some cases to repeat X-rays which were locked in the file room. An "efficiency" therefore can actually be counterproductive in financial and other ways.

Across the country states and counties have responded to the cost crunch by cutting back on vital, cost effective programs in public health, public hospitals and other areas. Even among those residents uninformed about or unconvinced by the macro-economic arguments, cutbacks in emergency, paramedic, outpatient, screening and preventive services provide a compelling argument for national cost control measures.

There are several very important features of S. 505 and the Finance Committee's staff alternatives report. They speak to the need for rationalizing health care finances. The policy on reimbursement for teaching physicians covered in Section 8 is an example. The system of patient care provided by teams of resident physicians

and supervising attending doctors is a remarkably productive one. Round-the-clock care of the highest order is the result. However the use of patient care funds generated by this service for non-patient care activities by medical schools is unwarranted. Medicare payments for "phantom" attending physicians not only increase costs but diminish the quality of care. Another important step we commend is outlined in item 7 of the Staff report. It deals with the cost of "weekending" by elective patients who will receive no real care until Monday but are brought in on Friday or Saturday to fill beds and generate revenue. This practice, a response to excess beds and the need to increase revenue by hospitals could be addressed by a combination of approaches all of which necessitate better planning: regionalization of services, eliminating excess beds, 7-day a week services in some areas.

The larger issue of health planning is a crucial one. We are seeing the effects, large and small, of an unplanned hospital system reacting to cost pressures. The urban public hospitals in particular are suffering under the stresses of tight financing and the unloading of expensive, uninsured patients and services by the private sector as it seeks to protect itself. The result in human terms can be devastating as services for which millions of people have no alternative are overloaded, cutback or even eliminated. It is remarkable to realize that many of these issues were fully anticipated by the Health planning and Resources Development Act of 1974. The implementation is all that is missing.

There is a growing understanding among young physicians that health care policy must be a joint concern of all those involved—provider and consumer alike. The "head in the sand" manner in which such issues have been treated previously must give way to a willingness to acknowledge problems and make changes where needed. Our organization looks forward to continue such efforts in the future.

Senator BAUCUS. Since there are no other witnesses, the hearing is now adjourned.

[Whereupon, at 12:40 p.m., the subcommittee was adjourned.]

[By direction of the chairman the following communications were made a part of the hearing record:]

STATEMENT OF DAVID C. CROWLEY, EXECUTIVE VICE PRESIDENT OF THE AMERICAN ASSOCIATION OF HOMES FOR THE AGING

I am David C. Crowley, executive vice president of the American Association of Homes for the Aging (AAHA). The American Association of Homes for the Aging represents the nonprofit providers of institutional services for older Americans, including housing, health-related services and medical care. Our 1,700 member homes serve nearly 300,000 senior citizens. Among our members are a number of facilities which participate in the title XVIII (medicare) program as skilled nursing facilities and in the title XIX (medicaid) program as skilled nursing facilities and intermediate care facilities.

We are pleased to have this opportunity to comment on S. 505, the Medicare-Medicaid Administrative and Reimbursement Reform Act. We commend this committee for its continuing efforts to improve the performance of these two programs, and our association joins with the many public interest groups which have come before the committee urging expeditious consideration of these reform amendments.

To facilitate review of our comments, we set forth our viewpoint with respect to S. 505 on a section-by-section basis, offering additional issues for possible consideration by the committee within this reform package as the final points of our testimony. Inasmuch as we filed extensive comments during committee consideration of a similar measure during the 95th Congress (statement of David C. Crowley on behalf of the American Association of Homes for the Aging regarding S. 1470, 95th Congress, June 16, 1977), we shall limit our remarks to new supportive materials which assist in explaining the position of our Association. Members are encouraged to review our previous statement for additional background information.

As the following summary table indicates, we have limited our remarks to the areas of membership expertise, that is, long-term care services. Our principal concern is that actions which reinforce the medical emphasis of the Medicare and Medicaid programs may restrict the eligibility of older persons to receive appropriate services. Caution must be exercised in moving toward a consolidation of the skilled nursing and intermediate care entitlements to prevent a reinforcement of only a medical model for long-term care.

While the inevitable evolution of present policies regarding utilization review, reimbursement and eligibility criteria are shaping the parameters of an acute model for nursing home services, these tendencies are being contested. We cannot take

lightly the preliminary findings of the 1977 Nursing Home Survey of the National Center for Health Care Statistics, which point out that there is a marked difference between residents' and discharges' length of time in a facility. This finding reaffirmed our observation to the committee that there are two separate groups of persons who use nursing homes: those admitted for relatively long periods of time because there is limited chance of their chronic problem improving and those admitted for relatively short periods of time because recuperative care is needed.

In pursuing policy objectives to strengthen the efficiencies of the providers of long-term care services, we must be mindful not only of the potential trade-offs which might occur between cost containment and quality, but also the external factors of differing products, i.e., differing patient mix, differing intensities of services, etc. Medicare and medicaid long term care policy goals must not be confused.

LONG-TERM CARE ISSUES IN S. 505 SUMMARY SHEET

Section number and short title	*AAHA's suggestions*
3 to 13—Conversion	Suggest experimental, limited approaches.
14—Nursing home reimbursement	Supports amendment. Policy should be clarified on capital accumulation opportunities for not-for-profit facilities.
15—Standardized certification process	May have some unintended consequences.
16—Visitation rights	Very strongly supports.
24—Restrictions on disposition of assets	Supports.
29—Removal of certain limitations on home health benefits.	Very supportive. Should be expanded to removal of prior hospitalization requirements on skilled nursing facilities.
30—Durable medical equipment	Should be strengthened to insure payment for services to individuals based on need rather than participation.
33—Charitable support	Very important, very supportive.
34—Study provision on availability of services.	Very supportive.
37—Study provision, classification of certain skilled nursing facilities	Very supportive.
Committee budget option 10—Repeal of section 249 cost-related reimbursement	Strongly opposed.

Sections 3 and 13.—Closings, conversions and hospital providers of long-term care

As we pointed out to members of the committee in our previous testimony, we question the appropriateness of hospital facilities for long-term care service delivery. The committee must be conscious that the rising demand for institutional long-term care services is most evident in the following areas: Congregate care, residential living with personal care services and intermediate care services. While the services offered in these institutional settings are as important as the medical care rendered in skilled nursing facilities, the primary thrust is to provide protective shelter with personal and environmental assistance to the ambulatory, long stay population. Certainly, the mere physical structure of a hospital setting inhibits the flexibility in a program necessary to meet these needs of patients and residents.

In solving the problem of surplus hospital beds, we should be careful that we do not create a worse problem: Isolating older people who need long term care in cold, sterile environments in which they become lonely and dependent. The trend in long term care is to build bridges with the community and to encourage a stimulating environment in which residents can interact. Old hospital buildings will require extensive renovation if they are to attend to the needs of the long term care patient/resident.

Section 13 appears to be a realistic approach to the conversion process, i.e., providing for an initiation of the program in those areas where the most severe shortages of long term care beds persist, and ensuring a parity in the reimbursement structure. We should be careful that the reimbursement incentives for conversion in the reimbursement process do not undermine our continued efforts to adequately fund services to all residents of long-term care facilities under the public programs.

In enacting these conversion incentives, the committee should instruct the Department to develop an effective evaluation process to ascertain if there is a difference in the quality of life within a converted hospital and other long term care

facilities. The evaluation could monitor both the efficiency and the effectiveness of care delivery along with the impact upon resident life. Such an evaluation could provide valuable information to this committee in exploring future policies with respect to providing an adequate supply of long-term care facilities.

Section 14.—Reimbursement rates under medicaid for SNF's and ICF's

Our Association vigorously opposes a repeal of the section 249 requirement as suggested in the budget options presented by committee staff. The enactment of section 249 was a recognition by the Congress that payment for services in skilled and intermediate care facilities under a flat rate system often has little relationship to the actual cost of providing quality services. Overlooked in the rhetoric of debate on the section 249 requirement is the important step which this Congressional enactment took in enhancing accountability in the payment for long-term care services. While allowing maximum state flexibility to design a system that meets local needs, this statute requires attention to the methodology used in developing a payment mechanism and it forces a positive federal review of the state decision. While we are concerned that the Congressional instruction to promote reasonableness in Medicaid reimbursement has been compromised in the implementation of the statute by delayed HEW regulations and benign neglect by state officials, repeal is not the solution for building accountability into the medicaid program.

Providers of long-term care services are engaged in an agonizing struggle with States to develop reimbursement policies that are reflective of congressional intent for reasonable, cost-related purchasing of services. While we support the intent of section 14, as proposed in S. 505, we ask the committee to clarify the availability of such payments to not-for-profit and public providers and to provide guidance to the Department on the types of incentives permissible.

Implicit in the Department's implementation of section 249 of Public Law 95-142 is a bias against the not-for-profit sector. Without justification, the preamble to the July 1, 1976, rules prejudges the inclusion of growth allowances as a valid form of reimbursement by the states, and without explanation read into section 1902(a)(13)(E) of the law a prohibition that is neither mentioned in the statute nor in the Committee supporting material. The guidelines which have been prepared by the Department specifically state that "in no case may the allowance include a factor as a return on equity for nonprofit providers."

Nonprofit homes have been severely squeezed in maintaining services at a high level of quality while government standards have been lowered to a level justified by the economics of the medicaid program. Growth has been suffocated by restrictions of surplus accumulation, lack of return on investment and control on expansion. With limited opportunities to accumulate needed investment for capital replacement and expansion, or to recoup costs associated with present investment opportunities, the not-for-profit sector is at a severe disadvantage in continuing to serve the elderly through the Medicare and Medicaid programs.

Repealing Section 249 is not the answer to building accountability into the medicaid program, nor does it solve the problem that many states are ignoring the actual costs of providing long-term care services in calculating their rate structures. Repeal only works to aggravate the crisis of whether quality services will be available and whether providers of those services will be held accountable. Repeal only works to condone the bureaucratic actions of a few who have attempted to construct every conceivable obstacle to the implementation of the 1972 statute. For those of us who are deeply concerned about the quality of care provided to patient/residents in nursing homes, the issue of adequate reimbursement is most important. Inadequate reimbursement levels will put a low ceiling on the quantity of purchasable care and will act to discourage the provision of adequate quality care.

Members of the committee should be conscious that within the mechanism of reimbursement lies the translation of the public concern for the type of services available to older persons and the expressed public preference for the means by which those services should be delivered.

We appeal to the members of the Commitee to perfect, not repeal, the requirement for reasonable, cost-related reimbursement. The Federal Government must continue to require that state Medicaid plans for reimbursing facilities be on a cost-basis sufficient to ensure a quality service delivery. Reimbursement policies should be altered to permit the not-for-profit sponsor to compete fairly with other service providers by permitting the opportunity to recover the costs of capital invested in long-term care services either through a return on equity or a growth allowance.

Because of the controversies surrounding the implementation of the cost-related reimbursement requirement, we encourage the Congress to force the Department of Health, Education, and Welfare to be open in its dealings with the states. In reviewing the numerous state plans, it is apparent that the Department has become

an accomplice both to the delayed implementation of the section 249 requirement and to the reimbursement of only the lowest common denominator of care services. To overcome this subterfuge of the 1972 enactment, we urge that State medicaid program plan revisions, subject to federal approval, be published in the Federal Register and be available for public comment. At a minimum, regional office reviews of the state plan amendments required by Section 249 should be published with the rationale for the regional office determination.

Congressional oversight on the reimbursement of long term care services should not opt for the easy out of repealing the troublesome provisions of public laws. Congress stimulated the public awareness of the neglect and shame which a minority of providers perpetrated upon their residents. Congress has repeatedly acted to strengthen the professionalism within the field and to eliminate the practices of fraud and abuse. Congress should continue to act with the focus, which our Association shares, that quality care can be provided to older Americans in need of long term care services. We appeal to the Congress to help us secure the resources necessary to prevent a stagnation of long term care servicec at a funding level that will not sustain the appropriate quality of such care.

Section 15.—Medicaid certification and approval of SNF's and ICF's

We are concerned that section 15 of S. 505 might have an unintended result of forcing all skilled nursing facilities to be participating providers under the medicare program before being eligible for participation under Medicaid. It cannot be overemphasized that any congressional effort to unify long term care policies and procedures under the two programs must address the differing focus of primary responsibilities. We run the risk of having a single policy instrument to address two differing patient needs with the end result being an emphasis on the requirements to meet acute, episodic illness.

While we do not oppose the proposed strengthening of the federal presence in the Medicaid long term care program, we appeal to the Committee to recognize that the certification process alone is not a good measure of quality, and that reorganizing the certification procedures may have serious ramifications if there is not a firmer commitment to move toward a long term care benefit which provides all services which positively contribute to the health, physical and social functioning of residents.

Section 16.—Visits away from institutions

The issue of home visits has generated a great deal of concern by some of the residents of AAHA member facilities. It seems that the implementation of the Medicaid policy with respect to home visits has generated much misunderstanding. While we accept the Department's attempt to clarify home visitation policies through regulations, it appears as if a number of states have instituted a more liberal leave policy than that of the federal standard. Removing the barrier to such visits through statute might aid in clarifyin the Department's policy.

Section 24.—Disposition of resources

Our members are supportive of the provisions suggested in section 24—restricting the disposition of assets. It is most unfortunate that some individuals with the ability to pay have been allowed to shift resources in order to become wards of the state. At the same time, we encourage the committee to provide careful guidance to the department so that the disposition of resources in the regulatory process does not inhibit the opportunity for categorically and medically eligible individuals to receive the care they need. Too burdensome of a regulatory process might work to the benefit of the State to delay the provision of services to program applicants. In our attempt to prevent the abusive practices of a few, we should be cautious not to impede the expeditious rendering of services to the many.

Section 29. Removal of 3-day hospitalization requirement for home Health services

While the issue of eliminating the requirement of section 1861(i) has been discussed in the context of liberalizing the home health benefit, we believe there is merit in eliminating the three day hospitalization requirement for skilled nursing services. Data from the 1977 Nursing Home Survey indicate that about half (54 percent) of the residents were admitted from a health facility. This group was composed mainly of those admitted from a general or short-stay hospital (32 percent) and those transferred from another nursing home (13 percent). Forty-one percent, however, had moved from a private or semi-private residence, where they had usually lived with others. We believe that the 32 percent admitted from a general or short-stay hospital could be drastically reduced if the prior hospitalization requirement were not imposed. This would result in a cost savings to the

program. Abusive practices could be minimized by (1) the requirement for a costly first-day deductible which would make it prohibitive to have a convenience stay in a facility, and (2) the increased tightening of utilization review and PSRO long-term care review instruments.

Our association is supportive of the several amendments pending before the committee for improving the reimbursement for home health care benefits under the Medicare program. There is a need to strengthen the option available to older Americans so that they receive quality care in the most appropriate setting. The American Association of Homes for the Aging supports: (1) Raising the limits on the number of visits under Parts A and B; (2) redefining skilled care under parts A and B; (3) eliminating the prior hospitalization requirement under part A; (4) providing greater flexibility in the interpretation of the homebound requirement unders parts A and B; and (5) adding homemaker-chore services to the home health benefit, we want members to be conscious of the fact that the tradeoff between institutional and noninstitutional services is modest and there will be only limited cost savings. By expanding home health services, we are reaching out to assist more older Americans who require health services, but who are not receiving them presently. Home health services should be strengthened and expanded not because they are a substitute for institutional services, but because they are a necessary extension of the continuun of health services needed by older Americans.

Section 30.—Durable medical equipment

A. *Statement of the problem.*— Section 1861(s)(6) of the Social Security Act provides that: "• • • durable medical equipment, including iron lungs, oxygen tents, hospital beds, and wheelchairs used in the patient's homes (including an institution used as his home other an institution that meets the requirements of subsection (e)(1) or (j)(1) of this section) whether furnished on a rental basis or purchased" • • • would be covered as a "medical and other health services" under Part B of Medicare. However, as with the definition of "spell of illness", the restriction on institution is based on the type of facility, not on whether the recipient is being furnished hospital or skilled nursing services covered under Part A. The apparent purpose of the parenthetical language is to make these benefits available to persons making their homes in institutional settings as well as to persons residing in individual homes, but to exclude them from coverage under Part B when they can be covered under Part A. The problem is created by the fact that the exclusion is written in terms of the characteristics of the institution in which a person may make his or her home rather than in terms of the person's entitlement to receive the services through the institutional care covered by Part A. The Senate had enacted a technical amendment as part of consideration of H.R. 10284 during the 94th Congress (Amendment number 1293 presented by Senator Beall and supported by Senator Long, December 17, 1975). However, the amendment was among those technical measures dropped by the conference committee because of time deadlines.

B. *Proposed amendment.*— Section 1861 (s) (6) of the Social Security Act is amended by inserting: "and which is used as the patient's home during a period for which the patient is entitled to have payment made under Part A for the inpatient hospital or post-hospital extended care services furnished to him by such institution," immediately after "on this section:"

Comment

This is the same language adopted by the Senate in 1975. The proposed change revises the context of Section 1861(s)(6) from a grant or denial of payment on the basis of what is the institution's overall license, to the basis of what services the individual patient is receiving. It is important to note that under the present law several categories of patients are denied Part B assistance in securing durable medical equipment. Among those disadvantaged are:

Skilled nursing facility patients who have exhausted their Medicare extended care facility benefits but who continue to need skilled care, e.g., private pay patients.

ICF residents living in an institution with a dual SNF-ICF certification (and which meets the requirements of Section 1861(j)), but who only qualify for and are only getting ICF care and ICF payments, and for whom the institution is serving as their home, and

Medicaid SNF patients residing in skilled nursing facilities in states which do not cover durable medical equipment in their rates.

The incidence of problems with the present linkage to a type of facility rather than furnished services, is particularly acute in rural areas. Over one-third of nursing homes are dually certified SNF and ICF.

Section 33.—Encouragement of philanthropic support for health care

Of particular interest to our members is Section 33—encouraging a community investment in the care provided by philanthropic, charitable and religious institutions. Charitable support to nonprofit facilities helps ensure quality care for our elderly by allowing an expansion of staffing, greater intensity of services and larger scopes of programs, which would otherwise be stifled by inadequate Medicaid reimbursement under state plans which condone minimum levels of care delivery. We urge your favorable consideration of this provision which would encourage the voluntary, philanthropic sector to pay a greater portion of long term care costs.

Our organization, which represents 1,700 homes and health-related facilities developed and operated by voluntary, nonprofit sponsors, hopes that the intent of the Committee can be made clear in the language of the bill and its legislative history. That is, we hope the bill and its legislative history, including any conference report that is issued, will indicate that it is the intent of Congress that "unrestricted grants, gifts, and endowments, and income therefrom" includes any funds received—other than those received for paying specific operation costs of a provider—for improving the health care delivery system and access to health care services. Unrestricted funds, thus, would include money obtained for expanding or developing or improving existing or new services.

Unfortunately, we fear that the language of the bill, as written, may create the impression that grants, gifts, and endowments, and income therefrom, that are expressly given for the purpose of facility expansion or construction should not be disregarded in determinations of reasonable costs of services furnished by Medicare and Medicaid providers. This is because the bill's language includes the word "unrestricted" in describing the types of grants, gifts, and endowments that are to be disregarded in computing a facility's reasonable costs.

In soliciting contributions for the expansion or development of existing or new services, nonprofit, voluntary sponsors inform the public as to how their contributions would be used. In this sense, funds accepted by a home to meet such an express goal are "restricted" funds. Also, sponsors inform the public as to how their contributions will be used, even for "experimental and innovative programs." These funds, then, also may be viewed as "restricted" gifts, since they are obtained for a specifically stated purpose.

Section 34.—Study provision on availability of services

We are supportive of the sponsor's recognition that a permanent policy decision regarding dual certification of facilities will necessitate a careful analysis of the participation patterns of skilled nursing facilities. A series of issues interrelate with respect to the participation issue, and, while in the modified amendment several of these items are identified for study, it has been our experience that the Department is cautious not to study more than requested. Therefore, it is important to start at the basic point of finding out the reasons for non-participation in Titles XVIII and XIX to include a review of beneficiary eligibility standards, as well as the need for and the desirability and feasibility of requiring dual certification. Likewise, it is important that in the final policy recommendations submitted by the Department an attempt be made to show the impact of implementing recommendations on the cost of skilled nursing facility services and the demands for such services. The study provision should require input from professional organizations, health experts, private insurers and consumers.

Although Medicare and Medicaid homes for the aging may have in common the one characteristic of caring for the elderly, they do so in different ways and with different objectives. A requirement that all SNFs provide both types of services cannot be imposed on homes around the country without the serious consequence of reducing the capacity of these arrangements for meeting the unique needs of the populations they serve.

A long term care facility (such as one that participates in the Medicaid program only) is designed, equipped, and staffed specifically for the care of long term patients. These facilities and their staffs are specially oriented to meeting the unique needs of their patients. Their service programs may, in fact, be incompatible with the provision of acute health services paid for under Medicare.

Conversely, some traditional homes for the aging offer shelter with residential services. These homes frequently provide limited nursing care in an infirmary. The infirmary may be certified to participate in the Medicare program, the purpose of which is to offer residents a means for recovery from short, acute spells of illness. This type of infirmary is not meant to be—nor can it easily be converted into—a long-term care facility. In fact, if the infirmary must alter its provision of services to care for the chronically disabled, long term care patient, it may find that it is no

longer able to care for the short-term, crisis-prompted needs of its elderly residents. This could have serious consequences, for these homes are specifically designed and planned to provide a protected setting for older people who otherwise might be confined to living in more costly nursing home environments.

Another reason why SNFs should not be required to participate in both programs is a financial one. Additional costs for reporting, billing, and auditing would be incurred. All of these costs may be recovered by a home if the total SNF population is either medicare or medicaid. But problems arise when only a portion of the patients in a SNF are Medicare eligible. This is because Medicare will reimburse homes only for a proportion of these additional costs, related to the number of Medicare patients in the SNF. Homes, thus, would find themselves subject to additional administrative and regulatory requirements, the costs of which would not be borne entirely by the Medicare program. It would become necessary, then, for the home to pass the additional costs on to its Medicaid or private pay patients.

A third reason why this provision should not be enacted is that it simply is not practical. Most of our members report that they have extensive waiting lists. Simply opening up Medicaid facilities to medicare beneficiaries or Medicare facilities to Medicaid recipients would not insure that these populations would be able to find care in their communities. This would be particularly true in the case of newly certified Medicare homes, whose beds would already be filled with Medicaid patients. Medicare patients need a SNF bed when a crisis occurs, and they cannot wait for a bed to be vacated—an event that rarely occurs in a long term care facility.

Section 37.—Study provision, classification of certain skilled nursing facilities

The American Association of Homes for the Aging is supportive of the study provisions suggested in Section 37. The focus of the study is to correct the spell-of-illness difficulties which some long term care residents have encountered. Section 1861(a) of the Social Security Act states that an individual's "spell of illness" begins on the first day on which (s)he receives inpatient hospital or extended care services and ends with the close of the first day of a period of 60 consecutive days thereafter on which (s)he is neither an inpatient of a hospital nor a skilled nursing facility. In interpreting the law, the Department has looked to the type of institution an individual is in, rather than the type of care rendered, in determining whether an individual is an "inpatient" under the statute. The result has been that a resident of an extended care facility, even if receiving no medical care at all, is considered under the "spell of illness" as long as (s)he is still in the facility. Thus, Medicare eligibility may run out regardless of the patient's actual health, and the services rendered by an institution. This application of the law is totally inequitable. Beneficiaries who reside at home or in an institution that does not provide skilled nursing services that meet the requirements of Section 1861(jX1) can renew their eligibility for hospital services under Medicare following 60 consecutive days during which they receive no skilled nursing services. However, beneficiaries residing in an institution that meets the requirements of Section 1861(jX1) cannot renew their eligibility for Medicare Part A benefits, regardless of the type of services actually furnished by the institution. This arbitrary interpretation has caused great hardship for many beneficiaries.

Recent court decisions have held that the existing HEW policy is totally incorrect and that "it is the nature of the services rendered, rather than the nature of the facility, which determines whether one is an inpatient for purposes of defining the term 'spell of illness' when further hospitalization benefits are sought." *Hasek* v. *Mathews,* U.S. District Court, Northern District of California, Feb. 8, 1977. Had Congress desired to make the nature of the facility all-determinative, it would not have used the term "inpatient" in its definition of "spell of illness," but would merely have required that one be in, or be a resident of, a facility. It did not do this, and the clear and reasonable interpretation of the law is that one who is receiving none of the services that define a "skilled nursing facility," and cannot otherwise be defined as an inpatient, should not be precluded from having a "spell of illness." The Department, while recognizing the inappropriateness of its policy still has not rectified its interpretation of "spell of illness," resulting in the denial of Medicare benefits to nursing home residents, regardless of the actual medical services rendered to those individuals.

Last July, as the House Ways and Means Committee and the Senate Finance Committee were considering possible reform of the Medicare law, various proposals were considered for clarifying the definition of "spell of illness" so as to preclude its inappropriate application and the resulting denial of Medicare benefits to those who were actually eligible for such assistance. At that time, Departmental representatives stated that the problems could be corrected through the regulatory processes by modifying the criteria used in determining whether a facility was classified as a

(jX1) or non-(jX1) facility, thereby not necessitating any legislative action. Departmental staff accurately recognized that the present criteria might result in the erroneous classification of some facilities because the facility was meeting these criteria due to the provision of higher quality care, and not actually providing the level of care set out in Section 1861(jX1). This is commonly a problem in nonprofit facilities serving the elderly because of their commitment to providing quality care, regardless of whether they are actually reimbursed for all the costs incurred in providing this needed care. Thus, these facilities are frequently staffed at higher levels, consistent with patient needs, than is provided in Section 1861(jX1).

The Department's representatives acknowledged the problem and stated that this problem could be rectified through the Department modifying its criteria and guides through regulations so that a facility would be classified as a Section 1861(jX1) facility only where it was determined that the facility's stated purpose and method of operation clearly indicated that it was primarily engaged in providing the level of care contemplated by Section 1861(jX1). In reliance on these representations, the Committees deferred initiating legislative action in this area.

To date, the Department has not followed up on its stated recognition of the problem and intention to correct this inequity through the regulatory processes. Fiscal intermediaries are still interpreting the "spell of illness" limitations in an objective way, looking at the nature of the facility, rather than the actual services provided to a patient, in determining whether a "spell of illness" has ended.

We are distressed by the Department's continued lack of good faith in correcting the inequitable interpretation of the "spell of illness" provision of the Medicare law. While acknowledging the hardships imposed on many beneficiaries and that a problem exists with the present interpretation, the Department has done nothing to rectify its position, contrary to judicial decisions and legislative inquiries. It is apparent that Congress must stimulate the Department to take action on this problem.

Additional technical amendments

A clear and present danger lies in the lack of knowledge and the habitual lack of attention to the conditions and the interactions of conditions which create long term care needs peculiar to the aged. In this lack of knowledge and inattention there is a tendency to fill this vacuum with the simple transference of methods, rules and norms which form the familiar ground of hospital practice. Caution must be exercised in the effort to unify long term care policies and procedures under the Medicare and Medicaid programs. We are forcing facilities to become mini-hospitals which ignore the social components necessary for quality life for the institutionalized. Furthermore, such standards are forcing the massive reclassification of patients/residents from the supportive assistance provided in the protective shelter of the home.

We urge consideration of the following additional amendments in strengthening the administration of the Medicare and Medicaid long term care programs:

(1) the levels of care concept now embodied in the Medicare and Medicaid program must be re-evaluated with a view toward development of a system which encourages greater flexibility and economy in meeting individual needs.

(2) Professional Standards Review Organization (PSRO) review in long term care should be suspended. An in-depth study should be done to ascertain the effectiveness of reviews undertaken to date and the impact of such reviews upon the recipient of services. PSRO guidelines for long term care review should be rewritten to encourage continuation of effective combinations of services which promote maintenance of health and maximum functioning for the patient/resident.

(3) Immediate action should be taken to extend the grace period policies imposed by PSROs upon long term care institutions to minimize the transfer trauma upon the resident and to permit an opportunity for arranging a continuation of appropriate nonmedical services following discharge; and

(4) The requirement for HEW development of a uniform cost-reporting system should be phased in with the effective date moved at least an additional two years.

We appreciate this opportunity to share with the committee our thoughts on this important piece of legislation.

STATEMENT OF THE AMERICAN COLLEGE OF PHYSICIANS

The American College of Physicians strongly supports the continuation of the Voluntary Effort by all physicians in the private and academic sectors as the best approach to containing cost while assuring the adequacy of health care of acceptable quality. We oppose mandatory controls but support rational modification of

Medicare and Medicaid provisions as indicated in several sections of S. 505, the proposed Medicare-Medicaid Administrative and Reimbursement Act of 1979. The American College of Physicians (ACP) is deeply committed to cost effectiveness in health services through a pluralistic approach. At three major College conferences in the past year and a half, cost effectiveness has been examined from a national perspective and from the aspect of what the individual physician can do to help restrain escalating medical costs. As a result, the College has made a firm commitment to exercise its best efforts in containing costs.

ACP APPROACH TO COST CONTAINMENT

Physicians can impact on cost within the limits of sound medical practice through "cost effectiveness" education, judicious hospital admissions, restraint in ordering of laboratory procedures, cautious resource allocation, and in the realistic use of technology while maintaining our support for increased research and development of new technology. The following are the essential aspects of the College's approach to cost containment:

1. An ad hoc Cost Effectiveness Committee has been appointed by the ACP Board of Regents and charged with designing and implementing a cost effectiveness action plan for the College.

2. To implement the action plan, a variety of means are being used including:

(A) Articles and professional journals;

(B) Teaching rounds in which discussions of the expense of diagnostic and therapeutic interventions are featured;

(C) Medical student and resident physician training in the practical economics of medical care;

(D) Hospital "cost effectiveness" committees which address local issues;

(E) Incorporation of cost effectiveness issues and programs in ACP regional and national meetings.

3. The College also believes that prudence in admitting patients to hospitals, reducing the number of hospital beds (when appropriate study proves there is an excess), and using hospital resources more efficiently are effective ways for physicians to help reduce medical expenses.

4. Exchange of information with hospital authorities and third party insurers continues to be a significant activity to achieve effective cost containment.

5. Through its participation in the Medical Necessity Project, the College is advocating the judicious use of diagnostic laboratory testing.

(A) In February, 1979, Blue Cross/Blue Shield, acting on the basis of recommendations from the College, advised its member plans that it would be phasing out 26 diagnostic laboratory procedures which the College had determined outmoded, unnecessary, unreliable or of no proven value.

(B) On the American College of Physicians' advice, Blue Cross/Blue Shield has recommended that member plans pay for routine diagnostic tests for admission to a hospital only when they are ordered specifically by a physician. The President of National Blue Cross/Blue Shield has indicated that if only 10 percent of the current routine admission tests are eliminated, savings of $150-$200 million would be realized.

6. It must be kept in mind that economic factors, far beyond the capacity of physicians, are significant in soaring costs of hospital and medical care as well as most other goods and services.

ACP LEGISLATIVE RECOMMENDATIONS

Regarding the specific sections of S. 505 and the Senate Finance Committee staff cost savings proposals, the American College of Physicians supports the following:

1. If a Health Care Facilities Cost Commission is created, it is essential to include physicians and surgeons among the membership.

2. There needs to be more efficient use of existing facilities. Where studies have indicated inappropriate use of such facilities, modifying, closing down and/or converting underutilized or misutilized patient care areas may provide satisfactory solution. Grant and loan programs to facilitate conversion are advisable.

3. The implementation date for Section 227 should be extended. Because such temporizing is inadequate, serious consideration should be given to repeal.

4. Special considerations need to be given to the unique problems of rural hospitals in converting acute care beds to skilled nursing care beds.

5. There should be further study regarding the availability and the need for long term care facilities and services under Medicare and Medicaid.

6. The advocacy of reimbursement incentives for efficient performance is laudatory.

7. Appropriate state officials need to be notified of audits, quality control performance reports, deficiencies, or changes in federal matching payments affecting programs authorized under the Social Security Act. In addition, Social Security Act audits need to be consolidated for efficiency.

8. Confidentiality of PSRO information that identifies an individual patient, practitioner, provider, supplier or reviewer needs to be assured.

PROCEDURES WHICH BLUE SHIELD SHOULD NOT REIMBURSE
ROUTINELY WITHOUT WRITTEN JUSTIFICATION

APPROVED

Blue Shield Code#		Reason (s) for Deletion
8076	Amylase, blood isozymes, electrophoretic	Not clinically useful
8118	Chromium, blood	No clinical indication
8181	Guanase, blood	Obsolete test; liver enzyme determinations more useful
8283	Mucoprotein, blood (seromucoid)	Obsolete; replaced by protein electrophoretic studies
8357	Zinc sulphate turbidity, blood	Obsolete; liver enzyme determination more useful
8543	Skin test, cat scratch fever	Deleted by Center for Disease Control, 1976. Test material not available commercially. Diagnosis based largely on clinical situation.
8548	Skin Test, lymphopathia venereum (Frei test)	Nonspecific, positive with other Clamydial diseases. Complement fixation with heat stable group reactive antigen is best test available.
9440	Circulation time, one test	Obsolete
6599	Cephalin Flocculation, Thymol turbidity	Obsolete; liver enzyme determinations accurate
8120	Congo red, blood	Obsolete; replaced by rectal or gingival biopsy
8204	Hormones, adrenocorticotropin quantitative animal tests	Obsolete; radioimmunoassay more accurate and specific
8206	Hormones, adrenocorticotropin quantitative bioassay	Obsolete; radioimmunoassay more accurate and specific
8334	Thymol turbidity, blood	Obsolete; liver enzyme determinations more accurate

APPROVED

Blue Shied Code#		Reason (s) for Deletion
8540	Skin test, actinomycosis	Deleted by Center for Disease Control in 1976; diagnosi made by microscopic identification of organism and positive culture
8542	Skin test, burcellosis	Deleted by CDC in 1976; diagnosis made by isolation of organism and suggested by presence of agglutinating antibodies
8547	Skin test, psittacosis	Deleted by CDC in 1976; diagnosis made by isolation of organism and serologic studies
8551	Skin test, psittacosis	Deleted by CDC in 1976; diagnosis made by isolation of organism or four-fold rise in complement fixing antibodies
8554	Skin test, trichinosis	Deleted by CDC in 1976; diagnosis made by presence of larvae in muscle biopsy
8601	Calcium, feces, 24-hour quantitative	Obsolete; replaced by quantitative stool for fat
8610	Starch, feces, screening	Not informative; impossible to interpret
8623	Chymotrypsin, duodenal contents	Unreliable; replaced by secretin test
8634	Gastric analysis pepsin	Not informative
8635	Gastric analysis, tubeless (Diagnex Blue)	Not reliable
8903	Autogenous vaccine	No proven value
8375	Calcium clotting time	Obsolete; replace by partial thromboplastin time
8376	Calcium saturation clotting time	Obsolete; replaced by thromboplastin generation time
8377	Capillary fragility test (Rumpel-Leede) (independent procedure)	Superfluous
8643	Colloidal gold	Obsolete; replaced by immunoelectrophoresis

"ACP ROUTINE HOSPITAL ADMISSIONS TEST APRIL, 1978"

"The American College of Physicians recommends that no diagnostic tests, including blood hemoglobin, urinalysis, biochemical blood screen, chest x-ray and electrocardiogram should be required as routine procedures for patients admitted to a hospital.

"Good medical practice dictates that diagnostic tests should be determined by the nature of the patient's problems and should be ordered individually by the patients physician. Thoughtful attention should be given to the parsimonious use of the diagnostic laboratory. The fact must be recognized that diagnostic testing should complement, but not replace, careful history taking and physical examination. Injudicious use of diagnostic laboratory tests contributes greatly to the cost of medical care. The burden of proof for the medical indication for diagnostic laboratory tests rests on the physician who orders it. He must consider possible diagnostic benefit (Will this test change the course of management?) and alternative, less costly, but equally effective methods of deriving the same information."

AMERICAN COLLEGE OF RADIOLOGY,
Chicago, Ill., March 20, 1979.

Senator HERMAN E. TALMADGE,
Chairman, Health Subcommittee, Senate Finance Committee,
Dirksen Senate Office Building, Washington, D.C.

DEAR SENATOR TALMADGE: The following comments on Senate Bill 505 are offered on behalf of the 14,000 members of the American College of Radiology. These physician specialists in the uses of ionizing and other radiation to diagnose and treat patients are affected by several sections of the pending bill. We respectfully request that this letter be included in the record of your recent hearings on the legislation.

We have had the privilege of discussing previous versions of this legislation with you and with your able staff. In this version, as before, we are grateful to you for your understanding of the desires of the nation's radiologists to practice their specialty on the same basis as do most other physicians. We also appreciate your awareness of elements of medical practice which make a significant difference between what we would all regard as good service and what we, at least, would identify as less desirable or inadequate conditions for health care.

Thus, in terms of those portions of the bill which affect the practice of radiology, this organization repeats its endorsement and support.

There are several modifications from previous drafts and some additions which deserve brief comment and a few suggestions for minor changes.

Section 5 deals with physician acceptance of the assignment of benefits by Medicare patients. This organization has consistently encouraged its members to accept assignments, even though the review policies and dilatory reimbursement of some carriers has made this a costly indulgence. We now think it important that you retain the right of physicians to opt in and out of "participating physician" status, even in the face of incentives to take assignment. While we have not sought coverage in the $1 incentive offered to "participating physicians," this is a discriminatory provision. Perhaps it will serve its purpose elsewhere.

Section 6 deals with reimbursement of "hospital-associated" physicians. Therein we are most grateful for the reaffirmation of the right of radiologists in voluntary hospitals to practice on a fee-for-service basis. The American College of Radiology since 1966 has urged its members to discontinue arrangements with hospitals under which physician income represented a fraction of the institutional charge. Our reasons have been stated before. We have not changed our policy. We also find reasonable the assertion that physician fees should relate to services provided to patients by physicians.

Despite the College's admonitions to its members since 1966, some radiologists in voluntary hospitals continue to practice under terms of reimbursement contracts based upon percentage sharing between doctor and hospital. It will be necessary to specify in the legislation or elsewhere a reasonable period during which these arrangements can be changed in an orderly and non-inflationary manner.

In our testimony of June 10, 1977, we called attention to the special needs of a relatively small number of radiologists who serve rural hospitals on a part-time basis. Rather than repeat the discussion in that testimony, we simply reference it here. The situation cited therein remains equally valid.

Some of our members work in other than voluntary hospitals where patients or their representatives are expected to pay for services. There, presumably, the "reasonable salary" would need to be defined by program administrators. We think it

unwise for the Congress to define a "reasonable salary." However, we do urge a continuing alertness by the Congress to offset demonstrable bureaucratic zeal for attacking physicians.

Section 7 deals with the proper role of relative value scales as a mechanism to aid third parties and providers in defining services. You are aware that relative value scales were devised by physician groups to assist insurance carriers, including the federal CHAMPUS program. Just the same, the ACR and other groups have been placed under consent orders by the Federal Trade Commission prohibiting further activities regarding relative value scales. This section would redress this prohibition to the extent that we are now free to respond to initiatives from the Health Care Financing Administration. We might have wished for a broader basis for professional initiative along the lines we suggested in 1977. However, the current language will be helpful.

Section 8 defers the implementation of section 227 from Public Law 92-603. Nearly 10 percent of radiologists are full-time faculty members, directly affected by interpretation and implementation of that section. We think the delay provided here will be beneficial.

Section 9 would recognize the advent and benefits of ambulatory surgery centers. We have recognized the value of avoiding costly institutional facilities in all circumstances where these resources are not immediately needed for patient care. Thus, many radiologists have provided their communities with supervoltage radiation therapy units and computerized tomographic scanners in privately operated offices and clinics. In some communities, these are the only such service available.

Where substantial capital expenses are borne by physicians in surgicenters or in the two types of radiation facilities cited, we submit that it would be efficacious and even cost-effective to consider extending the same coverage to these radiation facilities.

Section 10 reaffirms the policy of relying upon tested methods of determining allowable levels of reimbursement based upon "reasonable and prevailing" charges and the use of percentiles. Recently, the reimbursement for CT scans has been subjected to a totally arbitrary national ceiling urged upon the carriers by HCFA without consultation, justification or due process. Our protests have thus far been unanswered. Perhaps your restatement of policy will have more effect.

Section 19 relating to reasonable charges and costs, on the face of it, would not relate to the professional services of radiologists. This is as it should be.

Section 20 would broaden coverage of ambulance services to allow reimbursement for needed transportation to appropriate facilities. We applaud your inclusion of free-standing radiation therapy facilities in the transportation coverage provisions. Several of our members have suggested that where the only locally available computed tomographic unit is located in a non-institutional setting that ambulance costs be covered similarly.

Section 23 imposes desirable restraint upon the dissemination of information about physician billings under the Medicare program. With full respect to the right of the people to know the workings of public programs, this information has been used as a form of harassment by federal agencies. Most radiologists are affiliated with groups, often billing in the name of the senior partner for the services of three to 10 physicians. Even where the amounts quoted were correct, an infrequent occurence, the inference was that a single physician was abusing the system. We applaud your corrective measure.

Section 28 would allow physicians participating in the activities of PSRO's to have needed confidentiality in providing their professional expertise to the services of their peers. We supported the creation of the PSRO program in Public Law 92-603. We shared with you and the Finance Committee the expectation that the medical profession could accept the burden and respond to the challenge. The assurance of confidentiality for those physicians undertaking PSRO activities is essential. We favor your proposed action.

Section 31 deals with adoption of uniform claims forms by public and private programs. We have attempted to work with the Medicare Bureau and with the several private carrier groups in developing standard nomenclature and reporting procedures. We offer the caveat that a single form, oriented for the primary care physician, may impose unintended burdens upon consultants. For example, radiologists usually are asked to participate in the diagnostic process at an early stage in the patient's care. A clinician may rely upon his own examination, the patient's history, X-ray, laboratory and even surgical procedures before attaining a certain diagnosis. The diagnostic radiologist can identify densities in the lung or intestines strongly suggestive of disease. He is not made aware routinely or promptly of the pathologist's test findings or the result of a biopsy unless he is asked for additional

assistance. In this example, a form requiring a final diagnosis would not be suitable for use by consultants. Obviously, such details are not proper for legislative language. But the intent of section 31 is well taken with the single caveat.

Section 33 would encourage the continuation of private philanthropic support of health institutions. Hospitals in some states are exhausting endowments because of the pressure of rate commissions to use capital to offset operating expense. We hope section 33 would deter such short-sightedness by regulators.

We have limited our comments in the paragraphs above to those sections of the bill which affect the specialty of radiology and concerning which we might claim to have some informed interest. If you wish elaboration on any of the points, we respectfully urge you to request it of us through our legislative consultant, J. T. Rutherford.

Sincerely,

HAROLD N. SCHWINGER, M.D.,
Chairman, Board of Chancellors.

STATEMENT OF THE AMERICAN FARM BUREAU FEDERATION

We appreciate this opportunity to present the views of Farm Bureau on S. 570, the "Hospital Cost Containment Act of 1979." and S. 505, the "Medicare-Medicaid Administrative and Reimbursement Reform Act of 1979." Farm Bureau is the nation's largest general farm organization. It represents over 3 million American families. Though deeply concerned over recent increases in the costs of hospital and medical care, Farm Bureau believes that reliance should be placed upon the private sector, and not the federal government, to solve the financial aspects of health care problems.

At the most recent annual meeting of the American Farm Bureau Federation the official voting delegates of the member State Farm Bureaus adopted the following policies:

"We continue to be concerned over the increasingly high cost of hospital and medical care, the adequate delivery of primary health care, and the reduction of health care costs.

"We believe reliance should be placed mainly upon the private sector to solve the financial aspects of health care problems. Massive government intervention in the financing of health care will not be helpful either to the citizens or the health care system.

* * * * * * *

"Government participation in the area of health care management, where necessary, would be the most practical at the local level."

Farm Bureau believes that reliance upon the private sector is the most effective way to achieve the goal of reduced hospital costs. When the Administration failed to obtain legislation during the 95th Congress, the private sector began constructive and affirmative action to combat the problem. Its Voluntary Effort Program was organized to reduce the rate of increase for hospital costs by two percentage points per year for each of two years beginning in 1978. During 1978 the goal of a 2-percent reduction was surpassed when the Voluntary Effort Program reduced the rise of hospital costs from 15.6 percent in 1977 to 12.8 percent in 1978—a decrease of 2.8 percent and a savings of $1.5 billion in the first year alone.

This is a strong argument against the enactment of any federal program to control hospital costs. Such action could seriously undermine the private sector's approach—one that is succeeding very well.

HOSPITAL COST CONTAINMENT ACT OF 1979

This proposal would establish voluntary limits for increased hospital costs which hospitals must meet to avoid mandatory controls and sanctions. The measure describes these limits and also allows for exemptions, through a series of complex formulas. It provides that once a hospital is subject to mandatory federal control the hospital must meet the applicable limit or be subject to reduced reimbursement under federal programs and to federal excise tax penalties (150 percent) on excess charges and reimbursements.

The bill is exceedingly complex. Layers of bureaucratic red tape and higher administrative costs would be imposed on the health industry. The projected savings to be achieved through this legislation have been seriously challenged. More important, the adoption of S. 570 could reduce the availability of health care by confronting hospitals with mandatory ceilings.

Farm Bureau urges you to reject S. 570.

MEDICARE-MEDICAID ADMINISTRATIVE AND REIMBURSEMENT REFORM ACT OF 1979

S. 505 would create a new program for reimbursements under Medicare and Medicaid. The proposal would allow the reimbursement of an "average" cost, as established by routine costs of hospitals which are defined in the legislation. A per diem target would thus be established. Hospitals with rates below the target rate would be entitled to an incentive equal to 50 percent of the difference between the actual rate and the target rate (this incentive is limited to 5 percent of the target); while hospitals whose actual costs exceed the target rate would be reimbursed up to, but not in excess of, 115 percent of the target rate.

Setting arbitrary limits on hospital reimbursements nationwide could lead to a decrease in the quality of patient care in some areas. In addition, the measure does not significantly provide for the correction of any inefficiency in these two programs. Current programs, such as the recently established Professional Standard Review Organizations (PSROs) are succeeding in providing care in a cost-effective manner. Such efforts as these, along with the private sector's Voluntary Effort, are succeeding. New legislation is not needed.

Farm Bureau urges you to reject S. 505.

CONCLUSION

One very important point cannot be overlooked. The Administration has labeled S. 570 as "the most important piece of anti-inflation legislation before the 96th Congress." Farm Bureau believes that inflation is the number one problem facing the nation today. We do not believe that federal hospital cost containment legislation—or any other form of mandatory price control—would contribute in any way to the solution of the problem of inflation. We urge Congress and the Executive Branch of government to accept the responsibility for bringing inflation to a halt through the adoption of sound fiscal and monetary policies.

The private sector's Voluntary Effort Program is the most effective and responsible approach to containing the increased costs of hospital care. Any action by the federal government to place mandatory, rigid and complex controls on the health industry can only undermine the successful efforts of the private sector.

We appreciate your consideration of Farm Bureau's views on this important issue.

STATEMENT OF THE NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS

The National Association of Private Psychiatric Hospitals (NAPPH) is a national organization which represents 180 free-standing (nongovernmental) specialty psychiatric hospitals ranging in size from 25 beds to 500 or more beds. Our member facilities, which are located in rural and urban areas, run the gamut of treatment programs offering comprehensive and intensive inpatient treatment for children, adolescents, adults, geriatrics, alcohol abusers and substance abusers. Our membership includes residential treatment centers for children, community mental health centers, psychiatric units of general hospitals which are separately accredited under the appropriate psychiatric standards of the Joint Commission on Accreditation of Hospitals, and university affiliated hospitals. Membership classification includes both nonprofit and proprietary in ownership, and long-term and short-term in length of stay.

The NAPPH concerns itself with issues of patient care and is in the forefront when bringing into public focus the issues of adequate and necessary treatment settings for the mentally ill in the most cost-effective and cost-conscious ways. Our member hospitals are managed efficiently; patient care and patient concerns are integrated into the management, design and everyday operations of the hospitals.

The NAPPH welcomes this opportunity to present its views and support on many concepts of S 505, the Medicare and Medicaid Administrative and Reform Act of 1979. We commend Senator Talmadge on his reintroduction of this bill and view it as a clear indication that reform need not be punitive but can and should be a positive program involving all concerned; that to lower health care costs in this country one must take into the process physicians, suppliers of goods and services, hospital administrators and consumers. We commend Senator Talmadge also for recognizing that the hospital industry not only provides a service but is also a business and, to be a successful business, like any other it needs incentives for production and a fair return on equity. This is especially crucial to an industry in which modernization and the ability to modernize have a direct impact on its service: sound, quality patient care. Investment and equity capital, therefore, are necessary to maintain and upgrade patient care and allow the industry to continue

to meet the demands of an increasingly sophisticated population. Allowing for fair return on that equity is the only way to assure its continuance.

We concur in that the bill recognizes that there are circumstances which, of necessity, take into account certain percentage arrangements, such as facility management contracts where the contractor is a direct contributor to the efficiency and economical operation of the hospital. In many instances, for example, a management contractor receives payment on net revenues after all costs have been paid and, therefore, is keenly interested in containing and controlling costs.

Section 2—Criteria for determining reasonable costs

The bill provides for reimbursement to be made on a fair and equitable comparison between hospitals by classifying them in groups, bed size, type, rural or urban, and without regard to ownership. We urge that special consideration be given to the free-standing psychiatric hospital in terms of patient populations and diagnoses served.

While commending the overall approach and intent of this bill, there are several issues that are of particular concern to the specialty hospital. Often the mentally ill, the hospitals in which they are cared for, and the professionals who treat them are overlooked or compared to other specialties of a dissimilar nature. When determining the target rate for psychiatric hospitals, the committee should be aware that treatment philosophies, staffing patterns, treatment modalities, availability of alternative resources, etc., differ from hospital to hospital. Because of this, we feel that section 2(B)(iii) needs clarification. The section states that categories of hospitals shall be made in the same or separate categories as the Secretary may determine, and we question this approach for psychiatric hospitals. As mentioned earlier, particular care must be given to categorizing our membership; it should not be categorized with other specialty facilities that have no comparable factors.

We urge also that the bill reflect the fact that specialty hospitals need not be in a class by themselves. Any comparison of psychiatric services should include the identifiable, separate psychiatric units of general hospitals that accommodate short-term, acute crisis intervention or alcohol detoxification and/or rehabilitation. These units should be included when comparing cost-per-day, staffing patterns, length-of-stay and outcome. Often these units are glossed over in terms of surveys or accreditation standards. The free-standing psychiatric hospital is accredited by the appropriate psychiatric standards (child, adolescent, alcohol, adult) of the Joint Commission on Accreditation of Hospitals. Since this is a reform bill, we ask that all identifiable psychiatric units of general hospitals be included when categorizing services for comparison; that these units be certified and accredited under equal standards of accreditation and certification to assure appropriate utilization, treatment and reimbursement; and that only those services appropriately certified and accredited be reimbursed.

Section 3—Closing or conversions

We commend the bill for its provision to assure that conversions to new services be consistent with certificate of need provisions as set forth in the Planning Law and 1122 requirement of the Social Security Law, although one additional consideration should be made when converting medical/surgical beds to psychiatric beds and/or psychiatric services. In order to assure quality care, appropriate treatment, and equal treatment regardless of service setting, all identifiable programs or services should be expected to meet the same standards for accreditation and certification. Therefore, since JCAH accreditation for psychiatric facilities is required for Medicare participation, it seems fitting that the appropriate JCAH standards for certification and participation be met when a service is converted.

Section 6—Hospital associated physicians

Section 10—Criteria for determining reasonable charges for physician services

In determining physician or other person services that relate to an in-hospital assignment, we ask that fairness and equity be used. One must keep in mind that the specialty hospital is often considerably less costly on a cost-per-day basis than is the psychiatric unit of a general hospital. Yet, because of its intense treatment planning and philosophies, the specialty hospital maintains as employees the full compliment of the treatment team. A specialty hospital with a closed staff is less expensive than a psychiatric unit of a general hospital with an open staff because a psychiatric patient in a general hospital is paying the same per diem as a medical/surgical patient. Therefore, a psychiatrist's fee-for-service must be computed according to service, regardless of service setting.

Section 16—Visits away from the institution

The committee must be commended again for its recognition and understanding of the value of therapeutic leave days, under the Medicaid program, from skilled nursing facilities or intermediate care facilities. Since this is a reform bill, we ask that similar attention be given to the use of therapeutic leave days, under the medicare program, as they pertain to the psychiatric patient away from the psychiatric hospital. Medicare intermediaries disallow leave days under the guise that they are disallowed by law. However, medicare law does not specifically disallow such days, although the Hospital Insurance Manual (HIM) does. The intermediaries have been interpreting the HIM as law, even though it is neither regulation nor law. We feel it was not the intent of Congress to disallow such leave days, especially when they are required by the JCAH as a vital part of the treatment program. The bill states that there be no limitation placed on leave days by the Secretary and that the use of these days be left solely to the judgment of the physician, in conjunction with the total treatment plan. The same consideration should be given to the Medicare patient who is psychiatrically ill and awaiting discharge from a specialty hospital.

Section 28—Confidentiality

We implore the committee to retain last year's language which exempts, for purposes of this bill, PSRO's from being considered federal agencies. Confidentiality of patients' medical records is of concern to the medical community and moreso to the psychiatric community. Furthermore, free disclosure of information to and from the PSRO's would retard, if not destroy, the program before it had its chance to mature.

Section 31—Uniform claim forms

Section 31 calls for the development of uniform claim forms to to be used by the programs. While the bill directs the Secretary to work with other outside organizations that have developed similar forms, we ask that consistency be the guide. At a time when the industry is grappling with uniform discharge data, an impending system for hospital uniform reporting, PSRO discharge information, base line data requests from health systems agencies, and Medicare cost reports, we ask that the committee direct the Secretary to take into account all these forms before and during the process that will develop a new form.

The National Association of Private Psychiatric Hospitals would like to thank you for the opportunity and privilege of commenting on a true reform bill that has attempted to consolidate more than 30 necessary programs into one comprehensive reform measure as a first step in an honest cost containment era.

STATEMENT BY THE VIRGINIA HOSPITAL ASSOCIATION

The Virginia Hospital Association, representing substantially all the acute care, general hospitals in this Commonwealth, wishes to voice its strong opposition to President Carter's proposed "Hospital Cost Containment Act of 1979"—S.570 in the U.S. Senate and H.R. 2626 in the House of Representatives. We believe the proposed legislation represents an unworkable and unfair approach to the containment of hospital costs that will have a counterproductive impact on the provision of adequate health care to American citizens.

The Voluntary Effort—sponsored by the American Hospital Association, the Federation of American Hospitals, the American Medical Association, and supported by all States—has actually overachieved its stated goal of a 2-percent reduction with a 3.1 percent decrease in the rate of increase in hospital costs in 1978. It has pledged another 2-percent reduction in the rate of increase in 1979 or a 11.6 percent limit that allows for real growth to meet the needs of the public, needs that are especially important where costs in the general economy run high.

Since the Voluntary Effort is demonstrating considerable success, the Virginia Hospital Association fails to see the necessity for standby mandatory controls as proposed by President Carter with the unrealistic 9.7 percent limit on cost increase. The provision for an increase in this limit should inflation exceed current estimates does not make the possibility of mandatory controls more acceptable.

The Association also takes exception to the use of the term "voluntary" in the proposed legislation since it provides that should hospitals fail to meet the Government-imposed "voluntary" goal of 9.7 percent they will have controls slapped on them in 1980—a veritable iron fist in the velvet-glove type situation and a basic threat to the democratic processes.

The words "voluntary limit" were used seven times in the first page of a White House-prepared summary of President Carter's bill. How can a limit be called "voluntary" when failure to meet it means government control of one segment of the economy?

No other industry in the country has been singled out for standby mandatory controls. Indeed the President himself during his State of the Union message insisted that "America has the greatest economic system in the world. Let's reduce government interference and give it a chance to work."

We submit that standby mandatory controls on hospitals is no reduction of government interference. We therefore perceive this proposed legislation as a blatant political maneuver which would broaden the power base of the Secretary of Health, Education, and Welfare and invest in one government official a degree of authority that erodes the concepts of Democratic government.

Virginia holds an enviable reputation for sound government fiscal policies. Its hospital industry stands parallel to this reputation. As the united voice of the industry in this Commonwealth, the Virginia Hospital Association has given full support to three major cost containment efforts that now can be considered a part of the Voluntary Effort and in fact requested a fourth effort which is a mandated mechanism for the review of hospital financial data.

The first cost containment effort on a statewide basis was establishment of the Virginia Hospital Rate Review Program in 1974. Because of possible antitrust conflict, the program was reduced to a consulting service. Nevertheless, the Cost Analysis Service and the Rate Review Board of the Program have determined from initial data supplied by 30 hospitals that their total operating expenses for 1977-78 increased to $364 million from $333 million in 1976-77—or 9.2 percent.

On a per patient day basis, the increase was to $191.75 from $174.88 or 9.6 percent. The projected total for these hospitals for 1978-79 was $383 million as compared to the $364 million for 1977-78, or 5.1 percent increase.

Admittedly, Virginia's performance has been better than that called for in President Carter's proposed cost containment bill, but it has been a performance rendered without the additional burden of federal regulation which historically has proven to be extremely expensive, duplicative and unreasonable. In addition, the administration's bill would lock hospitals into limits which may appear to some to be reasonable today, but may not be so reasonable tomorrow.

Another remarkably successful cost containment effort in Virginia is the Virginia Hospital Insurance Reciprocal established as a mechanism for creating stability in the malpractice insurance market during that crisis of recent years. The participating hospitals own the VHIR which in two years has saved these hospitals in terms of equity in the reciprocal approximately $2 million or about 35 percent of premiums paid.

A third equally successful program is the Virginia Hospital Association coordinated group purchasing program which reached a volume of $10 million in business in less than a year. It is anticipated that this volume can be doubled during 1979 with the program becoming entirely self-supporting. In its first year (1977-78), the program realized an average savings of approximately $1.25 million or 13 percent.

By the end of next year, the program will have computerized savings and participation reports so that each member hospital's savings are documented. The reports will also include total cost avoidance values which will consist of raw savings as well as cost containment savings. They will graphically demonstrate the productivity of Virginia hospitals' voluntary effort.

Meanwhile, in 1978, the association requested to have introduced into the general assembly of the Commonwealth legislation to establish a Virginia Health Services Cost Review Commission which the legislature subsequently approved. This mechanism to monitor and review hospital financial data is testimony to the intent of hospitals to provide greater accountability and credibility to the communities they serve and to state government.

By 1980, after the Virginia Health Services Cost Review Commission has completed a year's activity, the Commonwealth will have more complete data on which to report. In the meantime, after its organizational meetings, it contracted with the Virginia Hospital Rate Review Program for technical assistance in the performance of its duties.

While all cost containment efforts in Virginia can be considered a part of the Voluntary Effort, certain other activities are directly linked to the national Voluntary Effort. At the request of the national steering committee for the program, Virginia—along with the other 49 states—established an advisory committee on cost containment which meets regularly to monitor progress of the voluntary effort in this Commonwealth. Its members represent major segments of the economy in the

Commonwealth. In addition, virtually all of our hospitals have been formally designated as cost containment facilities.

We recommend strongly that the Congress reject any effort to impose mandatory controls on the hospital industry which has considerably demonstrated its ability to handle its own affairs without governmental interference. Such interference is a direct attack on private industry which has been the bulwark of a stable economy in this country. Aside from economic considerations, private industry has also strongly influenced the rendering of quality care, the primary goal of all hospitals.

WISCONSIN HOSPITAL ASSOCIATION,
March 16, 1979.

Mr. MICHAEL STERN,
Staff director, Senate Committee on Finance,
Dirksen Senate Office Building, Washington, D.C.

DEAR MR. STERN: On behalf of Wisconsin's 150 acute care general hospitals we would like to request that the comments contained in this letter be placed in the record of the Hospital Cost Containment Act (S. 570) and the Medicare/Medicaid Reimbursement Reform Act (S. 505).

It is the position of the Wisconsin Hospital Association that the Senate Finance Committee should give serious consideration to the enactment of S. 505. We feel that the concepts contained in this bill represent a needed improvement in medicare/medicaid reimbursement and would lead to cost efficiencies for both of these important government programs.

From the perspective of the state of Wisconsin, we believe that the proposed reimbursement reforms contained in S. 505 would enable an improved system of Medicare and Medicaid reimbursement to operate in harmony with the Wisconsin Hospital Rate Review Program. We feel this compatability between S. 505 and the current Rate Review activities in Wisconsin would provide a system of insuring the public that hospital resources were being used effectively and that the rate of increases in hospital costs were the minimal level necessary to maintain quality medical care.

Our analysis of S. 570, on the other hand, indicates that enactment of this bill would undermine our successful Rate Review activities and would replace an effective state mechanism for controlling hospital costs with a burdensome system of Federal controls that could not meet the needs either of Wisconsin hospitals or the people they serve. While S. 570 contains an elaborate system of allowing for state exemption or delegation, it is our conclusion that over the long-run few, if any, states could qualify to continue to operate reimbursement systems currently in effect. We feel the specific quantitative limitations in S. 570 are irrational and propose to limit the allowable costs in hospitals while doing nothing to deal with the cost inputs that have led to the current inflation situation in our economy. We would urge all members of the Senate Finance Committee to oppose S. 570 as an unworkable and irrational expansion of Federal controls.

We will be developing specific comments on both S. 570 and S. 505 in the near future once we have had an opportunity to thoroughly review any revisions proposed in these complex bills.

Sincerely,

WARREN R. VON EHREN, *President.*

STATEMENT OF THE AMERICAN ACADEMY OF OPHTHALMOLOGY AND THE AMERICAN ASSOCIATION OF OPHTHALMOLOGY

Mr. Chairman, Members of the Subcommittee on Health, thank you for this opportunity to submit testimony on behalf of the American Academy of Ophthalmology and the American Association of Ophthalmology. Our specific interest today concerns legislation now pending before your subcommittee to expand Medicare reimbursement policies for aphakic patients.

The American Academy of Ophthalmology is comprised of 9,000 physicians who have achieved board-certification in the specialty of ophthalmology. Founded in 1896, it is the largest organization representing ophthalmology in the United States. The American Association of Ophthalmology, which was founded in 1956, represents 5,500 ophthalmologists in the United States.

In our extensive review of the proposed coverage for services furnished by optometrists in connection with treatment of aphakic patients, we have concluded that this amendment would extend the role of optometrists into an area of medicine

where they are not qualified by training, experience, or licensure. We therefore must oppose this extension of coverage.

We would like to clarify our understanding of the phrases "treatment of aphakia" and "treatment of aphakic patients". The optical treatment of aphakia is by spectacles, contact or implant lenses. Reimbursements for spectacles and contact lenses are already authorized under Medicare as prosthetic devices when prescribed by a physician or an optometrist. No extension of coverage is therefore necessary for this type of "treatment". Other "treatment" for aphakia is the surgical procedure of lens implantation which is covered by Medicare when performed by a qualified ophthalmologist.

Optometrists can provide spectacles or contact lenses following surgery, but not intraocular implants as they require placement in the eye at the time of the surgical removal of the cataract. No optometrist is licensed to perform surgery.

We advise the subcommittee not to provide reimbursement for optometrists or any class of providers who are not prepared educationally or professionally to provide such services. If "treatment" as used in this amendment is to cover other eye services being low vision aids, telescopic, and other similar devices, then this subcommittee should consider the cost involved as such costs may be substantial. If treatment refers to any medical or surgical condition arising independently of or as a complication of cataract surgery, optometrists are not licensed to, nor qualified by training to administer it to the aphakic patient.

The fact that treatment is not defined causes us great concern. A possible problem after fitting of contacts or spectacles for an aphakic patient is the danger of infection. Since infection requires drug therapy and optometrists are licensed to use therapeutic drugs in only two states, the use of the word treatment in the proposed legislation could have serious consequences. All things being equal, eye infection of any kind is much more serious in an eye that has been operated on for a cataract than in one which has not. Eye infection of any kind in the aphakic patient constitutes an emergency that requires immediate diagnosis and treatment.

In summary, Mr. Chairman, patients who have had cataract surgery and are aphakic require medical treatment. The incidence of ocular disease in aphakic patients is such that those patients require evaluation and treatment by physicians. The optometrist lacks the medical education, clinical training, and licensure to safely and effectively provide any treatment in addition to spectacles and contact lenses.

It is the recommendation of the American Academy of Ophthalmology and the American Association of Ophthalmology that it would be inappropriate to further extend Medicare reimbursement coverage for services by optometrists.

Statement of Home Health Services Association

Mr. Chairman and Members of the Subcommittee on Health, the Home Health Services Association respectfully requests the Subcommittee to modify Section 1861(o) of the Social Security Act to permit proprietary home health care providers to participate in the Medicare program on the same terms as other home health organizations.

The Association makes this request as the Subcommittee considers S.505, the Medicare-Medicaid Administrative and Reimbursement Reform Act of 1979 introduced on March 1, 1979, by Chairman Talmadge and Senator Dole. Proposed statutory language embodying our request is Appendix 1 to this statement. The effect of this revision will remove the existing discrimination against proprietary agencies and subject them to the same rules and regulations for Medicare participation as voluntary and private non-profit agencies.

Historical introduction to home health services and to the association

There are presently three major types of organizations providing home health services:

(1) Voluntary agencies, which are owned and operated by tax supported governmental agencies or by traditional non-profit charitable organizations;

(2) Private, non-profit agencies, which are organized as non-profit corporations but are owned by a single entrepreneur or group of individuals; and

(3) Proprietary, tax-paying organizations of the type represented by this Association.

Home health care is an old idea with a new focus. Traditionally, family and friends provided home care. With the advent of the Medicare and Medicaid programs, home health benefits came to be provided by Federal government programs. Not only has home health care become recognized as a more humane mode of

treatment for many illnesses, but it is a desirable alternative to institutionalization and is generally less expensive. For example, a General Accounting Office report stated: "Until older people become greatly or extremely impaired, the cost for home services, including the large portion provided by families and friends, is less than the cost of putting these people in institutions." [1]

Proprietary home health providers are a relatively recent phenomenon. A few came into existence in the mid-1960's, and significant growth began in the early 1970's because of the great, unmet need for home health services.

The Home Health Services Association represents over 600 proprietary home health organizations, providing home health services in almost every state. The Association was formed in 1978 to encourage efficiency, reliability, and safety in the delivery of home health care to the general public. Members of the Association employ a variety of people ranging in skills and training from registered nurses and physical therapists to home health aides and homemakers. The latter groups of employees include many welfare recipients and displaced homemakers who have been specially trained.

The Association provides an effective channel of communication between home health providers and government regulatory bodies, public health officials, consumers, other professional associations and groups interested in health. The Association devotes its expertise and experience in health services to developing high quality, workable standards within the framework of efficient, cost-effective delivery.

Present home health law discriminates against proprietary organizations, the only such discrimination in the medicare program

Present law, Section 1861(o) of the Social Security Act, was first enacted in 1965. It defines a home health agency to exclude specifically from Medicare reimbursement any organization which is not non-profit, unless it is licensed under state law and meets applicable standards.[2] This law is discriminatory. It is the only section in the Medicare law where tax-paying, for-profit organizations are excluded as providers. For example, profit-making nursing homes and hospitals are all eligible for Medicare reimbursement without regard to State action; profit-making home health providers are not.

In 1965, when Congress established the Medicare program and the definition of home health agency, no proprietary home health providers existed. Nevertheless, Congress envisioned the advent of such organizations, and the Finance Committee's report noted that: "It is the understanding of the committee that organizations providing organized home care on a profit basis are presently non-existent. However, the language of the bill permits covering such agencies if they come into being, are licensed, and meet the high standards which the present nonprofit agencies offering organized care meet."[3]

It is apparent from this statement of Congressional intent that the drafters of the 1965 law intended to allow tax-paying home health agencies to the Medicare providers, and that each state was expected to enact a licensure law for home health providers. In 1965, there being no experience with proprietary home health entities, this anticipation of State action is understandable. After all, the states have enacted licensure statutes for virtually every other segment of the health industry in the interests of the health and safety of their residents.

Unfortunately, states have been slow to enact licensing statutes for home health providers. Only 22 states have passed these laws to date (See Appendix 2). This lack of licensing means that tax-paying home health organizations cannot provide home health services to Medicare patients, even where there are not enough personnel in the non-profit agencies to serve them. The result is that proprietary agencies in the majority of states are limited to serving only patients who can afford to pay personally for home health services or to subcontract for providing services with the non-profit agencies. In spite of these limitations, proprietary agencies have grown because they fill a need that is not being met by other home health care agencies.

The Nation's need for home health services is not being met

The Congressional Budget Office estimates that only 300,000 to 500,000 adults can be served by personnel from existing home health care providers, while 1.7 to 2.7 million adults have a need for home care.[4] In addition, according to the CBO, 20-40

---

[1] Comptroller General's Report to the Congress, "Home Health—The Need for a National Health Policy to Better Provide for the Elderly"; December 30, 1977, page i.

[2] See Appendix 1 for the existing language of Section 1861(o).

[3] Senate Report 404, 89th Congress, 1st Session, June 30, 1965; U.S. Code Congressional and Administrative News, 1965, page 1975.

[4] Budget Issue Paper, "Long-Term Care for the Elderly and Disabled," Congressional Budget Office, February 1977, page x.

percent of nursing home patients could be cared for adequately without institutionalization if sufficient home health care were available.[4] Estimates are that the elderly will constitute 17 percent of the total population within fifty years instead of today's percentage of 11-12 percent.

It is now and will continue to be more humane and less costly to care for these people in their homes, but today's providers cannot even meet today's needs. Present law excludes one class of home health providers which could help to meet this present and future need.

As noted previously, proprietary agencies have grown in spite of this exclusion because people are willing to pay for needed home care out of their own pockets. Moreover, voluntary agencies which cannot meet needs for home health care frequently subcontract with proprietary organizations to provide that care. Also, many non-profit agencies only operate 40 hours each week, while the needs for home care obviously cannot be limited to one quarter of the hours in the week. Proprietary providers, as the Congressional Budget Office has said, "are often the only home health care providers that offer 24-hour and weekend care." [5] Consequently, proprietary organizations provide off-hours and weekend care under subcontract to the voluntary agencies. There is no justification for the costs inherent in such a mode of operation, particularly in an era where we are very concerned as a nation with health care costs.

The important point to note here is that the performance of proprietary providers is not in question. They perform as well as or better than other home health agencies. Their growing services to private pay patients and their frequent subcontracts with voluntary agencies are proofs of their creditable performance.

Competition will enhance the quality of all home health services

We recognize that in health care, economic conditions are different from the conventional marketplace because of the prevalence of third-party payment mechanisms. But we do believe that giving the patient a choice between several providers, profit and non-profit, will naturally lead to a choice of the agency which has the reputation for delivering the best quality care. We submit that allowing competition among different forms of provider organization will resultin an overall upgrading of the services given in the home health field. Certainly it is too late in the day to argue that providing health care services under Medicare in the same old ways they've always been provided will achieve better quality and more reasonable cost. We want to play by the same rules as other home health agencies. We believe that, if all home health care providers play by the same rules, the result will not just be more widely available home health services but improvement in the performance of all home health care providers.

Revision of section 1861(o) will not increase costs for the medicare program

There is presently a serious concern in this Subcommittee, the Congress and the public over the steeply rising costs of health care. Some may fear that allowing proprietary providers to participate in the Medicare program will inflate Medicare costs at a time when we can least afford it. This fear is, we believe, unfounded. The best support for our view comes from action last year in the 95th Congress.

Last October, the House of Representatives passed, 398-2, a Medicare benefits bill (H.R. 13097) which was designed to provide additional services while keeping additional costs to a minimum. That bill changed section 1861(o) to allow proprietary home health care providers to participate fully in Medicare. HEW actuaries, working with the Ways and Means Committee, determined that full participation of proprietary providers in the Medicare program would not increase the costs to Medicare at all in each of the next five years. The relevant Committee report is attached in Appendix 3.

Revision of section 1861(o) would not interfere with the States' rights to enact licensure statutes

Another concern with our proposal is that it would restrict the States' rights to protect their own citizens' health and safety by enacting licensure statutes for home health agencies. Here again, we believe that this concern is unfounded.

First, the full participation in Medicare by non-profit home health agencies since 1965 has not prevented 21 States from enacting licensure laws covering all home health agencies, non-profit agencies included. This is the best indication that there has in fact been no diminution of States' rights, and would be none if section 1861(o) were changed as we propose. Second, as a matter of legislative interpretation, the Congressional Research Service has reported that, even if the Federal government

[5] Budget Issue Paper, "Long-Term Care for the Elderly and Disabled," Congressional Budget Office, February 1977, page 29.

changes the law to allow proprietary home health organizations to qualify as a home health agency for participation in the Medicare program, states would not be precluded from licensing proprietary home care organizations. (A copy of the CRS study is attached as Appendix 4.)

The issue is not whether States' rights will be infringed; they will not be. The issue is whether a discriminatory Federal statute should be allowed to stand.

Revision of 1861(o) would encourage delivery of quality care and discourage fraud and abuse

Under present law, voluntary and private, non-profit agencies participate fully in Medicare only proprietary home health care providers are subject to requirements for State legislative action and subsequent licensure. We believe that subjecting all three types of agencies to the same Federal standards for Medicare participation will increase the chances that all types will provide high quality service, operate efficiently, avoid fraud and abuse, and generally operate to the benefit of beneficiaries who need home health care services.

Conclusion: Section 1861(o) should be changed to eliminate the requirements for State licensure of proprietary home health agencies

The Home Health Services Association proposes that proprietary home health providers be placed on an equal basis with other home health agencies by eliminating the present requirement that proprietary home health agencies be licensed under state law in order to participate in Medicare. We believe that this law has restricted the availability of services, increased costs, limited competition, and discriminated against one class of provider—the tax-paying provider. The revision we recommend was examined and approved by the House of Representatives last year. We urge the Subcommittee to approve this revision when it acts on S. 505.

The Association appreciates the opportunity to provide this statement for the Subcommittee's consideration and will be pleased to provide further information or views.

Respectfully submitted,

RONALD E. ROSENBERG,
Chairman, Home Health Services Association.

Attachments.

Statement of
Home Health Services Association
on S. 505.

The Association recommends that Section 1861(o) of the Social Security Act be changed to permit proprietary home health care providers to participate in the Medicare program on the same basis as all other home health care providers.

The proposed change can be accomplished by a simple deletion from the existing language of Section 1861(o). The complete section showing the proposed deletion in brackets is as follows:

"(o) The term 'home health agency' means a public agency or private organization, or subdivision of such an agency or organization, which—

"(1) is primarily engaged in providing skilled nursing services and other therapeutic services;

"(2) has policies, established by a group of professional personnel (associated with the agency or organization), including one or more physicians and one or more registered professional nurses, to govern the services (referred to in paragraph (1)) which it provides, and provides for supervision of such services by a physician or registered professional nurse;

"(3) maintains clinical records on all patients;

"(4) in the case of an agency or organization in any State in which State or applicable law provides for the licensure of agencies or organizations of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing agencies or organizations of this nature, as meeting the standards established for such licensing;

"(5) has in effect an overall plan and budget that meets the requirements of subsection (z) of this section; and

"(6) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such agency or organization;

"~~[except that such term shall not include a private organization which is not a nonprofit organization exempt from Federal income taxation under section 501 of Title 26 (or a subdivision of such organization) unless it is licensed pursuant to State law and it meets such additional standards and requirements as may be prescribed in regulations; and]~~ except that for purposes of part A such term shall not include any agency or organization which is primarily for the care and treatment of mental diseases."

Statement of
Home Health Services Association
on S. 505

Appendix 2

States with Home Health Agency Licensure Laws

Arizona

California

Connecticut

Florida

Hawaii

Idaho

Illinois

Indiana

Kentucky

Louisiana

Maryland

Montana

Nevada

New Jersey

New York (Licenses only non-profit organizations)

North Carolina

Oregon

Rhode Island

South Carolina

Tennessee

Virginia

Wisconsin

Statement of
Home Health Services Association
on S. 505.

Appendix 3

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

PROPOSED AMENDMENTS

TO THE

MEDICARE PROGRAM

AUGUST 4, 1978

Prepared for the use of the Committee on Ways and Means by its staff

---

U.S. GOVERNMENT PRINTING OFFICE
31-574 WASHINGTON : 1978

~~(e) Elimination of the homebound requirement~~

To be eligible for home health care, the patient must be confined to his or her home. A person does not have to be bedridden to be considered to be confined to his home. However, the patient's condition should be such that there exists a normal inability to leave home and, consequently, leaving home would require a considerable and taxing effort. Occasional absences from home are allowed for both medical and nonmedical reasons. Elimination of the homebound requirement, with no other change in the benefit, would expand benefits to a new category of patients who are in need of skilled care but would ordinarily be expected to obtain such care in an ambulatory setting, that is, a doctor's office or a clinic. Many have expressed concern that, given such a liberalization, beneficiaries now obtaining care in an ambulatory setting would have an incentive to receive the care under the home health benefit along with all the attendant supportive services. In addition, elimination of the homebound requirement would make enforcement of the skilled care requirement exceedingly difficult.

(f) Addition of homemaker services

Services furnished by homemakers are not presently covered under the home health benefit. The home health aide—whose primary function is to perform personal care duties for a patient—may perform certain household services, but only if such services do not substantially increase the time spent by the aide in the patient's home. Such household services can include light cleaning, shopping for food, assistance in the preparation of meals, and laundering essential to the comfort and cleanliness of the patient. Coverage of homemaker services would represent a significant benefit expansion and would be of particular assistance to those who do not have the services of family or friends available. Many have expressed concern, however, that such a benefit would serve largely to substitute for services presently being furnished by family and friends and be subject to over-~~utilization and abuse.~~

(g) Elimination of the licensing requirement for proprietary home health agencies

By law, proprietary or for-profit home health agencies are not eligible to participate in the medicare program unless the agency is licensed pursuant to State law and it meets such additional standards and requirements as may be prescribed in regulations. Currently 17 States license home health agencies. One of these States, New York, specifically licenses only nonproprietary home health agencies and reimbursement would not be made available to proprietary agencies in that State by virtue of this proposed change. With respect to additional standards which by law may be imposed on proprietary home health agencies, it is required that such agencies offer skilled nursing services and one other therapeutic service directly, whereas public and nonprofit agencies are allowed to contract for either the skilled nursing service or the other therapeutic service.

Those who advocate the elimination of the licensing requirement for proprietary agencies and elimination of authority to impose additional standards for such agencies argue that this is the only type of facility so discriminated against in the medicare program. When the medicare program was enacted, it was thought that eventually all States would license home health agencies and that such licensure would provide some assurance for provision of quality services and against possible abuse. In practice, however, States have not been quick to license home health agencies. Proponents of the change further argue that it would make home health services more available to those who need such services.

On the other hand, some have expressed strong concern that adequate standards for home health agencies do not exist and easing the barriers to the entry of many new proprietary agencies (particularly if they accept only medicare beneficiaries as clients) may lead to more abuse and higher expenditures for the program. Their concern is particularly with respect to the high utilization rates and high cost per patient generated, on the average, by those proprietary agencies that are licensed and participating in the program; however, this same concern extends to private nonprofit agencies. In this regard, HEW is required, under existing law, to report to the Congress by October 25, 1978, with recommendations for regulatory and legislative changes on the issues of quality assurance and administrative efficiency with respect to all home health agencies.

(h) Elimination of the skilled care requirement

It has also been suggested that the requirement that a beneficiary require skilled nursing care, speech therapy or physical therapy in order to qualify for the full range of home health benefits, be eliminated. The test of need for home health services would then be the need for any type of nursing services and or a need for any other of the home health benefits—for example, home health aide services.

Although the availability of nonskilled nursing services and personal care services would enable a number of those who are now in institutions to be cared for at home, it has been suggested that medicare—a medically oriented program—is not the appropriate program to use in making these services available. More importantly—since without a skilled care requirement, the medicare program would be providing home health benefits as an alternative to or extension of care which is generally paid for by the medicaid program, by private funds, or furnished by family and friends—such a liberalization would represent a significant additional expenditure to the program with no opportunity for offsetting savings.

It has been urged that any expansion of the present home health benefit be considered in light of the recent work by various committees of the Congress which indicate some incidence of fraud and abuse among home health agencies. The home health business can be highly profitable—little capital is required and those who serve only medicare patients are virtually assured that 100 percent of their costs will be reimbursed.

There also is some concern that medicare home health expenditures have been growing so rapidly in the last few years. Program expenditures have averaged a yearly increase of over 50 percent in the last 5 years and have exceeded—by as much as 1¼ times—the medicare expenditures for skilled nursing facility benefits in the last 3 years. Others would counter this concern by pointing out that home health expenditures still account for only 3 percent of total medicare expenditures. This rapid growth in the medicare home health benefit, the ease with which home health agencies can be established, and the evidence of abuse suggest that any significant expansion of the present benefit should be accompanied by efforts to provide for more efficient and uniform reimbursement policies, the tightening of conditions of participation for home health agencies, and improvement in administration by medicare intermediaries.

Cost:

[In millions except where otherwise specified]

	Eliminate 3-day requirement	Unlimited visits	Eliminate homebound requirement	Add homemaker services	Eliminate skilled care requirement (billions)	Occupational therapy	Eliminate licensing requirement for proprietaries
Fiscal year:							
1979	$8	$4	$105	$300	$1.2	$28	0
1980	9	4	130	370	1.5	35	0
1981	11	5	150	440	1.7	41	0
1982	12	6	180	520	2.0	49	0
1983	13	7	210	600	2.3	56	0

2. Services Furnished to Medicare Beneficiaries Outside the United States

Present law: Medicare coverage is provided, with a few limited exceptions, only for health care services rendered within the United States. These exceptions cover only cases in which the beneficiary needs emergency hospital services while traveling in Canada between the 48 contiguous States and Alaska; or needs hospital services because of a medical problem that arose while traveling or residing within the United States near the border, and a Canadian or Mexican hospital is more accessible than the nearest United States hospital. This limitation on medicare coverage was included in the law because of the administrative problems involved in verifying the medical necessity for services furnished outside the United States, establishing the qualifications of foreign medical practitioners and institutions, and determining the appropriate amount of payment to make for services.

Issue: A significant number of medicare beneficiaries are deprived, during such times as they may be traveling or living outside the United States, of their medicare benefits. Since the basis of the limitation in present law is administrative, it is widely believed that considerations of equity dictate the development of a reasonably workable arrangement for assuring medicare protection, to the extent feasible, for such beneficiaries.

Discussion: A proposal has been made to authorize the negotiation of reciprocal agreements with other countries under which provision

STATEMENT OF HOME HEALTH SERVICES ASSOCIATION
APPENDIX 4

This summarizes our telephone conversation regarding an analysis of Section 1861(o) of the Social Security Act, as amended, 42 U.S.C. § 1395x(o). That section reads as follows:

HOME HEALTH AGENCY

(o) The term "home health agency" means a public agency or private organization, or a subdivision of such an agency or organization, which—

(1) is primarily engaged in providing skilled nursing services and other therapeutic services;

(2) has policies, established by a group of professional personnel (associated with the agency or organization), including one or more physicians and one or more registered professional nurses, to govern the services (referred to in paragraph (1)) which it provides, and provides for supervision of such services by a physician or registered professional nurse;

(3) maintains clinical records on all patients;

(4) in the case of an agency or organization in any State in which State or applicable local law provides for the licensing of agencies or organizations of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing agencies or organizations of this nature, as meeting the standards established for such licensing;

(5) has in effect an overall plan and budget that meets the requirements of subsection (z) of this section; and

(6) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such agency or organization:

except that such term shall not include a private organization which is not a nonprofit organization exempt from Federal income taxation under section 501 of Title 26 (or a subdivision of such organization) unless it is licensed pursuant to State law and it meets such additional standards and requirements as may be prescribed in regulations: and except that for purposes of part A such term shall not include any agency or organization which is primarily for the care and treatment of mental diseases.

A question has been raised as to the effect of deleting from the above section the underlined portion. Section 1861(o) defines the term "home health agency" for purposes of the Supplementary Medical Insurance Benefits for the Aged and Disabled Program (Medicare). "Home health agency" specifically includes a public agency or private organization which (1) primarily provides skilled nursing or other therapeutic services; (2) has policies established by a professional (medical) group to govern provisions of services; (3) maintains clinical records on all patients; (4) is licensed, or meets licensing standards, if state law requires licensing; (5) has in effect a budget plan meeting federal requirements; and (6) meets other conditions set by the Secretary of HEW. The term does not include a private organization which is not a nonprofit organization exempt from federal income taxation unless it is licensed pursuant to state law and meets federal standards. For purposes of part A "home health agency" does not include any organization primarily engaged in the treatment of mental diseases. See legislative history of P.L. 89-97, section 102(a), U.S. Cong. and Admin. News, 89th Cong., 1st Sess. 1965, p. 2124.

The effect of this section as it presently reads is to disallow reimbursement under Medicare to proprietary home health organizations (i.e., a "private organization which is not a nonprofit organization exempt from federal income taxation"), unless such organizations are state licensed and meet federal requirements. Thus, non-licensed proprietary home health agencies may not receive reimbursement under Medicare.

If this exception were deleted from Section 1861(o) then the effect would be to allow non-licensed proprietary organizations to qualify as a "home health agency" under this section. However under subsection (4) of this section, if States require licensing of such proprietary organizations, then such organizations must be either licensed or approved for licensing in order to meet definitional requirements. In addition, Section 1861(o) would not preclude state licensing of proprietary home care organizations at present or in the future.

While a reading of Section 1861(o) indicates that state licensing of proprietary home care organizations would be unaffected by deleting the present exception, congressional intent regarding retention of the right of States to require such licensing might be expressed in the report accompanying deletion of the exception.

We hope you will find the above discussion helpful for your needs. If further information or analysis is needed, please let us know.

KATHLEEN S. SWENDIMAN,
Legislative Attorney.

STATEMENT OF THE AMERICAN ASSOCIATION OF ORAL AND MAXILLOFACIAL SURGEONS

The American Association of Oral and Maxillofacial Surgeons ("AAOMS") is the official organization for the dental specialty of oral and maxillofacial surgery. AAOMS represents approximately 3,700 oral surgeons from all fifty states, the District of Columbia and Puerto Rico. Today all members must complete three or more years in an accredited surgical residency in a hospital following completion of four years of dental school. Members practice oral surgery in offices and in hospitals as medical staff members.

There are two important inequities affecting the patients of oral surgeons in the reimbursement provisions under present Medicare laws. Section 35 of S. 505 addresses and would correct one of these inequities.

Section 35 of the bill would cover under Medicare any services performed by an oral surgeon or other dentist which he is trained and licensed to perform where the same services are covered under existing law if performed by a physician. Under existing law, if an oral surgeon is the provider, only surgical services are covered. However, the professional practice of oral surgeons overlaps with that of physicians to a significant extent in nonsurgical matters including, for examples, diagnostic care and treatment of oral infections. Nonsurgical procedures such as these would be covered under the bill where they are performed by an oral surgeon. The bill would not add coverage for any services not presently covered in the case of physicians.

The existing discrimination is based solely upon the academic degree of the provider and has serious consequences for the patient, and is important to the professional life of the oral surgeon. If the patient is aware of the discrimination, his freedom of choice of provider between a physician and an oral surgeon will be prejudiced. If he is not aware of this legal pitfall when he is treated by an oral surgeon, he will be deprived of reimbursement for what surely must appear to him a completely arbitrary distinction.

Section 35 is noncontroversial. The same provision was included in H.R. 5285 in the 95th Congress as reported by the Finance Committee and as passed by the Senate. A similar provision was passed by the House in H.R. 13097 during the 95th Congress. It is also included in S. 507. AAOMS respectfully urges favorable consideration of this provision at the earliest possible time.

The second inequity for Medicare patients which the AAOMS would like to bring to the attention of the Subcommittee concerns reimbursement for hospitalization required by the severity of a patient's dental condition. To correct this problem will increase benefits and thereby the cost of the program by a relatively modest amount.

Existing Medicare law differentiates between cases in which the dental procedure itself is a covered service (and thus the dentist's fee is reimbursable) and cases involving noncovered procedures. If the procedure is covered, the inpatient hospital expenses are also covered. However, the present Medicare statute as interpreted by the Social Security Administration severely restricts the payment of inpatient hospital expenses in the case of a noncovered dental procedure. Coverage of the hospital expenses is permitted only if performance of the dental procedure risks aggravation of a specific, pre-existing medical impairment to the extent that hospitalization would be required for proper management, control or treatment of that pre-existing medical impairment. The only example of a medical impairment justifying the hospitalization of a patient for a noncovered dental service given in the Social Security Administration's "Intermediary Manual" is "a patient who has a history of repeated heart attacks who must have all of his teeth extracted." No weight is given to the severity of the dental procedure alone or in conjunction with the patient's age and general health.

The effect of existing law is to preclude hospitalization coverage where, in the judgment of the patient's dentist, the severity of the dental procedure alone requires hospitalization for its safe performance. Professional opinion establishes that many relatively healthy, aged individuals should have available the sophistication and immediacy of a hospital, inpatient level of care when undergoing extensive or serious dental procedures. In these cases, however, the patient must find his own

means of payment for the hospital expenses. Sample Medicare rejections when contrasted with the example in the S.S.A. manual starkly demonstrate the problem under present law. For example:

A 74 year old woman in Louisiana had a full mouth extraction consisting of twenty-two teeth, alveoloplasty of the maxilla and mandible, removal of bilateral mandibular lingual tori and removal of torus palatinus, and insertion of a full upper and full lower denture, with an estimated blood loss of about 400 cc during the procedure; and her claim for the expenses of hospitalization was denied, notwithstanding reconsideration and thorough review, because her hospitalization was not required for medical management of any nondental impairment but only "to ensure high quality dental care";

An 81 year old woman in Florida who was hospitalized by her oral surgeon for the removal of six maxillary teeth had her claim rejected because the Medicare Intermediary found that she was treated for a purely dental condition;

A 93 year old man in Illinois who was hospitalized by his oral surgeon for the extraction of eleven seriously diseased teeth had his claim denied; and

In Missouri a Medicare patient had to pay his own hospital bill because he was hospitalized by his oral surgeon for preparation of the lower jaw for dentures using a skin graft.

These are only four of the examples regularly received by AAOMS every year but they graphically illustrate the problem.

AAOMS urges that Medicare should cover inpatient hospital expenses if in the judgment of his dentist the severity of a patient's dental condition requires him to be hospitalized for performance of a dental procedure notwithstanding that the procedure itself is not a covered health service. This will not increase the coverage of dental fees. It will only increase hospital coverage and aid the patient.

The House during the 95th Congress passed an amendment to cover these hospital expenses as part of H.R. 13097, and the same provision is currently pending before the Ways and Means Committee. This amendment is comparable to the miscellaneous items already included in S. 505 and separately in S. 507 and AAOMS believes that it would be appropriate to provide for coverage of these hospitalization expenses in those bills. The following language is respectfully submitted:

Section 1814(a)(2)(E) of the Social Security Act is amended to read as follows:

"(E) in the case of inpatient hospital services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services; or"; and

Section 1862(a)(12) of the Act is amended by inserting "or because of the severity of the dental procedure" after "clinical status".

AAOMS also urges the Subcommittee to consider at the appropriate time the status of dentists in Professional Standards Review Organizations. The National PSR Council has recommended, HEW has supported, and during the 95th Congress the House has approved, in H.R. 13817, an amendment to the PSRO law that would provide membership for a dentist on the National PSR Council and enable local PSROs to offer membership to dentists who are members of hospital medical staffs and hold independent hospital admitting privileges. H.R. 13817 was not considered by the Finance Committee during the last Congress.

This amendment would solve an immediate need. Without membership in local PSROs, dentists who are hospital staff members cannot be assured peer review of inpatient services which they are providing and which are currently being reviewed. Looking at the longer term there should also be provision for inclusion of dentists in the PSRO process to assure peer review of dental services which are provided in noninstitutional settings. AAOMS believes that at least the immediate problems considered in H.R. 13817 should be addressed during this Congress.

Statement of the Montana Senior Citizens Association, Inc.

Mr. Chairman, members of the committee, I am Chas. A. Banderob of Ballantine, Montana, a small rural town, fast becoming a bedroom community of Billings. Today I am here as President of The Montana Senior Citizens Association, and also a board member of The Mountain Plains Congress of Senior Organizations.

We Senior Citizens are very deeply disturbed with the gross inequities found in Medicare assigned rates from state to state; with the bungelsome in which claims are handeled; with the permissiveness of alowing the doctors and hospitals owned insurance's to be Medicare insurance carriers; and with the out right fraud that has been allowed to creep into the Medicare program.

In Montana only 21.6 percent of the doctors will assept the Medicare assigned rate in full settelment of their charges, while in some other states up to 67.6 percent of the doctors do, over the nation as a hole it averages 52 percent. Here is part of the reason why, in one state Medicare sets an assigned rate for a given ailment treatment, at $1,085.60, in another state it is $613.90, and still another it is only $355 for the same opporation.

Now each Senior Citizen who carries Medicare has the same amount of premum deducted from our Social Security check each month, but we in Montana and several other states receive only about 50 percent of as much benifits payed. 78 percent of the doctors in Montana are chargeing us considerable more over and above the Medicare assigned rates.

What ever the reasons, it is unfair to ask the the Elderly Poor and the Elderly general to pay higher out of pocket medical expenses based on a poorly designed Medicare System.

It most certainly appears that when insurance companies, which are dominated and controled by the doctors and/or the hospitals, are allowed to be insurance carriers for medicare, (namely The Blue's) that there is grave question of conflict of interest, they should be required to devest themselves of the insurance companies, or sease to be carriers. When statistics are showing that two out of every three opporations, are found unnecessary when the patient consults a second or third doctor. We seniors wonder to what extent they are opporating on our pocket books.

When statistics show that of the 15 billion dollars of fraud that has been uncovered so far by HEW investigators, over half, 8 billion dollars has been directly connected to the medical profession and Medicare. Then drastic steps must be taken to correct such abuse.

The high cost of doctor's services, some times fraudelent, plus the high cost of hospitalization, coupled with Medicare's inequalities has created such a degree of insecurity amoung all Americans, and especialy those who are the elderly, that a great many of them are dieing of shear fear. We feel that we would just rather die than be subjected to all this.

What a blight, what a disgrace for a nation which is as indowed with the abilities to do much better for its people, that has the wealth with which to do the things that are nessary to have adiquate health care for its people. The mal-distribution of this wealth is man made, and therefore intensefies the plight of the blight. It certianly makes mockery of our nations professed intellegence.

When a nation allows the sysophening off, of the buying power of the masses of our population in one years economic turn over, the amount of $108 billion's of dollars in net profits. (and co-incidentaly, The total value of all agricultureal production in the U.S. last year, the same year was $108 billion dollars) our total agri. production was sysophoned off in net profits, but we cant provide adiquate health care for all of our people. Much of the medical profession and the health insurance industries, are great gatherers of these hugh nets. Let me point out also that these nets did not employ one single person during the period they were gathered, therefor, some one was unemployed, or underemployed, or underpaid, one week for every $200 of net extracted out of the economic turnover.

The Montana Senior Citizens Association and The Mountains Plains Congress of Senior Organizations are on record, and I wish to again reinforce that position, That we favor A National Health Security Act, such as the Plan proposed by Senator Kenedy. This Nation can no longer afford to short change its people in its health care.

I wish to thank this committee and Senator Baucus for this opportunity to present this testimony on behalf of the people of the U.S. and of the people of Montana in perticular.

Thank You.

CHAS. A. BANDEROB.

ASSOCIATION OF DELAWARE HOSPITALS, INC.,
Dover, Del., March 15, 1979.

CHAIRMAN, SENATE FINANCE COMMITTEE,
Dirksen Senate Office Building,
Washington, D.C.
(Attention Michael Stern, staff director).

DEAR SIR: The purpose of this letter is to comment briefly on S.570, the proposed hospital cost containment act of 1979 and to request that this letter be included in the record of hearings on the bill. Unfortunately, these comments must be general and relatively brief since there is no way that we can adequately study, analyze,

and report on so complicated a bill in the time allowed. We consider it improper and unfair that the Department of Health, Education, and Welfare has had so much time to structure and write the bill while hospitals and the public have relatively no time to consider the probable consequences, ramifications and to respond appropriately.

We must oppose the bill in the strongest possible way. The proposal is unnecessary, conceptually unreasonable, arbitrary and, worst of all, delegates excessive authority to the executive branch of government. The Congress has so delegated in legislation in the past with horrid results. For the Congress to act favorably and hastily on so crucial a piece of legislation which has such far-reaching implications, seems irresponsible. This bill contains the seeds for bureaucratic disruption or destruction of community hospitals.

This bill is clearly deceptive and designed to be punitive. It is deceptive in that there is nothing "voluntary" about it. We can only assume that the Department will use its vast authority under this bill by interpreting its authority even greater than the Congress intends. The bill is punitive in that it sets up "voluntary" goals which are impossible to meet in order to trigger mandatory controls most of which are left to the discretion of the secretary.

Under the circumstances, S.570 is not justified. Hospitals have demonstrated their commitment to fight inflation. The congressional budget office apparently sees the voluntary effort as probably saving more federal and nonfederal dollars than any Government-mandated scheme. The rest of the economy has not made so impressive a demonstration of voluntary restraint as requested by the President previously. It may well be that the rest of the economy is out of control considering present federal policies which do significantly influence and promote inflation. I refer to the ever increasing costs of government, deficit spending, ineffective energy programs, the printing of excessive (fiat) money, unheard of debt levels, etc. The administration's proposal that the place to begin in fighting inflation is to tightly constrain hospitals in an otherwise uncontrolled economy and add to the mammoth bureaucracy is simply wrong.

We ask the Congress to let the voluntary effort work, free of the "gun to the head." We ask the Congress to see this bill for what it really is—one of the ugliest of so many efforts in recent years by the bureaucracy to further usurp the powers of the people and their legislative branch of government. This legislation would only destroy a working voluntary program and make the problem of inflation worse.

Sincerely,

JACK CROSS, *President.*

STATEMENT OF THE ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS

Mr. Chairman and Senators of the subcommittee, the Association of American Physicians and Surgeons appreciates this opportunity to submit testimony on proposed hospital cost containment legislation and S. 570. The association represents physicians in the private practice of medicine throughout the entire nation including the District of Columbia and Puerto Rico. The members of this association are committed to values of a free choice, competitive market system. The members are also committed to principles of individual freedom and certainly that includes family responsibility. We are committed to providing patients the highest level of health care within a free competitive society. We are committed to encouraging the medical profession to provide assistance to needy patients, even when they are unable to pay. We are committed to quality care at reasonable cost arrived at by competition without government intervention. It is in this spirit that we present our views on this legislation.

We are concerned with the impact of cost—all cost on the family including of course government cost, not only in terms of general inflation or the cost of medical expenses, but also in terms of the family's ability to obtain the best care from the doctor and the hospital of their choice.

We believe this legislation is against the interest of all patients and physicians who attend patients.

We are dismayed by the testimony presented by DHEW Secretary, Joseph A. Califano, Jr., before your subcommittee on Senate bill S. 570. First, he used the term "hospital inflation" for "hospital cost." Second, he claimed that this hospital cost legislation bill was a "litmus test" of whether or not Senators and Representatives would vote to control spending and inflation by voting for passage of this bill.

In Secretary Califano's prepared statement and in his answers to questions of the subcommittee, he fails to make a clear distinction between "inflation" and "cost." Not all increases in cost are inflationary. Some of the increased cost in health care

has been due to factors such as volume, improved care and shifts in population by age group. Juggling these factors either carelessly or intentionally with general inflation factors does not provide a sound basis for this Committee to consider legislation.

If this legislation can stand on its merits, which we do not believe that it can, it should not be necessary to erroneously exaggerate the affect of hospital cost on inflation.

In addressing the causes of hospital inflation Mr. Califano cites three items: "Over 90 percent of hospital bills are paid by third parties—most patients do not pay rising cost directly; hospitals are reimbursed by an inefficient 'cost-plus' system—thus there is no incentive to save; and, there is no buyer and seller relationship—physicians make 70 percent of health care decisions, but have no incentive to hold down costs."

While these factors have some influence on hospital cost, Mr. Califano has left out the most important factors that have increased cost. For example, government policies have greatly inflated cost. In designing a solution to the problem he takes a meat-ax approach by establishing an arbitrary federal cost lid rather than by presenting a program of de-regulation. Of course, as most of us know, regulation and government intervention are, as we will show, the real cause of the increased cost of medical care.

To get a better perspective of what has happened to hospital cost and what it means, we would like to present material by John R. Virts, corporate staff economist of Eli Lilly and Co. His study is based upon an HEW report that U.S. spending for health care increased about $80 billion from 1965 to 1975. He not only used the federal government's figures but also its methods of calculation. Approximately 1/2 of the increased cost was caused by general inflation for which the Federal Government was primarily responsible.

The facts as reflected by Government figures are nakedly and strikingly disclosed by Virts as follows. Of the $80 billion increase, the causes were due to:

Causes:	*Billions*
General inflation caused by central government financing	$37.5
Medicare and medicaid increased demand because of inelasticity short-term supply	$2.5
Medicare ($1.1 billion) and medicaid ($1.2 billion) program inefficiencies	2.3
Medicare and medicaid redtape forcing hospitals and doctors to hire more help to comply	1.0
Government forcing doctors to practice defensive medicine	4.5
Subtotal of medicare, medicaid, and other governmental actions	10.3
Professional liability insurance premium increases caused by malpractice of the judiciary—a Government fault	1.0
Changing custodial care from charity to paid care (monetized)	3.0
Inefficiencies of Government health care programs—Armed Forces, Veterans' Administration, research, construction	8.0
Total of all governmental actions	60.1
Population growth	6.8
Aging of population	0.2
New technology	4.2
Increase due to income growth	8.3
Intern and residency training programs with more and higher paid doctors	0.3
Total of nongovernmental actions	19.5

This table shows clearly that government caused 75 percent of the increase and the private sector only 25 percent. If government had not interferred with the willing exchange of goods and services for medical care and if government had restrained itself to being an impartial referee as intended by the authors of the United States Constitution and if the Congress had not bowed down to the largest, most zealous and best financed lobby in the world—the federal bureaucracy—the increases in health care cost would not be approximately $80 billion but $20 billion.

The American people, we have every reason to believe, would not be revolting against the arrogant appropriation of their earnings and savings by Congress for the bureaucratic dictators if government excesses were eliminated.

No reasonable person can quarrel with increased medical care expenditures due to increases in population growth ($6.8 billion) or in increased demand ($8.3 billion) because people have more resources to buy what they want.

When the Congress and the President spend billions of dollars to make the people believe the increased cost of hospitals and doctors is due to anything other than bureaucratic excesses, Congress and the President are engaging in deception which further undermines our free choice system which is the basis of freedom.

Congress and the President should stop pointing a finger at the private sector and clear up the mess government has created. This country is sick from government excesses. Government usurption of power is the problem. Giving the government bureaucracy more power can make the sickness of government deadly. Congress should focus on the cause of the sickness of government.

We should have learned from our experiences that medicare, medicaid, and excessive monopoly labor union demands backed by federal law, have created unjust increases in spending for health care.

We have shown that 75 percent of the increases in health care are directly attributable to government. This is indefensible. Blame government, not doctors and hospitals who have been dragged into this mess by the government bureaucracy and their allies among the labor union bosses and even among business. Unions with less than 25 percent of the labor force under their domination have forced up health cost with government support. Leading labor union bosses in the auto, farm machinery and airline industries forced business to pay for unsound inflationary health care insurance. The demands were to give employees and their dependents, with little or no apparent cost to the employee, complete health insurance. The insurance demanded was (1) first dollar coverage with no deductions, (2) community type rating excluding experience rating, (3) service type contracts instead of indemnity type contract payments.

Business caved in to these demands. Costs have skyrocketed due to the unsound features of these contracts. All incentives for conservative use of these insurance programs are removed.

First dollar coverage means an employee can demand insurance payment for even a bandaid. All responsibility for holding down on use is removed from the employee.

Community rating also forces insurance cost up. The reason is the employing company has no incentive to hold down cost. Under an experience rating, the company would get the benefit of carefully holding down unnecessary cost of hospitalization, which it loses under the community type rating.

Service type contracts further remove any incentive from employees or employers to save on cost.

All these artificial increases in cost to which the Blues and many other insurance companies have quietly acquiesced should be stopped. They would be stopped by private contracts if government didn't support these costly and unreasonable demands of labor union bosses in labor union contracts.

Thus, those in the labor force under union contract (less than 25 percent) and the non-union employees (over 75 percent) are paying for these unsound insurance schemes through inflation.

Corporations are being persuaded that compulsory government medicine is the way to get the excess health care cost off their back onto the general treasury—thus sticking all earners and savers with the cost through the hidden tax of general inflation. This is exactly what the bureaucrats want.

Secretary Califano has made light of and even ignored the current impact of inflation. Instead he continually points to a fifteen percent inflation rate for hospital expenditures for the period 1969-77. The actual rate of increase in the average expenditures for hospital services for this period was eight percent. The difference between the Califano hospital inflation figure of fifteen percent and the actual hospital inflation figure of eight percent is the seven percent average volume increase of hospital services. This fact raises a legitimate question. Did these increases result in benefits worth the cost? This question should be examined before any more thought is given to so-called necessity of more federal intrusion into the health field as proposed by this legislation.

We believe that, although there is room for more productivity and efficiency in the hospital setting, there are clearly identifiable benefits that have resulted from the increased volume in health services. As one example, the life expectancy has increased from 70 years in 1967 to 73.2 years in 1977. Also, with the tremendous

population shift upward by age group, more chronic and intensive care has become necessary with a demand for more volume as a result.

Most significantly, Secretary Califano has failed to articulate how the federal government has greatly increased costs by:

(a) Running huge deficits and financing them by borrowing and printing paper money without any backing; this is one of the main reasons for general inflation;

(b) Increasing demand by promising certain classes care at prices below cost or at no direct cost to the user;

(c) Increasing demand by subsidizing states to promise certain classes of citizens care for zero cost to the person seeking the service;

(d) Binding hospitals and doctors with red tape so their costs of doing business are substantially increased;

(e) Collecting huge sums of money through taxes on everything everyone buys so that a dollar saved in 1940 will buy less now than 1/5 of what it would buy then;

(f) Supporting labor union bosses in their demands on business to give employees and their dependents medical care with little or no cost to the employee, consequently removing reasonable self-restraints on over utilization.

(g) Increased expenditures of $40 1/2 billion for the Armed Forces, military dependents, veterans hospitals and doctors, research, construction—both defense and veterans, medicare, medicaid and others.

Thus, government accounted directly for over 50 percent of the increased spending from 1965 to 1975. Yet government blames private medicine for the increased cost when, in fact, most of the cost increases are due to government excesses and wastes. Most of the increase is due to general inflation.

We all know that Secretary Califano knows the facts about the impact of public policy on health care cost in the United States. Is there something going on behind the scenes—something we don't know about? No; the Secretary is not really pulling the wool over our eyes. He does not have a hidden agenda, only an obscure one. He has told us in his direct testimony what he is up to. His goal is clear. He wants to establish a federalization of health care. He said, "federal savings from hospital cost containment might be used to provide needed benefits under a national health plan." He did not even flinch when Senator Edward M. Kennedy emphasized the need for hospital cost containment as an interim measure to phase in national health insurance. Senator Kennedy has laid it on the line when he added, "only through national health insurance can we guarantee effective cost containment over our entire health care sector." The clear purpose of such legislation is to move the country closer to the goal of centralized control of health care delivery under the federal government's Secretary of HEW. Under such legislation he is seeking massive authority to ration health services in the hospital sector under the guise of the pocket book issue of inflation.

The administration is operating under a premise that suggests that the federal government alone is capable of guaranteeing "comprehensive" medical care for everyone. The federal government cannot guarantee comprehensive medical care for all because its political goal must be equal care for all. The only way government could carry out a political decision to provide equal care for all would be to ration services. Rationing, by definition, is denial of services. So is government regulation.

In closing, Mr. Chairman, a vote on this legislation is not a litmus test on Congress's willingness to control inflation. It is a litmus test on Congress's willingness to convert the private practice of medicine to a dictatorial form of socialized medicine. The plan is not to cut health spending but to shift it from private control to Califano's control. This would be terrible public policy that would destroy quality private health care and innovation, and diminish individual freedom and family responsibility. More government regulation is clearly detrimental to our economy. More government health care cost control should be rejected. Instead deregulation legislation should be adopted and competition should be fostered while at the same time federal spending should be restrained.

NATIONAL FARMERS UNION,
Washington, D.C., March 13, 1979.

Hon. HERMAN E. TALMADGE,
Chairman, Subcommittee on Health, Senate Finance Committee,
U.S. Senate, Washington, D.C.

DEAR CHAIRMAN TALMADGE: Please include this letter in your hearing record as part of the testimony on S. 570, the Hospital Cost Containment Bill.

National Farmers Union urges the enactment of the Hospital Cost Containment Bill now before your Subcommittee. We endorsed the proposal which was before

Congress last year and we believe the bill that is now being considered will effectively deal with the continuing escalation of hospital costs.

All of the reasons which caused President Carter to propose cost control in the last Session of Congress hold true today with the added urgency of the need to control inflation in general. We believe the new legislation which is being proposed, with its greater emphasis on voluntary programs, is more acceptable to providers and can be successful. The public is appalled at the high costs of hospital-based care and is supportive of efforts to hold the rising hospital costs at least to the present inflation rate.

We also endorse the provisions in the legislation which exempt hospitals in rural areas and hospitals operated by Health Maintenance Organizations. The small rural hospital is not able to institute the kinds of cost controls which are possible in the metropolitan institution and they do not offer the specialized care which has been one of the main causes of the rising costs. HMOs have their own built-in cost controls.

We urge you to act quickly on the Hospital Cost Containment legislation so that it can take effect as soon as possible.

Sincerely,

TONY T. DECHANT.

MISSOURI HOSPITAL ASSOCIATION,
Jefferson City, Mo., March 15, 1979.

Mr. MICHAEL STERN,
Staff Director, Senate Committee on Finance,
Dirksen Senate Office Building, Washington, D.C.

DEAR MR. STERN: The Missouri Hospital Association, representing the hospitals in Missouri, offers the following comments on S. 570, the Hospital Cost Containment Act of 1979, for the hearing record.

The Missouri hospitals are engaged in the highly successful Voluntary Effort (VE). In 1978, Missouri hospitals reduced the rate of increase in total expenditures from 15.8 percent to less than 13.7 percent. This progress was accomplished in the face of rising inflation, increased utilization, aging population, greater intensity of services, improvement of services, equipment and facilities and extension of services. This program saved Missouri patients more than $25 million in 1978 alone.

Nationwide, the VE brought the rate of increase in total expenditures down to 12.8 percent. These unprecedented accomplishments saved millions of dollars.

Missouri hospitals

There are 163 general community hospitals in Missouri. The existing hospitals provide 29,000 beds. During 1978, Missouri hospitals treated more than 900,000 inpatients and rendered over 4.5 million units of outpatient and emergency service.

Missouri's hospital system is one of the finest in the nation, providing Missourians with several outstanding secondary and tertiary care centers and many excellent general community hospitals.

Hospitals in Missouri—public, not-for-profit, private and investor-owned institutions—represent a composite of interests and offer a wide range of medical and social services. Our state is fortunate to have several schools to train medical doctors and osteopathic physicians, most of whom practice in Missouri after graduation. Exclusive of federal and state institutions, Missouri hospitals provided in 1978 essential community service jobs to more than 100,000 people, with an annual payroll exceeding $750 million. In addition, the economy of the state was strengthened by many other Missouri businesses and industries which provide hospitals with goods, services and supplies.

Hospital costs

In 1978, inpatient costs averaged $193 per day in Missouri community hospitals, compared to the national average of $219 for all community hospitals.

Two-thirds of the increase in hospitals costs is due to inflation, and one-third is the result of new services and technology, intensity of services and increased patient demand, according to studies of the American Hospital Association.

The environment of hospitals makes them atypical of most businesses and industries. Some of the more notable differences are listed below:

1. *Public demand.*—Public demand and governmentally-created expectations have caused an increase in expenditures for hospital care, particularly since the enactment of Public Law 89-97 (Medicare and Medicaid). We have observed that whenever the government promises services or provides free coverage, public demand for

and use of those services increases. In 1972, for example, Medicare coverage was extended to end-stage renal disease and care for the blind and disabled. The demand, and cost, for these services has risen sharply, far beyond HEW's estimates.

People create and live in an environment which is increasingly detrimental to their health. The lifestyles of many people, with little emphasis placed on health maintenance, only add to the problem. A staggering number of health care dollars could be saved if we would accept individual responsibility for modifying personal habits relative to smoking, drinking, drug abuse, stress, overeating and lack of exercise. We continue to place greater demands upon the curative and more expensive modalities of treatment, however, rather than adopt proper health care habits and preventive practices.

2. *Utilization changes.*—Advancements in the diagnosis and treatment of patients have resulted in better care, shorter lengths of stay in hospitals and increased utilization of outpatient and ambulatory services. While such improvements cause an increase in the cost of care on the inpatient unit, they produce a net savings to the entire population. Early diagnosis allows treatment at an earlier stage in the disease; individuals are able to return to productive lives sooner; and the period of stress and interruption experienced by the family during an illness or accident is significantly reduced.

3. *Labor.*—Hospitals are labor intensive, with over 55 percent of their expenses allocated to personnel. The federal minimum wage bill, which raised the minimum wage to $2.90 on January 1, 1979, will increase hospital costs in many Missouri hospitals by more than $5 per patient day. This external force, beyond the influence of hospitals, will increase hospital costs by more than $25 million in 1979.

4. *Regulations.*—The cost of complying with federal regulations is staggering. Nevertheless, the red tape and paperwork continue to increase with almost every new regulation and interpretation issued by HEW and others.

5. *Malpractice insurance.*—Malpractice insurance rates for Missouri hospitals skyrocketed between 1973 and 1976. The Missouri General Assembly has enacted eight measures in the past four years to alleviate the problem, and Missouri hospitals have responded by forming the Missouri Professional Liability Insurance Association (MPLIA) to provide professional and general liability coverage at a stabilized, reasonable rate. MPLIA is successfully fulfilling the intent of the state law enacted in 1975, but the cost of such coverage remains relatively high because of the frequency and severity of claims.

Since MPLIA began offering insurance in July 1976, over $50 million have been saved by Missouri hospitals.

6. *Technology.*—Space age technology in health care is commonplace, with breakthroughs in the diagnosis and treatment of patients' illnesses occurring almost weekly. This development, much of it supported by federal grants, creates new services and increases patient demand.

7. *Energy and petroleum-based products.*—Hospitals are dependent upon energy 24 hours each day to maintain patient services. The cost of primary and standby fuels in hospitals has increased markedly since the energy crisis began. Despite considerable savings being realized through inhouse energy management programs, hospitals still are faced with a mounting energy bill.

Hospitals use many petroleum-based products, ranging from standby fuel and pharmaceuticals to disposables. As the cost of these products increase, hospitals must recover their expense through higher charges.

8. *Education and training.*—Many Missouri hospitals are involved in the training of physicians and other health care personnel. The cost of preparatory as well as continuing education adds to the cost of hospital care, yet it is essential if health care services are to be provided throughout the state.

9. *Unemployment compensation.*—In 1976, Congress enacted a law which requires public employers to provide unemployment compensation protection for their employees, effective January 1, 1978. As a result, unemployment compensation protection costs Missouri's public hospitals $1 million annually.

10. *Doctrine of sovereign immunity.*—The Missouri Supreme Court abrogated the doctrine of sovereign immunity in Missouri in a landmark decision handed down September 12, 1977. The state's 67 public-general hospitals purchased professional and general liability insurance in 1978, at a cost of $6 per patient day ($14.5 million total). This externally generated cost increase is another example of uncontrollable cost increases.

11. *Disability income protection.*—In 1978, Congress passed P.L. 95-555, which requires employers to include pregnancy as a disability under their income protection plans. Hospitals, with an extraordinarily high proportion of female employees, will be forced to pay higher premiums to cover this added benefit.

12. *Social security.*—Congress increased the tax rate and base of taxation for Social Security. While such a law will affect all employers, the impact is particularly severe for hospitals because of their labor intensive characteristics. This additional expense will be translated into higher hospital costs.

There has been considerable publicity about empty beds and unused facilities during the past two or three years. HEW alleges that there are 100,000 excess hospital beds in the country. The Missouri State Health Planning and Development Agency applied a figure of 4.77 beds per thousand population and concluded that there are 2,609 excess beds in the state. The agency then assumed that it costs $20,390 annually to maintain an empty bed; they concluded that excess beds in Missouri yield an annual expense of $53,197,510.

Actions to contain costs

Missouri hospitals, the Missouri Hospital Association and the metropolitan associations in Kansas City and St. Louis have been working aggressively to contain costs and become more cost effective. One or more of the three associations operate the following programs to improve hospitals and help contain costs: Group purchasing; shared laundry; shared data processing; management engineering; peer review program; educational programs; group employee benefit programs; creation of the Missouri Professional Liability; Insurance Association to stabilize the cost of professional and general liability insurance; establishment of the Missouri Health Data Corporation to consolidate data collection and reduce duplication among state and voluntary agencies; creation of Shared Hospital Activites and Regional Efforts, Inc. (SHARE) to provide shared services to Missouri hospitals; Missouri Voluntary Cost Effectiveness Program, Missouri's program to carry out the national Voluntary Effort.

In cooperation with the Blue Cross plans which are based in Kansas City and St. Louis, agreements have been developed to support areawide health planning. According to the agreements, hospitals participate in health planning and seek HSA approval for projects exceeding specified dollar limits.

The three associations, in support of health planning, have adopted statements which recommend that member hospitals submit their capital projects to the appropriate planning agency on a voluntary basis.

Individual hospitals and groups of hospitals have embarked on many cost savings programs, ranging from shared clinical services, equipment and personnel to shared facilities. Cost containment programs have been implemented by many Missouri hospitals covering, for example, staffing, energy conservation, and the purchase of goods, services, equipment and facilities. In addition, a large number of hospitals have minimized operational expenses through the formation of multi-disciplinary cost containment committees and implementation of cost containment programs.

Many Missouri hospitals share facilities, services and equipment, including computerized axial tomography scanners and other radiological services, laboratory equipment and services, obstetrical facilities, pediatric services, psychiatric services, and others too numerous to mention. Even though such cooperation is in evidence in every area of the state, duplication of certain services and facilities will continue. It should be pointed out that duplication is not bad; only unnecessary duplication adds unjustifiable increases to the cost of health care.

Hospitals are forming consortia and other organization to meet the demands of today's environment. Multi-institutional systems are being developed through which single hospitals may attain a level of quality and economy otherwise unachievable.

Local community needs, institutional differences, patient requirements, time and travel distances, physician distribution and many other factors determine whether a particular facility, service or piece of equipment is needed. Because there is no magic formula to quantify all of the variables which are important in finding the best course of action for a particular community, local and regional input is needed to assist health care providers plan for the current and future needs of our state. This process can best be carried out with positive, constructive leadership of health care providers. Missouri's hospital physicians and other health professionals have been active participants in the health planning process. They have played a major role in its success and will continue to contribute their talents to this effort.

Although effective management within hospitals and greater cooperation among them have saved millions of dollars, costs have continued to rise. As long as inflation, public demand, the hospital's atypical marketbasket, advances in medical science and external cost-increasing forces continue, hospital costs will increase. Hospitals are one part of a complex and changing health care system which is, in turn, part of a broad interdependent socio-economic system. Until the entire economy is balanced with our economic structure and social climate, hospital costs, just as other services and products, must continue to increase.

Hospital Cost Containment Act of 1979

In view of the Administration's firm position against wage and price controls, we cannot understand its intense effort to establish such controls on hospitals.

Economic controls have not solved inflation in this country. Selective controls on hospitals will not solve the problem today. The results of the Administration's mandatory cap bill will be: Depletion of hospitals' assets and reserves; layoffs of employees; widening gap between technological advancements and services provided; reduction of services; rationing of services; elimination of expensive services, educational programs and standby services; lower quality of care; delays, and ultimately failure, in the maintenance of equipment and facilities.

Our comments on the Hospital Cost Containment Act of 1979 are given below:

Section 2

Section 2 would direct the Secretary of Health, Education, and Welfare to establish annual limits on increases in hospital expenses. The Secretary would estimate in January of each year the national percentage increases in the costs of goods and services (other than for non-supervisory wages). At the beginning of the following year, the Secretary would make the actual calculation of the so-called "voluntary" limits to apply to increases in hospital expenses in the previous year. Hospitals would not know in advance of their budget year of the voluntary limit set by the Secretary. It would be virtually impossible to effectively manage a hospital under these circumstances.

This section of the bill would provide only a one percent annual allowance for needed improvements in hospital services and medical technology on a continuing basis. This fixed and essentially arbitrary allowance would result in the denial of needed and efficacious medical care to large segments of the American public. We do not believe that the public will support a policy that prevents the health delivery system from extending the results of research and technological innovation to the treatment of illness and injury in Missouri or throughout.

Section 2 does not deal adequately with the impact of our growing and aging population on the use of institutional health services. It disregards the significant growth in the over-65 age group of our nation. Extensive data on hospital utilization by the elderly, as compared to the population as a whole, demonstrates that this group has a rate of hospitalization more than three times greater. The failure of the bill to recognize the impact of local population shifts compounds these problems and dramatizes the unreasonable and inequitable assumptions underlying this proposal.

Another illustration of the unrealistic nature of this section is its promise that wage increases of non-supervisory hospital workers (about 40 percent of hospital payroll expenses) would, in effect, be passed through any voluntary or mandatory limits set by HEW. In fact, the definition of such wages in the bill excludes wage costs for shift differentials and overtime, both of which are very significant for the 24-hour operation of hospitals, as well as fringe benefits that have a direct relationship with real wage increases. Thus, while the bill appears to accommodate wage increases for such employees, hospitals would be unable to fulfill this misleading promise. This practical problem is further extended by the inevitable ripple effect on the hospital's wage structure resulting from upward adjustments of the lower wage levels.

Section 3

The Secretary of HEW would be authorized to use estimated data for the purpose of determining whether hospitals nationally, by state, or individually met a fixed "voluntary" limit. If hospitals were determined to have failed to meet this limit, a mandatory revenue cap program would be automatically imposed. There is no procedure for evaluating variations from the limit. The arbitrary and automatic features of this provision would trigger a broad and complex federal regulatory program. The controls would become effective retroactively; that is, the so-called 1980 program applies to hospital fiscal years beginning after January 1, 1979. Thus, the program, which has been described as standby in nature, if triggered in 1980, would in fact be in force today. These provisions further demonstrate the unreasonableness of this proposal.

Section 4

Section 4 would permit the Secretary to exempt from the application of mandatory controls all the hospitals in a state if and for so long as the Secretary found that the state had in effect a mandatory hospital cost containment program that meets certain conditions. Section 4 provides an excessive delegation of authority to the Secretary of HEW. Within the limited criteria for delegation included in this section, state cost containment programs would be required to deal equitably with

all payers, hospital employees, and patients, but there is no requirement that hospitals be treated equitably.

Section 6

This section would apply a percentage cap on the per admission revenues of hospitals on a class of purchaser basis for any year in which mandatory controls are triggered. Reliance on a per admission revenue cap applied on a class of purchaser basis would be costly and inequitable, and would threaten hospital solvency. First, the data and administrative burden imposed by such a control structure would be excessive and costly—on hospitals, intermediaries, and the federal government. Second, a per admission control program on a class of purchaser basis ignores the existing variations in levels of payments by third party payers, and denies hospitals the opportunity to establish pricing policies that reflect these payment realities. For example, there is no recognition of the cost impact of providing uncompensated care for those persons unable to pay or the need to generate revenues sufficient to cover the inadequate payments under the Missouri Medicaid program. In fact, while this methodology provides a cap on revenues from each payer, it does not assure that each purchaser will pay appropriately or provide a means to compensate for inadequate payments. Finally, a per admission control program on a class of purchaser basis artificially segregates sources of revenues without regard to changes in the patient mix or benefit structure.

Section 7

This section provides detailed instructions for calculating the allowable, percentage increase in per admission revenues on a class of purchaser basis for each hospital covered under the mandatory program. In addition to the deficiencies identified earlier with respect to the calculatio of the "voluntary" limits, this section includes further inequitable and arbitrary features.

The complex formula for determining the revenue increase limit for hospitals under the mandatory program does not explicitly allow for cost increases related to needed improvements and advancements in medical care delivery. While the "voluntary" expenditure limit inadequately recognized the cost impact of improvements in health care, the mandatory per admission cap ignores this factor. This policy thus would support a virtual freeze on such advancements.

The proposed penalty (or bonus) provision is general and vague. It is clear that the potential for penalty is substantially greater than possible rewards. Here again there is excessive delegation of authority to the Secretary.

The brief and vague description of possible exceptions or adjustments to be made at the Secretary's discretion is so incomplete as to preclude any evaluation of its adequacy.

Adjustments to be made by the Secretary in the calculation of the allowable per admission revenue cap with respect to a hospital's performance are punitive. Further, hospital expenditure performance for periods as far back as three years may be used in the calculation of these penalties.

Section 10

This section would permit the Secretary to exclude a hospital from the Medicare, Medicaid, or Maternal and Child Health programs if the hospital changed its admission practices in order to reduce its proportion of low-income patients. This provision assumes that the reasons for changes in admission patterns are related to reimbursement considerations, when in fact changes in admission patterns can occur for reasons unrelated to the source or amount of payment. There are no criteria to define an unacceptable change in admission experience, and, there is no provision for due process in the consideration of complaints.

SUMMARY

Missouri hospitals oppose the arbitrary mandatory approach to cost containment which has been proposed by the Administration. Hospitals are community service organizations, serving local needs through local control and initiatives.

We believe that a federal bureaucratically-controlled system will be counterproductive to the needs of patients and urge its defeat.

Thank you for the opportunity to submit our views.

Sincerely,

C. DUANE DAUNER, *President.*

ARIZONA HOSPITAL ASSOCIATION,
Phoenix, Ariz., March 15, 1979.

MICHAEL STERN,
Staff Director, Senate Committee on Finance,
Dirksen Senate Office Building, Washington, D.C.

DEAR MR. STERN: Please accept this letter and the attached supplemental information as the official testimony of the Arizona Hospital Association on S. 570, The Hospital Cost Containment Act of 1979. On behalf of our 72 member institutions which comprise 87 percent of the total nonfederal beds in Arizona, we would like to voice our strong opposition to this proposed legislation and take this opportunity to explain briefly our reasoning and key concerns.

Complexity

Although we have not had an opportunity to conduct an indepth analysis of the bill due to its only recent availability, the most glaring aspect to us is the monumental complexity of the legislation. Although the Secretary of DHEW has commented publicly that relatively little, both in terms of dollars and manpower, would be needed to implement the proposed legislation, it is impossible for us to conceive of anything but another huge bureaucracy at the helm of this program. The multitude of vaguely worded exemptions, and the complexity of determining expense increase targets and revenue caps will necessitate the production, collection, and processing of huge amounts of data. Rather than helping to control escalating costs, this legislation already possesses the characteristics of other governmental programs whose good intentions resulted in nonexistent benefits, bureaucratic nightmares, and a cost of implementation that eradicated any hypothetical savings.

Expenditure increase limit

Already the Administration has determined that this year's target limit for increases in hospital expenditures is 9.7%. DHEW arrived at this figure by considering three factors and assessing a numerical value increase to each:

Increases in the costs of goods and services that hospitals must purchase.

Increases in hospital utilization resulting from both a larger and older population.

Increases resulting from improvements in medical technologies and extension of services.

It is our belief that this "formulistic" approach in determining a target figure is inappropriate and inaccurate as it cannot possibly account for the myriad of factors which influence hospital expenses. In Arizona, for example, our tremendous overall population growth, seasonal influx of tourists and visitors, and rapidly growing retirement communities have resulted in a substantial increase in the demand for hospital services.

Furthermore, the costs of food and energy alone, which are exempt from the voluntary wage/price guidelines, are escalating at a phenomenal rate and play a large part in driving up hospital expenses. In short, it is ludicrous to believe that a formula can adequately incorporate or account for all the factors which play a part in determining a given hospital's expenses. If Arizona's hospitals were limited to a 9.7 percent target, we could expect to see reduction in services, something which Arizona's growing population is not ready to accept.

Revenue caps

The Arizona Hospital Association is opposed to the imposition of a revenue cap as proposed by S. 570. Placing price controls on one industry without similar measures for industries from which hospitals buy goods and services is incomprehensible and unworkable. Revenue caps in any form cannot accommodate or account for such things as patient mix, treatment and diagnostic capabilities, regional cost disparities, wage escalation caused by manpower shortages, or specialized community demands. The nature of Arizona's topography, environment, and growth presents a set of unique health delivery demands that will not be accounted for by S. 570. The legislation also ignores the existence of programs such as the Arizona Rate Review System which does not qualify as a "mandatory statewide cost containment program" but is, in the opinion of many, a very effective method of insuring that hospital rates accurately reflect operational costs.

Arizona's voluntary effort

While the Arizona Hospital Association remains strongly opposed to any type of fedeally mandated revenue cap, our membership has been aggressively involved in a successful voluntary cost containment program for nearly three years. Through this program, we can document in excess of $10 million in cost savings/avoidance and for 1978, a 2 percentage point reduction in the rate of increase in hospital expendi-

tures per admission. More detailed information pertaining to this effort is attached and will not be repeated here.

We believe our efforts are proving successful and are being implemented without the aid of mandatory revenue caps as embodied in S. 570. We further believe that the cooperative commitment of our member hospitals to control the rate of hospital cost increases will be quickly diffused if this legislation is adopted. S. 570 is both complex and shortsighted and from our perspective can only achieve a negative impact on the delivery of health services which are considered by most persons as a "right."

Sincerely,

RONALD D. KRAUSE, *President.*

Attachments.

Consistent with the Arizona Hospital Association's review of the AHA 15 point program, the following points were adopted by the ArHA Board of Directors at its March 10 and May 24, 1978 meetings:

1. Form state committee.

2. The Arizona Hospital Association supports the national goal of a 2 percent reduction in the rate of increase in hospital expenditures. As Arizona is a rapidly growing state with concomitant increases in the demand for hospital services, progress toward the goal will be monitored on the basis of expenses per admission for the entire state. The rate of increase in expenses per admission in Arizona between 1976 and 1977 was 12.8 percent.

3. Ask each hospital board to formally endorse/commit to the state program and strive to meet those targets.

4. Ask each hospital to routinely submit key fiscal and utilization data.

5. Recognizing that there is presently an effective statutory Certificate of Need program operational in Arizona, the Arizona Hospital Association agrees that there should be no net increase in beds in service during 1978, except for beds for which a certificate of need had been granted prior to January 1, 1978. This does not preclude institutions from filing certificate of need applications during 1978 for additional beds to come into service after December 31, 1978.

6. Inasmuch as the 1978 financial impact on patients and payers of capital expenditures is already dealt with in the goal dealing with the reduction in the rate of increase of expenses per admission (No. 2), and inasmuch as Arizona has had in place since January 1972 a statutory certificate of need system requiring government approval of capital expenditures exceeding $100,000 or 3 percent of institutional expenses, whichever is less, and inasmuch as planned 1978 capital expenditures have been proven to be necessary through the Certificate of Need Process the Association considers it highly unlikely that the national capital expenditure goal (80 percent of the 1975-77 price adjusted average) can be met in Arizona in 1978. We urge all hospitals to consider carefully the current and future impact on patients and payors of their plans involving capital expenditures, attempting to minimize these expenditures to the extent consistent with the need to provide high quality service to an expanding population.

7. Request hospital medical staffs to reaffirm this commitment to effective UR programs.

8. The Arizona Hospital Association is dedicated to the goal of improving hospital productivity through the sharing of ideas, resources and services; the development of methods to more effectively utilize hospital personnel and capital resources; and encourages the implementation by all hospitals of a human resource/productivity measurement/monitoring system. It must be recognized, however, that while there are presently several indices being utilized as productivity measures (i.e., length of stay, FTE's per bed, man-hours per patient day, etc.), no system has yet been developed and accepted to adequately measure overall hospital productivity. For this reason it is not possible at this time to establish meaningful numerical goals. Efforts to develop and refine such a system will be undertaken by ArHA and must be supported by all participants in the health care delivery system.

9. Accelerate trends toward shared services, ambulatory care, etc.

10. Ask suppliers to exercise price restraint.

11. Develop public education program regarding VCCP and effects of demand on hospital cost increases.

12. Ask purchasers of care (insurance, labor, etc.) to consider mechanisms to enhance consumer awareness of health care costs.

SUMMARY OF ARIZONA HOSPITAL ASSOCIATION, COST CONTAINMENT REPORTING

The Arizona Hospital Association published its first Cost Containment Progress Report on September 2, 1976. It contained 170 examples of documented cost containment efforts reported to the Association by 14 Arizona hospitals.

Cost Containment Progress Report II was published on December 17, 1976, and contained 81 examples reported by 10 hospitals ranging in size from 26 to 560 beds.

On October 21, 1977, Cost Containment Progress Report III was distributed. Approximately 200 additional cost containment/avoidance efforts undertaken in 27 member hospitals were documented in this report.

Cost Containment Progress Report IV was published on June 20, 1978. This report contained greater detail and description of fewer and more unique examples of cost containment efforts, with 19 member institutions reporting. Attached is a copy of this latest report.

Collectively, savings in excess of $10 million have been documented to the Association since the original request for information in 1976.

MEMORANDUM 71

To: Administrators of member institutions.
Subject: Cost Containment Progress Report IV.
Suggested distribution: Administrative staff department heads.

The need has never been greater . . . the time never more appropriate than now to continue to focus on containing and avoiding costs. Hospital dedication to voluntarily cut costs is the best avenue to avoid mandatory governmental regulations.

Examples of how nineteen ArHA member institutions are limiting, containing and avoiding costs, or are enhancing revenue, are included in the enclosed Cost Containment Progress Report IV. The hospitals range in size from 23 to 699 beds, representing a cross section by location, facilities, services and ownership. Cost Containment Progress Report IV utilizes a new reporting format. Greater detail and description of fewer and more unique examples have replaced the voluminous efforts previously reported through Progress Reports I, II and III (Memoranda 84, 133 and 127, September 2 and December 17, 1976 and October 21, 1977).

Information contained in this progress report has been provided by nineteen member institutions. Some represent the first reporting efforts; the majority represent updated reports supplied by the membership. Participants are: Walter O. Boswell Memorial Hospital, Sun City; Community Hospital in Chandler; Desert Samaritan Hospital & Health Center, Mesa; Flagstaff Community Hospital; Glendale Samaritan Hospital; Good Samaritan Hospital, Phoenix; Holbrook Hospital; John C. Lincoln Hospital, Phoenix; Maryvale Samaritan Hospital, Phoenix; Mesa General Hospital; Palo Verde Hospital, Tucson; Phoenix General Hospital, Inc.; Pinal General Hospital, Florence; St. Joseph's Hospital, Nogales; St. Luke's Hospital Medical Center, Phoenix; Scottsdale Memorial Hospital; Valley View Community Hospital, Youngtown; Veterans Administration Hospital, Tucson; and White Mountain Communities Hospital, Springerville.

The documentation contained in the Association's four Cost Containment Progress Reports emphasizes voluntary efforts currently underway to contain costs. The four reports are an important part of the Association's Voluntary Cost Containment Program which began in mid-June 1976 with collection of data for Cost Containment Progress Report I.

Member institutions are encouraged to utilize information shared through each of the four progress reports for development of new and enhancement of existing cost containment/avoidance efforts.

Members should continue to send to the Association the cost containment section of their rate review packets, or other similar cost documentation, as it is produced. This material will be summarized for inclusion in subsequent cost containment progress reports and reported in upcoming issues of "P*A*rAP*H*RASE" (See April 1976 to June 1978 "P*A*rAP*H*RASE").

For additional information regarding any of the cost containment efforts listed in the attached report, please contact Carol Hale, staff assistant-publications, or me.

JOAN E. KLOOS,
Director of Public Information.

Attachment.

ARIZONA HOSPITAL ASSOCIATION, COST CONTAINMENT PROGRESS REPORT IV, JUNE 20, 1978

Preventive efforts affect costs

The speed at which patients can be discharged from the hospital, or through preventive efforts can be sustained in the community, has a direct affect on the cost of rendering medical care. The social work service department of one governmental hospital reported sizable cost containing results from their efforts in these areas.

Productivity management system identifies needs/contains costs

The establishment of performance standards at the procedure level in each cost center is being accomplished under a productivity management system by several Valley hospitals. This process involves analysis of work load and determination of time requirements to accomplish specific tasks. A comparison of the actual manpower resources utilized to the standard hours earned results in a productivity index. This index is used by hospital management to isolate areas where improvements in productivity are feasible and where they have actually occurred. A major operational advantage of the program is that the productivity measurement indicates areas of increased activity and allows staffing adjustments to be made that match resources to need.

Cross-training/preoperative tests

One metropolitan hospital cross-trains respiratory therapy and pulmonary function personnel to help eliminate call-back and standby salaries for coverage of pulmonary function services. Consolidation of all preoperative tests in one area facilitates efficient and timely testing—minimizing patient transportation.

Decreased blood requirements lower costs

Maintaining adequate blood supplies continues to be a problem throughout the country. The shortage is magnified on holidays and long weekends, and the situation is not expected to improve. One Valley hospital is involved in a study to decrease blood requirements and charges to patients by lowering the preoperative cross-match "coverage" for procedures which are highly unlikely to require transfusions. For patients falling into this category, the surgeon merely orders a "Group, Type, Hold" for a small number of units of blood. An antibody screen is performed; however, no cross-match is set up. If the patient requires transfusion, fully crossed-matched blood can be available within 30 minutes. If there is emergent need for transfusion, the surgeon can ask for uncrossed matched "Group" and "Type" specific blood. As the blood is being transfused, the blood bank is performing the complete crossmatch. The chances of these patients receiving an incompatable unit of blood have been calculated at 1 in 10,000. Since the patient's antibody screen is known to be negative, the chances of transfusion reaction to any incompatable unit are extremely remote. Each "Group, Type and Hold" in lieu of a one-unit crossmatch would save the patient $20, and in lieu of a two-unit crossmatch; $56.

Four hospitals share paging system

Four Phoenix hospitals are sharing one computerized paging system. Some of the equipment is owned by individual hospitals and the balance is leased from the equipment's designer. Pages are placed by dialing a phone number and speaking the message into the handset. The computer then routes the message by automatic sequence to the paging device carried by the on-call employee. When the holder of the paging device presses the button, the message is repeated by the computer. Considerable cost savings over other paging methods has been realized.

Clinical engineering consulting program eliminates multiple contracts

A 40-bed hospital reports participation in the Arizona Hospital Association clinical engineering consulting program. Through the program the hospital receives preventive maintenance, safety inspections of patient care equipment, and assistance in evaluation and purchase of new equipment. As a result, several individual preventive maintenance contracts have been eliminated.

Automated pharmacy service yields savings

Physicians and pharmacy personnel at one Tucson hospital utilize computer reports from the Automated Pharmacy Information Service (APIS) to help contain costs. The service generates a semi-annual, updated pharmacy formulary of prescription drug usage and costs. Information provided by APIS includes a listing of all drugs and their costs; drug utilization by service; physician usage of 7-8 select drugs; an antibiotics report; indication of drugs inactive during the previous six

months; those for which the hospital spent more than $250; and any drugs with a 50 percent or higher monthly usage increase.

Shared insurance programs cut costs

Participation in shared insurance programs can result in considerable cost savings. One Tucson hospital reports participation in various shared insurance programs sponsored or endorsed by the Arizona Hospital Association. These include professional liability, general liability and workmen's compensation. Additionally, carriers for the hospital's insurance policies are determined after competitive bidding.

Volume/comparative purchasing results in savings

Polypropylene-type drop foot braces which were usually ordered from a speciality shop at $125 each were purchased at $190 per dozen as a result of price comparisons by physical therapy personnel in a Tucson hospital. Comparative shopping and volume purchasing on this item alone saved $1,310.

Close tabs on purchases save money

One small Tucson hospital clears all purchases over $10 through the centralized purchasing officer. Additionally, a minimum of three bids is required on all quantity items and selection is based on cost where possible. Stock list and standard supply items are catalogued and all purchase requisitions approved by the program director or his designee.

Cost savings through supply controls

Standardization of exchange cart stock minimizes labor required for restocking at one Valley hospital. Additionally, implementation of supply charge monitoring, reporting and recovery system has minimized lost charges.

Saving through dietary department

A 100-bed hospital has documented total savings of $76,768 through 33 cost containment efforts—with individual savings ranging from $150 to $23,688. In the dietary area, food prices were raised 46 percent to non-employees, producing an additional $2,634 in revenue; coffee savings were realized through better control of distribution ($5,000); and inhouse remodeling of the dietary department generated a $300 savings.

Costs avoided through computer combination

A Tucson hospital now utilizes one inhouse mini-computer in place of five different computer systems/applications previously engaged. The computer hardware is being purchased on a five year basis, rather than being leased. Net monthly hardware savings are coupled with resultant staff reductions, representing a major cost containment.

Internal audit department reduces costs for outside services

An Internal Audit Department was formally established by a Valley hospital to ensure that financial policy and procedures are consistently followed and that any abuse is isolated so proper corrective action can be taken. Additionally, the existence and proper operation of the internal audit function has decreased the costs of outside services by reducing the scope of external audit involvement in the details of various routine financial transactions. The benefits of the internal audit program are relatively long-term in nature and the impact cannot be measured in exact dollars. However, studies conducted in other industries have concluded that an internal audit program has a payoff in excess of two to one.

Bad debt collection improved

An internal letter writing collection system for bad debts has been initiated by a rural Arizona hospital in place of automatic assignment to a collection agency. In the past, collection agency costs were 40 percent of the total collected bill—the new internal system costs only $5 per account. Estimated annual savings are $2,500.

Surgery charge form reduces lost charges

A "Check the Box" surgery charge form has been implemented by a Valley hospital to reduce lost charges in the operating room from 5 percent to less than 2 percent. This is expected to decrease lost revenue by approximately $22,000.

Flexible use of chillers/boilers reduces costs

Monthly savings of approximately $1,500 are realized by one Phoenix hospital through utilization of only one chiller and boiler for ten months of the year, rather

than two chillers and two boilers year-round. Additionally, chemicals for boilers and chillers have been reduced from $15,000 to $6,000 annually.

Heating-cooling system overhauled inexpensively

The heating-cooling system at a rural hospital was overhauled under the direction of a retired board member, saving an estimated $49,500 in wages, travel and lodging quoted by outside repair personnel. The only costs to the hospital were parts and inhouse maintenance payroll.

Surplus items produce revenue

One small hospital has a unique revenue enhancement project. Surplus or scrap items are accumulated throughout the year and sold at an annual sale.

Forecasting demand important to hospital costs

A considerable amount of progress is being made toward developing the ability of a health care system to accurately forecast the level of future demand and resulting costs for budget purposes. The forecasted data is provided to all levels of management for use in developing detailed action plans for short-term management of individual functions, with cost containment resulting from higher levels of facility use and effectiveness.

Employee incentive programs contain costs

An investor-owned hospital saves money through three employee incentive programs. Department heads and other employees participate in the Cost Avoidance through Responsibility and Efficiency (CARE) Program to avoid waste and inefficiency in energy consumption, control of supplies and hours worked. Through the Employee Suggestion Program, employees submitting viable cost savings ideas are monetarily rewarded. A committee evaluates the suggestions, making cash awards based on anticipated savings or procedural improvement. Following any hospital-wide accident-free month, all employees are eligible for a cash drawing as part of the Cash Incentive Safety Program conducted by the hospital's Safety Committee.

Employee education and training reap benefits to hospitals

One Valley hospital has shown that inservice education programs are a contributing factor in such cost containment measures as reduced absenteeism, slower turnover rates, less overtime, and a reduction in the labor costs. These programs generally consist of: (1) orientation (general) to help new employees adjust to the hospital environment; and (specialized) developed as an adjunct to general orientation to further prepare employees for their specific area of employment; (2) skill training to provide employees with skills and attitudes required for their jobs and provide a means for dispensing information regarding new procedures and the updating of skills; (3) leadership and management training to plan and implement classes, workshops and seminars for all employees; and (4) continuing education to assist all personnel in securing increased knowledge, understanding, and competency, and make provision for additional academic education.

Seven revenue enhancement programs

In addition to numerous ongoing cost avoidance programs, one Valley hospital reported seven revenue enhancement programs with forecasted savings exceeding $340,000. Included is a marketing program for services which have high fixed costs and low variable costs which is expected to generate $75,000; lost/late charge recovery through internal audit and system control ($40,000); increased contributions through development programs ($100,000); maximizing investment of hospital funds ($75,000); and minimizing bad debt experience ($50,000). The hospital also plans to enhance revenue by maximizing Medicare costs reimbursement; and assuring equitable charge/cost relationship in hospital rate structure.

Cost per unit of service index

A rural county hospital will be utilizing a "cost per unit of service" index as a measurement of cost containment, which will be part of their management information system. The "cost per unit of service" increases will be limited to those which are inflationary in nature; with resources being devoted to minimizing increases through application of technological advances. During the past year, the hospital reported a total of $84,617 saved through cost containment efforts by the hospital's clinical laboratory, radiology, respiratory therapy, housekeeping and material management departments, as well as administration.

Cost effectiveness program

A 100-bed hospital has identified three major areas in its 1977 Cost Effectiveness Program—cost avoidance ($53,000), cost containment ($282,700) and cost and revenue improvement programs ($36,100). Collectively for 1977, this Cost Effectiveness Program represents $371,900.

Patient transport avoids duplication/INCREASES UTILIZATION OF SPECIAL SERVICES

To enhance the quality of patient care and increase availability of specialized services to all patients in any system hospital without a tremendous duplication in equipment and manpower, a patient transport system has been developed and implemented. It is designed to allow the physician in one hospital to order a special procedure which may or may not be available in that hospital. Arrangements can be made to transport the patient to the hospital where the procedure can be performed on a priority basis, with the patient then being returned to the original hospital. The impact of the patient transport system is two-fold—it serves to increase the utilization of highly technical equipment located in the hospital, thereby reducing the total cost of providing that service on a per unit basis; and makes that service available to all system hospitals, thereby avoiding the duplication of required expertise in each hospital.

MEMORANDUM, DECEMBER 20, 1978

To: Arizona Advisory Committee on Health Cost Containment.
Subject: Third-quarter 1978 analysis of cost containment monitor.

The attached tables and graphs represent data obtained from 49 of 61 member hospitals, representing 7,863 of 8,873 beds, or 89 percent of the non-federal Association membership beds. The data was submitted by individual hospitals in response to an Association survey and/or drawn from data submitted by participants in the Association's Management Analysis Reporting System (a management information system in which 34 member hospitals participate).

One of the primary goals of the Arizona Voluntary Cost Containment Program was a reduction in the rate of increase in expenses per admission from 1976-77 to 1977-78 of 2 percent. As the rate of increase in 1976-77 was 12.80 percent, the goal for 1977-78 is 10.80 percent. Table 2 indicates that Arizona has indeed met that goal with a rate of increase of 10.78 percent through the first three quarters of 1978.

The revenue analysis presented on Table 3 further indicates that the increase in the cost (hospital revenue) to those individuals utilizing hospital services is moderating. From 1976 to 1977 the revenue per admission increased by 14.86 percent, while through the third quarter of 1978 the increase has only been 10.83 percent.

Another statistic which warrants discussion relates to the number of admissions and the number of inpatient days of care provided. As seen on Table 2 and Graph 2 admissions have increased in 1978; however, inpatient days have decreased for the same period (Table 4 and Graph 4). This indicates a number of things, one of which is that while Arizona hospitals are caring for an increasing number of patients, they are doing so in less time, thereby returning the patient to normal activity sooner. This is a significant, yet less measurable, cost savings. Additionally, this shorter length of stay suggests that the intensity of the service is increasing. This increase in intensity will make comparision of cost per patient day in the future even more difficult.

An additional reason for the decrease in patient days is that more services are being provided on an ambulatory basis. This results in definite savings, but also has the tendency to distort the comparison of cost per admission statistics. As hospital admissions gradually become limited to those patients more acutely ill, the cost per admission must rise.

ROBERT M. CHERNER,
Director of Association Services.

Attachments.

THE ARIZONA VOLUNTARY EFFORT, STATUS REPORT, JANUARY, 1979

The Arizona Voluntary Effort (VE) initiated formally in early 1978 in cooperation with the National Voluntary Effort, is an extension of formal Association voluntary cost containment programs in, with and for member hospitals beginning in early 1976.

The Arizona Voluntary Effort is guided by the Arizona Advisory Committee on Health Cost Containment which was organized and is staffed by the Association. A Committee membership listing is attached. The Committee adopted 12 goals for the Arizona Voluntary Effort (copy attached). A major goal was the reduction in 1978 of

two percentage points in the rate of increase in hospital expense per admission. In 1977, expense per admission increased 12.80 percent over 1976. Through the third quarter of 1978, expenses per admission have increased 10.78 percent over 1977 (annualized), meeting the goal.

In addition, the Committee and the Association have solicited formal hospital governing board resolutions supporting the Arizona Voluntary Effort and pledging individual institutional action toward cost avoidance and containment. Fifty-three hospital governing boards have passed such resolutions representing more than 83% of the state's beds.

Preparation of state Voluntary Effort goals for 1979 is now underway.

STATEMENT BY EDWIN C. WHITEHEAD, CHAIRMAN OF THE BOARD, TECHNICON CORP. TARRYTOWN, N.Y.

Mr. Chairman and members of the subcommittee, thank you for inviting me to appear before your subcommittee to testify on health cost containment.

I am Edwin C. Whitehead, cofounder, chairman, and chief executive officer of Technicon Corp., a $250 million, N.Y. Stock Exchange international company with a 40-year history of innovation in medicine.

Regulation versus market incentives

To make clear our position on cost containment, I will begin my testimony by stating that we wholeheartedly agree with the statement of the distinguished chairman of this subcommittee and its ranking minority member that health costs are rising at a faster rate than this country can continue to afford for very long. Furthermore, I agree that legislation is required to correct some of the defects of the health care system. These defects arise because market forces that provide automatic, free enterprise controls to much of the American economy do not now perform adequately in the health services industry. However, I do not agree with an approach that seems to be intended to try to correct the defects of the health system entirely through further government regulation. What we need to do instead is to increase the degree to which market-like forces are permitted to impact on health services.

I am convinced by the success of market controls on the major part of the American economy and by the failures that characterize economic regulation where it has been applied that, to the degree possible, we should apply market incentives to improve the health system, and I am convinced that there are ways to accomplish this effect. I would like to suggest some specific ideas for the committee's consideration.

But first let me discuss why the present health system has such difficulty with its costs.

Market incentives

Market forces work because of the incentives they provide—the rewards they offer for delivering a desirable product at a fair price and the penalties they apply to those who seek to sell a shoddy or overpriced product. A company that is a success in the market profits and grows, while failures in the marketplace decline and often go bankrupt.

The health services industry presents a sharp contrast to this picture of the market. The most important government health services programs, Medicare and Medicaid, provide no rewards for efficiency and instead tend to insure the indefinite survival of the most inefficient health service suppliers. Health care products, and particularly hospital services, are purchased in large part for people protected by health insurance and government programs from the impact of the price of care. At the same time, the reimbursement rules used by insurers and the government do not seek to provide market-like incentives, but rather pay whatever the service costs. This is an approach that begs for reform.

It does not seem possible to create an ideal market for health services—where people pay for care out-of-pocket when received—because of the need to employ insurance and other programs to prevent financial disasters from resulting when illness strikes. However, reimbursement reform of Medicare and Medicaid and private health insurance can and should be adopted to introduce market incentives, as S. 505, the Talmadge-Dole bill, would do, into the payment practices of these programs.

My view is that we are most likely to achieve long term health care cost containment if we introduce into the reimbursement process rewards for efficient hospitals and penalties for inefficient ones. We are likely to fail in cost containment if we

take a short range, purely budget-oriented view that focuses almost exclusively on the cost increases of next year over this for each hospital, with little regard for the differences among hospitals in efficiency or cost. Long run health system improvement requires instead that we foster a climate in which efficient producers grow, increasing their revenues over time, while inefficient ones wither away. Focussing on year-to-year changes has essentially the opposite effect, providing a relatively easy reimbursement limit target to meet for hospitals with a history of laxity and a difficult target for those that have run a tight ship.

We are also very concerned about lids that have been proposed to be placed on health capital expenditure. Such a lid is a page from a regulator's handbook. It has no place in a system based on market incentives that punish any investor who makes a wasteful capital expenditure. Knowledge that such a loss will occur would prevent improper capital expanditures without further ado. On the other hand, placing a lid on capital investment has the serious detriment that it arbitrarily limits the ability of the industry to invest in productivity—improving resources.

Proposals to apply capital caps seem to derive from the simplistic notion that new health capital, and specifically, health technology, raises costs and provides no benefits. This idea is wrong and very dangerous. In the health services industry, as in other industries, technology based on new capital investment is—and can be made even more—a main source of improvement in productivity. We should be sponsoring, not inhibiting, further growth of productivity in health care and other fields.

Cost effectiveness of health capital investment

It is true that there have been instances in which medical instrumentation inventions have been brought to market which have been without value. However, none of these inventions have had more than minor acceptance, and the total investment in all such cases combined is an insignificant amount.

The real impact of limits on capital expenditures would fall on technology that increases hospital productivity. Providing a mindless limit on capital expenditures may deprive society of health advantages that no rational decision process would agree to forego. Instead of arbitrarily limiting our ability to improve the treatment of illness, we should judge each advance in terms of its price, as a market would.

Furthermore, a limit on capital investment might prevent the adoption of those very cost saving techniques that cost containment should be seeking to induce.

Mr. Chairman, an example may help tomake clearer and more concrete the effects of technology that automates hospital processes. A case in which a hospital laboratory was automated was described in a paper by Richard Lent, M.D., of Montefiore Hospital, N.Y. The paper provides the statistical results of this automation. In this case the response time to a request to perform a laboratory test was cut by five hours between 1965, before automation occurred, and 1975. At the same time, the total costs of the laboratory were kept essentially constant, after taking account of price inflation, and despite a large increase in patients served and tests performed.

Montefiore and Albert Einstein Laboratory Impact of Automation

	1965	1975	Change (percent)
Inpatients served	13,318	22,740	1.7
Outpatients served	60,151	234,192	3.9
Tests performed	214,000	2,213,000	10.3
Budget	$562,000	$1,126,000	2.0
Budget in 1965 dollars	$562,000	$624,000	1.1
Cost per test in 1965 dollars	$2.63	$0.29	[1] 9.1
Results to floor [2]			

[1] Less

[2] 1965, 5 p.m.; 1975, 12 noon, change, 5 hr earlier

The number of inpatients doubled in this period, and the number of outpatients quadrupled. The number of tests increased more than ten-fold. Not only were total laboratory costs held to 1965 levels, but also, patient care was improved by the large increase in the laboratory information that was made available. The new laboratory equipment is an important tool for the early detection of disease. While it is not possible to calculate the value of the patient care benefits provided by the improved data on the patients' well-being, this value adds further justification for the investment in this cost-reducing automation.

One of the newer contributions of automation to health labor productivity is offered by integrated medical information systems. Such systems offer the promise of optimizing the use of high capacity computers and related devices to record the making of a medical treatment decision and automatically translate the decision simultaneously into orders and convenient records wherever they are needed—the pharmacy, nursing stations, accounting department, and medical records—all with perfect accuracy. Such a system is in place at the National Institutes of Health Clinical Center here in Washington, resulting in improved efficiency, reduced errors, and enhanced research capacity. Automation such as this communicates orders for tests, and delivers the results, far more rapidly than older methods, thus contributing to reduced length of patient stay. It provides convenient summaries of treatment orders, reducing the change that conflicting orders will go unnoticed and offers significant opportunities for improving treatment processes. It is somewhat paradoxical that the Federal government, which has such a great concern for cost reduction and increased labor productivity, has been slow to act to take advantage of the power of medical information systems to reduce costs in government institutions. The control placed on capital expenditures by the Defense Department and the Veterans Administration may be, at least in part, responsible for the slow pace of application of this innovation. Another contributing factor is the apparent hesitancy in government to allow any one hospital to take advantage of an immediate cost potential, but rather to prefer to wait until all the information processing issues for the entire Defense and Veterans health establishment are resolved before moving at all.

This failure of government to take advantage of available cost reductions through investment in automation of information processing does not suggest that regulation of capital investment following the government model will be cost effective.

Recommendations and conclusion

In conclusion, I should like to offer for your consideration my recommendations for cost containment legislation. I suggest the following:

1. Modify the reimbursement provisions of government programs to provide marketlike incentives that reward effective producers and penalize ineffective ones.
2. Do not add capital investment limits to existing controls on investment in health, but leave producers free to obtain the capacity to improve their services and their productivity within the constraints provided by reimbursement methods that penalize inefficiency.
3. Link the health planning system more closely to the system for paying for care, so that those hospitals whose plans for investment are wasteful will know they will be held to account and so that productive investment will be rewarded. Thus, planning would cease to be a negative device, a barrier to actions, and become a device for assisting in investment where productive results can be anticipated.
4. Introduce into the reimbursement system provisions that will ease the financing of cost reducing automation.
5. Use the reimbursement system to enforce the passing through of the benefits of improved productivity to patients and others who bear the costs of care.

If these steps are taken, and most of them are already in S. 505, the energies of hospital management will be directed toward seeking to increase hospital efficiency, and health equipment manufacturers will be encouraged by a receptive market to develop further approaches to improving hospital productivity. These steps would not only reduce present impediments to cost reduction, but create an economic climate that will provide positive incentives for more effective health service performance.

Thank you. I will be glad to answer any questions members of the Subcommittee may have.

STATEMENT BY DR. ROBERT H. PUCKETT, DEPARTMENT OF POLITICAL SCIENCE, INDIANA STATE UNIVERSITY

I would like to urge the Committee on Finance to seriously consider strengthening the authority and increasing the funding of the Health Systems Agency system. Future decisions about the allocation of health services resources must be made at the local level. Health Systems Agencies are certainly the best potential mechanisms for such determinations, assuming that they are adequately funded and staffed, and given broader authority than they presently have.

I urge the Committee to include four provisions in any cost containment program: (1) A cap on capital expenditures, (2) a broader certificate of need process, (3) a stronger appropriateness review and decertification procedure, and (4) a new cost and charge data collection system.

(1) I support a national cap on new capital expenditures and expansions. However, a more effective control over costs would be achieved by allocating capital expenditures and expansions limits by Health Systems Agency areas—instead of by states.

(2) The certificate of need process should be substantially strengthened by including all major capital expenditures, regardless of their ownership and regardless of where the equipment or services are to be located. In addition, there should be provision for a periodic recertification procedure, coupled with effective public disclosure requirements.

(3) The appropriateness review system should be broadened to include non-institutional health service centers and physicians' offices in order to prevent excessive duplication of equipment and services. There must be cler legislative provisions for decertification of unneeded hospital beds, services, and equipment. In addition, Health Systems Agencies should have the power to recommend reassignment of functions and sharing of services.

(4) Each hospital subject to the cost containment program should be required to provide certain cost and charge data to its area Health Systems Agency. This will facilitate comparisons of costs and charges by consumers. All reports submitted to cost payers, to state rate setting programs, and to Medicare should be submitted to the Health Systems Agency. Such data would then be published by the HSA so that comparisons among the hospitals in the area could be made by the public.

PUBLIC CITIZEN,
Washington, D.C., March 20, 1979.

Re comments on section 28 of S. 505, section 19 of S. 507 and S. 526, concerning confidentiality of PSRO data.

MICHAEL STERN,
Staff Director, Senate Finance Committee,
Dirksen Senate Office Building, Washington, D.C.

DEAR MR. STERN: The Public Citizen Health Research Group strongly opposes section 28 of S.505 and the other bills described above, which would have the effect of completely exempting Professional Standards Review Organizations (PSROs) from the Freedom of Information Act (FOIA).

Our reasons for opposing these bills are described in detail in the attached letter sent last year to Senator Abourezk, who then chaired the Subcommittee on Administrative Practice and Procedure of the Judiciary Committee, which has jurisdiction over the Freedom of Information Act.

In addition, we note that Senator Dole, when introducing S.507 on March 1, incorrectly stated that the provision on PSRO data disclosure (section 19) was passed by the Senate in 1978. In fact, the language of section 19 was not included in any bill in the 95th Congress. Another provision dealing with this issue was reported by the Finance Committee as part of H.R. 5285 (Section 25) but was struck from the bill on the Senate floor by Senator Talmadge at the request of Senator Abourezk and without objection by Senator Dole (see Congressional Record, p. S18351, October 12, 1978). Senator Dole's characterization of this language as relatively minor and non-controversial is therefore inaccurate.

The litigation which gave rise to these bills is still pending in the U.S. District Court for the District of Columbia. The defendant PSRO has not yet been ordered by the Court to disclose any data to plaintiff Public Citizen Health Research Group. In fact, the Court has agreed to stay such an order until after all the issues raised by the lawsuit have been litigated in the District Court and any appeal has been decided. Since an appeal is likely, it will be at least another year before the precise application of the FOIA to PSRO data has been judicially resolved. It is entirely possible that the courts will find either that PSROs are not at all subject to the

FOIA or that the data sought by HRG falls within FOIA exemptions. In either case, these bills will be rendered unnecessary.

'In any event, an issue of this importance to the Freedom of Information Act and to the PSRO program should be considered only after all interested parties have had a full opportunity to be heard. These include the members of the Subcommittee on Administrative Practice and Procedure of the Senate Judiciary Committee as well as affected consumer groups and state and local health planning agencies and other public health agencies which are potential users of PSRO data.

Letters opposing exemption of PSROs from the FOIA from several such groups, including the Consumer Coalition for Health, the Consumer Health Advocacy Program in Massachusetts, the Western Massachusetts Health Planning Council, and a committee of the National Governors' Association were inserted last session in the Congressional Record (see p. E3346, June 19, 1978; p. S15160, September 14, 1978; and p. S17002, October 3, 1978). Attached is a letter opposing such an exemption from the American Health Planning Association.

Sincerely,

TED BOGUE,
Staff Attorney.

Enclosures.

PUBLIC CITIZEN,
Washington, D.C., August 22, 1978.

Re section 25 of S.1470, which would exempt Professional Standards Review Organizations from the Freedom of Information Act.

Senator JAMES ABOUREZK,
Chairman Subcommittee on Administrative Practice and Procedure, Senate Judiciary Committee, Russell Senate Office Building, Washington, D.C.

DEAR SENATOR ABOUREZK: You have asked the Public Citizen Health Research Group to respond to the arguments made by the Senate Finance Committee in Senate Report 95-1111 in support of section 25 of S.1470 as reported by the Committee. Section 25 would exempt Professional Standards Review Organizations (PSROs) from the Freedom of Information Act (FOIA). The arguments made by the Finance Committee in support of such an exemption are exaggerated, misleading, and reflect a fundamental misunderstanding of the FOIA. The discussion also contains several key factual inaccuracies. Finally, the potential benefits of public disclosure of some types of PSRO data are completely ignored. The following is an attempt to correct the misimpressions created by the Finance Committee Report.

The statement by the Finance Committee that, under the FOIA, "all data acquired by PSROs [would] be disseminated without safeguards" is flatly wrong. The FOIA completely exempts from mandatory disclosure nine categories of sensitive information. At least three of these exemptions clearly apply to some types of PSRO information. In fact, the FOIA exemptions, as interpreted by the courts, are far more specific than the language of section 1166 of the Social Security Act—preferred by the Finance Committee—which delegates to the Secretary of HEW almost complete discretion to disclose PSRO data, guided by only the vaguest of criteria.

For example, patient-identifiable information is clearly exempt from disclosure under the FOIA as an invasion of personal privacy, while, contrary to the statement by the Finance Committee, section 1166 does not specifically prevent such disclosure.

It is also noteworthy that neither the Public Citizen Health Research Group in the case being litigated nor any other consumer group has ever sought data which identifies patients.

The confidentiality of PSRO internal review proceedings would also clearly be protected by the FOIA exemptions concerning personal privacy and internal communications. Thus, PSRO physician reviewers can be as candid as they wish in internal discussions about the performance of other providers without any concern that their private, subjective, and evaluative comments can be disclosed to the public. The Health Research Group specifically excluded information about PSRO deliberations from its FOIA request. Again, there is nothing in section 1166 which explicitly excludes such records and meetings from disclosure.

Accordingly, PSROs would be unable to recruit physicians to perform review functions as a result of being subject to the FOIA, as stated in the Report, only if they misunderstand or have failed to inform doctors about the protections for sensitive information contained in the FOIA. It also should be noted that physician participation in PSROs is not entirely voluntary, as asserted by the Finance Committee. PSRO physician reviewers are paid up to $44 per hour for performing PSRO review functions. In addition, the Department of HEW is required to establish

PSROs in every area of the country, using non-physician organizations to perform review if physician groups refuse to cooperate. Finally, the reporting of data to PSROs for their review is legally mandated for all physicians and hospitals serving Medicare and Medicaid patients. The providers can receive Medicare and Medicaid payment only for services which the PSRO has approved.

The Finance Committee claims that "subjecting PSROs to the FOIA would result in increased administrative burdens, large additional expenses for the defense of lawsuits, and great uncertainty and delay in the performance of PSRO functions." It is also suggested that applying the FOIA to PSROs somehow prevents HEW from developing their own disclosure regulations. None of these assertions is true.

All Federal agencies are required to develop regulations implementing the FOIA. Thus, HEW would develop PSRO disclosure regulations, which may be extremely specific and detailed with regard to both the procedures and substance of data disclosure, consistent with the FOIA. Further, the precise applicability of exemptions to various categories of PSRO data will be litigated in the Public Citizen Health Research Group case both in U.S. District Court and in the D.C. Circuit U.S. Court of Appeals, unless section 25 is passed into law.

Contrary to the statement in the Finance Committee Report, the case has not yet been appealed, though an appeal will be taken at some point.

Therefore, complying with the FOIA should not create any significant uncertainty or administrative burdens for PSROs nor is further litigation likely. Other Federal programs routinely respond to FOIA requests according to established procedures without apparent disruption of their activities. Health Systems Agencies, which are also locally-based and funded by HEW, are required to disclose virtually all records and data to the public.

In any event, no PSRO will be in any way subject to the FOIA until the Public Citizen case has been fully litigated in the U.S. District Court and the U.S. Court of Appeals has also considered all issues in the case, including whether PSROs are subject to the FOIA at all. Thus, the legal process may render this action by Congress unnecessary. Congress should not act prematurely by completely exempting PSROs from the FOIA before the courts have had an opportunity to fully consider the issues and the groups seeking access to PSRO data have had a full public hearing.

The Finance Committee contends the court holding that PSROs are Federal agencies and therefore subject to the FOIA "is clearly inconsistent with Congressional intent." Although the legislative history does provide that PSRO review decisions be made by local physicians, it also stresses that PSROs be publicly accountable (S. Rep. 92-1230, p. 258, 1972). The District Court decision was based on the finding that PSROs exercise substantial governmental decision-making authority. PSRO approval is an essential prerequisite to payment for Medicare and Medicaid services. Such authority can not legally be delegated to a private group insulated from public accountability. PSROs are also subject to pervasive scrutiny and control by HEW with regard to organization and procedures. Thus, shielding PSROs from the public information requirements applicable to other Federal programs would be inconsistent with Congressional intent.

Finally, the Finance Committee completely ignores the potential benefits of public disclosure of PSRO data. PSROs are virtually the only source of reliable data and analysis about the quality of health care provided by doctors and hospitals. Consumers currently have no objective way of making comparisons among providers on the basis of their competence or track record and thus cannot make well-informed choices in the health care marketplace.

PSROs collect uniform data and compare the actual performance of providers against pre-determined criteria developed by PSRO physicians. In this way PSROs identify differences among providers in quality of treatment of comparable patients. For example, PSROs review the medical necessity of surgical procedures on the basis of pre-developed indications for various types of surgery. Consumers are entitled to know for each surgeon in what percentage of cases proposed operations have been disapproved by the PSRO as medically unnecessary. Such ratings would enable consumers to avoid careless surgeons.

Other public agencies could also benefit from access to PSRO data. For example, health planning agencies are required by the National Health Planning and Resources Development Act to review periodically the quality and appropriateness of existing health services in their area. Under section 1166 health planning agencies can obtain aggregate PSRO data about the volume and mix of services in a hospital but cannot obtain the results of PSRO "medical care evaluation" studies assessing the quality of care in the hospital. This severely impedes the ability of health planning agencies to perform functions required by the Congress.

Thus, HEW will not permit access by the public or public agencies to critical PSRO data, disclosure of which could improve the quality of health care. Apparently, HEW is responding to the displeasure voiced by physicians and hospitals who are opposed to any public disclosure of PSRO data. If, after being educated as to the actual operation of the FOIA and its exemptions, physicians still oppose its application to PSROs, it can only be because they do not want consumers to have objective information which reveals differences in quality of care among individual doctors and hospitals. While doctors who receive unfavorable evaluations from the PSRO may in fact be embarrassed, this should not prevent public disclosure of accurate, objective information. The taxpayers who fund PSROs ought to have access to the results of PSRO professional evaluations of quality of care.

Finally, it is difficult if not impossible, for the public to evaluate the operation of PSROs themselves without knowing what impact they have on the quality of care of individual providers. Oversight of PSROs by HEW alone, in the absence of public disclosure of evaluative information, does not assure that they will perform well, contrary to the assertion of the Finance Committee. HEW review must be accompanied by public review.

I hope that this clarifies how the FOIA would apply to disclosure of PSRO information.

Sincerely,

TED BOGUE.

AMERICAN HEALTH PLANNING ASSOCIATION,
Alexandria, Va., September 20, 1978.

DEAR SENATOR: The American Health Planning Association, which represents over 50,000 volunteer participants in the health planning programs and their staffs at the state and local levels, would like to call your attention to several provisions in H.R. 5285 (formerly S. 1470, the Talmadge proposal on Medicare-Medicaid reform). Most importantly, we are concerned with Section 3 of this proposal which creates a Hospital Transitional Allowance Board to make payments under Medicare-Medicaid for voluntary closure and conversion of underutilized facilities.

AHPA supports the principle of closing and converting underutilized facilities. However, Section 3 of the Talmadge proposal creates an approach to this problem totally inconsistent with Congressional intent to allow state and local participation in facilities review. Specifically, we refer to the total absence of linkages to state and local planning agencies which by law are required to review such programs. These agencies are certainly more prepared to make recommendations and be of assistance to facilities as they consider closure and conversion. We have strong doubts that any board established at the Federal level can be cognizant of, much less sensitive to, local proposals for closure and conversion of facilities. Therefore, we strongly support Senator Schweiker's amendment no. 3584 to H.R. 5285 which deletes Section 3.

Senators Kennedy and Schweiker have already offered a voluntary closure and conversation program which is more comprehensive in scope than the Talmadge proposal and which has been passed by the full Senate in S. 2410.

If the Senate decides to add the resources of Medicare-Medicaid to the closure and conversion program (which we would support), an amendment could be introduced to coordinate these Medicare-Medicaid payments with Senators Kennedy's and Schweiker's program.

There are two other issues also having significant implications for effective cost containment in Senator Talmadge's proposal which we feel have not been adequately considered. The first of these is part of Section 4, an amendment to Section 1122 of the Social Security Act which exempts from this program transfer of ownership or sale of inpatient and nursing home facilities which does not lead to an addition in beds or change in services. Proponents of this measure indicate that it was never the intent of the original concept in Section 1122 to cover such simple sales, and the amendment as it presently stands assures the freedom to buy and sell property.

Our view is that this position does not take into account the realities of the transfer and sale of properties such as nursing homes. As it now stands, Section 1122 does not prohibit the sale or transfer of such facilities, but only limits Federal reimbursements when they are inappropriate. This authority is a helpful response to a 10-year history of abusive sale and resale of nursing home properties with full depreciation being paid for out of the public budget through Medicare and Medicaid. We believe that until an alternative authority has been developed, such as a requirement of some form of one-time depreciation allowance, with adequate adjustment for modernization and life safety additions, this provision of the 1122 program

should stand unchanged. At present, it is the one safeguard in an area which has cost U.S. taxpayers tens of millions of dollars.

Finally, Section 25 of H.R. 5285 would exempt Professional Standards Review Organizations from the Freedom of Information Act. This section is perceived by its supporters as being necessary to encourage physicians to participate in PSRO programs and to protect their personal privacy. We have no quarrel with either of these objectives. Again, however, the practical result of this provision would be to undo existing data-sharing relationships between PSROs, HSAs, and other public entities at a time when these relationships are just beginning to form; clear guidelines for data-sharing under Section 1166 and regulations promulgated by the Division of PSROs and the Bureau of Health Planning have just been established.

Quite apart from the arguments that have been made that Congressional intervention in this matter without full hearing of the issues is premature, the explicit priorities of Congress as set forth in both the Planning Act (P.L. 93-641) and the Medicare-Medicaid Antifraud and Abuse Amendments require data-sharing between PSROs and health planning agencies to realize the success of both programs. Without this data-sharing (which already has adequate confidentiality protection provisions), not only will the public be handicapped in making critical decisions regarding the cost effectiveness and allocation of scarce resources in communities, but also the very reason for being of these programs would be mitigated. Therefore, we urge that this amendment be deleted.

If you or your staff have questions concerning any of these issues, the Government Policy staff of the American Health Planning Association would be pleased to answer them.

Sincerely,

ANTHONY T. MOTT, *President.*

STATEMENT OF THE AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION

Mr. Chairman, the American Speech-Language-Hearing Association appreciates the opportunity to testify on proposals to contain hospital costs.

The association is composed of nearly 30,200 speech-language pathologists and audiologists whose professional lives are devoted to the research, prevention, and clinical rehabilitation of disorders in human communication. Let me take a little time to explain what our members do.

Speech, language, and hearing are to human activity what sun, air, and water are to our natural environment. Easily taken for granted or ignored by most of us, the ability to communicate is a part of our lives from the first utterance at birth until the last moments of life. Communicatin provides the means by which we make contact with our families, our peers, our society, and largely how we define our own identity. The ability to communicate provides the opportunity to fully participate in life; the alternative is life without hearing or without the ability to speak.

Uttering a single word requires the coordination of muscles that regulate breathing, those of the larynx, tongue, soft palate, and lips. It has been aptly described as the most complex voluntary activity that human beings engage in. The muscle movements and sound of speech are the mere physical manifestations of a vastly complex process that begins in the deeper recesses of the brain—where language, like a greater computer's tapes, is stored.

The average literate person's brain stores tens of thousands of words. When we hear or wish to speak, the brain searches for the word using all kinds of complex criteria at the same time. These criteria are the meaning of the word, its rhythm, its spelling, and multitudes of associations. When we hear, the brain checks incoming sounds against the language bank to make sure we have recognized them correctly. When we speak, the brain continually selects the words we need in the appropriate sequence to express our thoughts.

The energy provided for speech begins with air forced out of the lungs, in an exactly timed sequence of the sounds in the word, and in coordination with the syntactical requirements of the sentence. The vocal cords in the larynx, the muscles of the face in the jaw, tongue, lips, and soft palate shape the air into words. Articulate speech results from the extremely sophisticated manipulation of all these parts.

The process of hearing oneself speaking provides an auditory feedback circuit through which we judge background noise, the acoustics of our environment, and errors in our own speech. All this happens in a few milliseconds. Speech is a complicated marvel of nature, the most brilliant technical achievement of the human brain.

There is little wonder that according to Genesis the power to name things—language—was among the first gifts to man and that the separation of the world into many languages at the Tower of Bable was his second greatest punishment. Speech is universally equated with freedom, the eiptome of human expression.

Hearing is no less complex than speech. The mechanisms of the ear change sounds into electrical impulses which the brain then reassembles into meaningful sounds. Hearing is a basic ability to understand the world around us. The ability to hear develops prior to birth. The deterioration of the ability to hear unfortunately is associated with age, but it can affect all of us at any age.

The facts reveal that great numbers of Americans suffer communicative disorders of various kinds:

20 million Americans, or one-tenth of the nation, have communication handicaps.[1]

10 million Americans of all ages have speech disorders.[2]

600,000 adults suffer from aphasia—a disruption of language skills as a result of brain trauma, stroke, brain tumor, or infections.

3 to 5 percent of all cancer results in removal of the larynx with total loss of voice. In 1975, this type of cancer affected 9,000 persons.[3]

Impairment of hearing is the single most prevalent chronic disability in the United States.

13 million Americans have some degree of impaired hearing.

1.8 million Americans are deaf.[4]

17.37 percent of all Americans over the age of 65 suffer significant bilateral hearing impairment severe enough to restrict their understanding of speech.[5]

It is natural, therefore, that the professions with the responsibility of dealing with communicative disorders through research, prevention, and rehabilitation must meet high educational and experiential requirements. The association maintains active programs to accredit college and university graduate programs, to accredit clinics, and to certify practitioners. To be certified by the association, an applicant must: Have a graduate degree with particular study in human communication—the general course of study often includes psychology, anatomy, physiology, sociology, neurology, acoustics, linguistics, psycholinguistics, speechreading, clinical psychology, and speech disorders; Complete 300 clock hours of supervised clinical experience; Complete nine months of full-time professional experience; and Pass a national examination.

The 30 States which license speech pathologists and audiologists maintain similarly high standards.

This extensive preparation assures consumers that the speech-language pathology and audiology services are provided by persons with demonstrated competency.

In speech-language pathology, services include:

1. Diagnostic and evaluation services in which the type, causal factors, and severity of the disorder are determined; and

2. Therapeutic services which are often provided after a medical or surgical procedure where speech has to be restored. These services are often connected with: (a) Disorders of the cerebrovascular system resulting in such problems as dysarthria, aphasia, and apraxia; (b) neurological diseases such as Parkinsonism, multiple sclerosis, or cerebral palsy; or (c) laryngeal carcinomas which result in a laryngectomy.

3. Counseling of individuals and families regarding the speech/language impairment or about prevention of speech/language disorders.

Audiological services include the prevention, identification, evaluation, and rehabilitation of persons with disorders that impede or prevent the reception and perception of speech and other acoustic signals. Data provided by audiologists is often valuable to physicians in identifying medical pathologies. But audiologists primarily function to determine the impact of impaired hearing on a person's total communication abilities. Audiological services include: Evaluating the type and extent of the hearing impairment; determining the relationship of the impairment to physical and educational development, social and emotional well-being, and vocational needs; determining candidacy for amplification (a hearing aid); determining the degree of

---

[1] U.S. Department of Health, Education, and Welfare, Report on Hearing and Speech to Committee on Appropriations, 1976, p. 17.

[2] National Institute of Neurological Disease and Stroke, National Institutes of Health, U.S. Department of Health, Education, and Welfare. Human Communication and Its Disorders: An Overview. Bethesda, Md.: NINDS Monograph No. 10, 1969, p. 16.

[3] Boone, Daniel R. "The Voice and Voice Therapy." Englewood Cliffs, N.Jersey: Prentice-Hall, Inc., 1971, p. 198.

[4] Schein, Jerome D. and Delk, Marcus T., Jr. "The Deaf Population of the United States." Silver Spring, Md.: National Association of the Deaf, 1974, p. 16.

[5] Ibid., p. 29.

benefit to be derived from an aid; and providing necessary counseling and other audiological rehabilitative services.

Audiologists also are actively concerned with the prevention of noise-induced hearing loss and have a record of active support for noise control legislation at the federal, state, and local levels.

Speech-language pathologists and audiologists work in a wide variety of settings—Veterans Administration hospitals, public and private schools, the military, maternal and child health programs, universities, federal and state rehabilitation services programs, private and public freestanding clinics, home health agencies, nursing homes, hospitals, and in private practice.

The American Speech-Language-Hearing Association supports the Administration and Congressional efforts to limit the rate of increases in hospital costs. Such costs are rising at an alarming rate, exceeding the rate of inflation in other goods and services.

There are several reasons why the Association favors this legislation. Firstly, speech-language pathologists and audiologists and their clients, often the very young and the elderly, suffer from the effects of inflation. Their ability to obtain health care services is decreasing as the costs skyrocket.

Secondly, we are very concerned that our members' services are accessible to those who need those services. These services are often funded by federal or state programs such as Medicare, Medicaid, maternal and child health, and veterans programs. But programs for the education of handicapped children, research on communicative disorders, Medicare coverage of audiological services, and expanded maternal and child health programs will not be affordable at the present rate at which hospitals eat up national health care dollars. This consumption needs to be lessened, not so that there will be less care, but so that it may be apportioned more broadly.

Thirdly, many hospitals have already engaged in cost control procedures whose effects appear to fall indiscriminately on various departments. A national cost containment program would make effective long-range planning more likely and ultimately make the cuts logical.

Fourthly, in a report on speech pathology services in United States' hospitals,[*] data were presented showing that 21 percent of hospitals surveyed in 1974 reported providing speech pathology services. According to the report, about two-thirds of the speech pathology patients being seen were outpatients. The Administration's proposal as introduced by Senator Gaylord Nelson would not call for mandatory controls unless a hospital exceeds the national voluntary limit. The mandatory limit would apply to reimbursements per admission or average inpatient charges. We believe that this manner of computing and determining the limits rightly excludes outpatient services. Outpatient charges have not to our knowledge been identified as a contributor to hospital inflation. Such services are generally low-cost services because they do not involve the costs of services to maintain beds and similar services. Low-cost rehabilitative services such as those provided by speech and hearing clinics deserve a measure of protection against cost cutting. These vital rehabilitation services often are not particularly lucrative for the hospital. Therefore, without this protection, some hospitals might cut services and retain less necessary but more financially productive operations. This travesty should be avoided.

Fifthly, the legislation is an improvement over last year's versions in its treatment of the wage increases. Under proposals discussed in the 95th Congress, the increases in wages achieved as a result of collective bargaining would not have been computed in determining a hospital's rate of increase of costs. This would have had an unforeseen effect of encouraging unionization among health care professionals. The Association has no position on the issue of members belonging to unions, preferring to leave this to the judgment of individual members in their own work settings. A cost containment bill, we believe, should also be neutral on the subject of unionization; it also should not penalize hospital employees who are not highly paid. The Administration's current proposal avoids this problem by only considering physicians' and supervisors' wage increases in calculating the hospital's overall rate of increase. This is an improvement of which we approve.

The President's proposal would also establish a National Commission on Hospital Cost Containment consisting of 15 members—five representatives of hospitals, five representatives of entities that reimburse hospitals, and five persons who do not represent either hospitals or reimbursing entities. This composition poses an unanswered question: Will the Commissioner include health care professionals? It is likely that several of the five open seats would go to physicians; it is also likely that

---

[*] A National Study of United States' Hospital Speech Pathology Services, Report No. 1, Asha, February 1977, p. 69.

some seats would go to consumer members. That means that independent health care professionals who have a stake in hospitals, who provided services and who will be greatly affected by any cost containment program, will not be represented. This Association believes that two positions on the Commission should be available to health care professionals who are neither physicians nor nurses. The Commission has an important responsibility to recommend to the Secretary modifications of the act, and to consult on other matters that may affect hospital expenses or revenues. Such an important Commission should include a broad cross-section of affected entities. At the very least, such representation will provide an advocate to examine ways in which nonphysician health care professionals may be best utilized.

Finally, we ask that the Committee give careful consideration to the provision in the President's proposal which would give hospitals only a one percent allowance for the provision of new services. We are concerned that this might be too low a figure to allow hospitals to bring new services on line.

STATEMENT OF THE NATIONAL HEALTH LAW PROGRAM AND THE NATIONAL SENIOR CITIZENS LAW CENTER

Provision

Section 2 (S. 505).

Problem

This provision would discourage hospitals from participating in the Medicare and Medicaid programs, would encourage hospitals to dump present Medicare and Medicaid patients, and would encourage hospitals to simply pass costs which are not reimbursed under Medicare or Medicaid on to other third party payers or on to private payers.

Discussion

In introducing this bill, Senator Talmadge pointed out that the increased expenditures for Medicare and Medicaid "alone clearly indicate that change isnecessary." Moreover, as Senator Dole indicated, the design of Medicare and Medicaid reimbursement does not insure "the best possible access to health care services for the individuals they sought to assist." Unfortunately, although change is necessary, the change that is proposed will not realize the desired goals.

Provider participation in the Medicare and Medicaid programs is a problem of increasing concern. By reducing the fees that the government will pay for medical care, without reducing the fees that other third parties and private parties must pay for health care, Medicare and Medicaid beneficiaries become even less attractive patients for facilities. This reduces access even further to necessary care.

The provision would also have the effect of reducing the significance of section 1122 approval for facilities. If Medicare and Medicaid reimbursement become less attractive for facilities, these facilities will alter their admissions and treatment patterns to discourage dependence on Medicare and Medicaid. The loss of reimbursement under section 1122 will therefore also be less significant. Thus, the federal government may lose an existing incentive for controlling costs.

Moreover, there is nothing to prevent a facility that wishes to continue to treat Medicare and Medicaid patients from passing on costs to other classes of patients. As Secretary Califano noted in his testimony before the Committee, this provision would be like pushing down on one part of a balloon. The other part would simply expand.

Cost controls are desperately needed under the Medicare and Medicaid programs to protect benefit packages from further reductions due to inflation of medical costs. These controls must be designed, however, to insure true cost control without depriving patients of access to necessary care.

Recommendation

Cost controls should be adopted to apply to all purchasers of health care. In addition, any cost containment provisions should contain a strong anti-dumping requirement to discourage private hospitals from transferring Medicare and Medicaid patients to public facilities for care.

Provision

Section 3 (S. 505).

Problem

This provision does not contain adequate safeguards to insure that an underutilized service will not be discontinued or substituted to the detriment of low-income patients, the elderly, minorities, or the handicapped.

Discussion

Medicare and Medicaid patients often have limited access to health care facilities. Although the advent of Medicare and Medicaid was supposed to end the dual track system of medical care in this country, many patients remain dependent on public facilities as their primary source of care and treatment. These facilities may be underutilized by the general population, but may represent the only source of care for certain segments of the population.

The proposed legislation would allow the elimination of excess bed capacity, the discontinuanace of underutilized services or the substitution for underutilized services of some other services. Only the discontinuance of an underutilized service requires consideration of whether there are adequate alternative sources of care. The term "adequate alternative sources" really provides little guidance to the Board or to the Secretary.

Thus, the availability of federal assistance may encourage the closure of needed facilities. This will have disastrous consequences for many patients.

Recommendation

Amend section 3 of S. 505 adding section 1128 to the Act by striking the word "and" at the end of section (c)(2)(A), by adding the word "and" at the end of section (c)(2)(B), and by adding subsection (c)(2)(C) as follows: "(C) the facility conversion will not have an adverse impact on the access of low-income persons, the elderly, minorities, or the handicapped to needed health care services,".

Provision

Section 22 (S. 505).

Problem

The provision would remove the present safeguards for Medicare and Medicaid beneficiaries and would allow research projects of questionable scientific or experimental value.

Discussion

This provision arose initially in the aftermath of the decision in *Crane* v. *Mathews*, 417 F. Supp. 532 (N.D. Ga. 1976). That decision invalidated the attempt by the Georgia Medicaid agency to impose cost-sharing on categorically needy Medicaid recipients for certain mandatory and optional services. This was to be done under the authorization of a section 1115 waiver.

The *Crane* court concluded that such a demonstration project involved experimentation on human subjects and therefore had to be approved by the State Institutional Review Board. That Board rejected the project on the grounds that the risks to the needy individuals involved far outweighed any potential benefits.

The proposed legislation would exempt any demonstration projects with respect "to coverage, or copayments, deductibles, or other limitations on payment for services" under the Medicare or Medicaid programs. The error of this approach is evident from the *Crane* decision.

The State-selected Institutional Review Board in that case concluded that the cost-sharing experiment was dangerous to recipients. That decision conforms to the position of the Committee on Finance that "cost-sharing devices in the medicaid program should not impose such a financial hardship on the recipient that he is hesitatnt to seek needed medical services when he is ill * * *." S. Rep. No. 92-1230, 92d Cong., 2nd Sess. (1972), at 219. If it had not been for the human experimentation safeguard, that policy would have been contravened by the Georgia Medicaid agency.

It is important to remember that the human subject protections are not an absolute bar to any class of project. All that is required is that in each case the risks/benefits be assessed. In that way, safeguards can be developed against misguided, ill-conceived, or maladministered research. Thus, valid demonstration projects are not unduly hindered by this requirement. Invalid demonstration projects that could harm the poor and the elderly are barred.

Recommendation

Section 22 should be deleted from S. 505.

Provision

Section 24 (S. 505), Section 13 (S. 507).

Problem

The provision would adversely affect many innocent recipients and would not adequately protect state fiscal interests.

Discussion

Several legislators and Medicaid administrators have expressed concern over the possibility that an otherwise eligible aged, blind, or disabled person can dispose of significant assets by giving them away or by selling them for substantially less than fair market value in order to establish Medicaid eligibility. A review of 29 state Medicaid programs during the late summer and early fall of 1978 indicated that this was not really a problem. In large part this was because applicants or recipients with any assets to protect were unwilling to live on the $25 personal needs allowance allowed in nearly every state.

Despite this recognition, many people still believe that a transfer of asset prohibition is necessary. We do not believe that such a requirement is cost-effective or administratively wise. However, if such a provision is enacted, it should not utilize the present language which is both over-and under-inclusive.

Under the proposed section, an individual who has transferred property within the preceding 12 months would have the property considered as a resource in determining eligibility. That individual would then have an opportunity to request a hearing to demonstrate that the transfer was not made for the purpose of establishing eligibility or that the transfer was made for fair market value.

It is unlikely that the population affected by this provision, the aged, blind and disabled, will utilize their fair hearing rights even if they would be eligible. Thus, for example, the State of Utah indicated that only a small segment of the individuals affected by the transfer of assets prohibition requested hearings. Of those requesting hearings, however, more than 70 percent were successful at the fair hearing level.

The proposed legislation would therefore create an undue hardship on the innocent victimized recipient who has been talked into transferring assets or who has had an asset transferred without his/her consent. In one common situation, a child with a power of attorney transferred the parent's home to his name without any knowledge by the parent. In other situations, elderly persons with diminished mental capacities have transferred assets without understanding the consequences of their actions.

In all such cases, the individuals would be denied Medicaid coverage initially. This denial would stand unless and until the affected person could overcome the statutory presumption that the transfer was for the purpose of obtaining medical assistance. Moreover, the person who received something for nothing, the transferee, would get off "scott free."

Problems with gratuitous transfers arise most frequently with individuals entering nursing homes. Often, a person is reluctant to sell a home prior to moving into the nursing home because s/he hopes to return to the home after a brief absence. The availability of a home to return to may be crucial in the rehabilitative and restorative process since it provides a goal for the individual to strive for. The forced sale of the home, therefore, will often have serious detrimental effects on the applicant's or recipient's health.

Another problem relates to the spouse and/or dependent children of an institutionalized individual. Once an individual becomes institutionalized in a nursing home, income eligibility for SSI is reduced to $25.00 per month. Resource standards are also necessarily affected since a home is only exempted if "used by the individual (and spouse, if any) as his principal place of residence." 20 C.F.R. § 416.1212. Pursuant to section 12570(b) of the Claims Manual, the institutionalized recipient's interest in the home would only be exempt for 6 months. Beyond 6 months, the absence no longer is considered temporary unless the recipient can demonstrate to the contrary. This will be true regardless of whether the home continues to be occupied by a spouse or minor dependent child.

During the 1978 review of trends in state administration of Medicaid programs, it was discovered that nearly every state continued to exempt the home so long as it was occupied by the spouse or minor dependent child regardless of the duration of the absence. In effect, these states are allowing a gratuitous transfer of the institutionalized spouse's interest in the home to the noninstitutionalized spouse and child. This would not be permitted under the proposed legislation.

Finally, the proposed legislation would reward those individuals who are clever enough to work around the system. If an elderly applicant can demonstrate that s/

he was truly victimized by the transfer, then that applicant will receive Medicaid. The transferee will still get the value of the asset untouched, however. Similarly, a transfer more than 1 year prior to applying for Medicaid will allow the transferor to receive Medicaid, but will not allow the state to reach the asset to recover the cost of medical care provided. It is for these reasons that it was indicated, at the outset, that the proposed legislation is both over- and under-inclusive.

Recommendation

There are several possible approaches that can be adopted to protect the fiscal integrity of the Medicaid program without unduly jeopardizing the interests of recipients:

1. Provide an exemption for small estates, perhaps less than $50,000. This will allow parents to pass on something to children and may help to preserve small farms. Estates exceeding a specified amount would have the excess estate subject to one of the other provisions.

2. Require states to establish a right of recovery against the gratuitous transferee. This approach is comparable to that presently being used under the Medicaid program for collection of third party liability. Thus, section 1902(a) of the Act could be amended:

(1) by striking out "and" at the end of paragraph (39);

(2) by striking out the period at the end of paragraph (40) and inserting "; and"; and

(3) by adding at the end thereof the following new paragraph:

"(41) contain provisions reasonably directed at the recovery from a person of the costs of medical assistance provided on behalf of an individual during the 12 months subsequent to a transfer of an asset to that person for substantially less than fair market value."

This provision would avoid the necessity of making determinations regarding the intent of the person who made the transfer and would insure that medical assistance would not be interrupted.

3. Remove the prohibition on owning a home when it is not being occupied by the recipient. Instead, provide an exemption if it is occupied by a spouse or minor dependent child. If it is not so occupied, require that it be utilized to produce income consistent with its value. This might be accomplished by renting the house out. In this way, the rental can be used to defray the costs of care and the house will still be available if the recipient can leave the nursing home.

TESTIMONY OF JOHN J. AFFLECK, DIRECTOR, RHODE ISLAND DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES AND CHAIRMAN, NATIONAL COUNCIL OF STATE PUBLIC WELFARE ADMINISTRATORS, FOR THE NATIONAL COUNCIL OF STATE PUBLIC WELFARE ADMINISTRATORS, AMERICAN PUBLIC WELFARE ASSOCIATION

The National Council of State Public Welfare Administrators (NCSPWA) of the American Public Welfare Association is pleased that Congress has again taken up the issue of health care cost containment and is appreciative of the opportunity to express our views on this subject. The NCSPWA is an organization made up of the directors of the human services in all the states, the territories, and the District of Columbia. In most states, these agencies are directly responsible for the administration and management of the Title XIX Medicaid program. We would like to offer comments first on the general issue of cost control and, secondly, on some of the specific Medicaid-related provisions of S. 505, the Medicare-Medicaid Administrative and Reimbursement Reform Act of 1979

The National Council lends its wholehearted support to efforts to contain the rising cost of health care, whether these efforts are at the federal, state, or local level, or whether they originate from the public or private sector. Certainly states have felt the crunch of inflation in the health care industry, particularly through its impact on their Medicaid programs. Since the program first became operational, Medicaid expenditures have increased dramatically from $363 million in 1966 to an estimated $20.2 billion in 1979. It cannot be over-emphasized that because of the partnership nature of the Title XIX program, these increases in Medicaid cost are borne almost equally by both federal and state government. As a result, Medicaid has grown to the point where it now accounts for one-half of every state dollar spent on social welfare programs and has stretched state budgets to the breaking point.

A number of factors account for this astronomical increase in the size of the Medicaid program. Far and away, the two most significant are the increase in the number of Medicaid recipients and the rise in health care costs. The number of recipients increased from 11.5 million in 1968 to an estimated 21.3 million in 1978.

However, when the effects of the increased size of the Medicaid population are removed by looking at the annual payments per individual Medicaid recipient, we see that average annual per capita payments have risen from $300 in 1968 to $850 in 1978—more than a 180 percent increase. Most of this increase is directly attributable to the price inflation of services purchased through the Medicaid program.

As executives responsible for the administration of the state Medicaid programs, the members of the National Council of State Public Welfare Administrators are directly affected by the escalating cost of health care. We have reacted, however, by utilizing whatever means are at our disposal to control this inflationary spiral. Our principle efforts have been directed at seeking ways to improve the administration of the Medicaid program and achieve cost savings without detracting from our attainment of the program's objectives. Given the inherent complexities of the Title XIX program, this is indeed oftentimes a challenging task. We shall persevere in our effort, however, and welcome the support that can be provided by addressing the problem of rising health care costs on a nationwide basis.

While we have been speaking of the rise in all health care costs, we are aware that the principal focus of pending federal legislation is upon containment of hospital costs. In that hospital care represents a significant portion of our national expenditures on health care and the cost of these services are rising at a rate which exceeds that of the overall Medical Care Price Index, such an emphasis is understandable. In 1977, Medicaid payments for inpatient hospital care equalled $5.1 billion or 31.5 percent of total Medicaid expenditures. In 1967, Medicaid hospital payments were only $913 million. Data from 1976 show Medicaid payments as accounting for 14.6 percent of public expenditures for hospital care and 8 percent of total expenditures—public and private—for such services.

The National Council therefore understands the rationale for focusing on the containment of hospital costs as a first step toward controlling the upward spiral of health care costs in general. However, there are many other types of services that contribute to our national health care bill of nearly $200 billion and efforts must be devoted to assuring that money spent on these other items will be able to purchase services that are provided in an efficient manner and not subject to the ravages of uncontrolled inflation. Nursing home care, for example, currently accounts for 40 percent of Medicaid expenditures and, with the rapid aging of our national population, the demand for this type of care can only be expected to increase. Certainly an overall approach to controlling costs in the health care sector is a necessary prerequisite to the development of any truly effective national health policy. The National Council, therefore, would like to lend encouragement and support to the Senate Finance Committee's efforts to explore measures which will provide states the flexibility to implement cost saving approaches which will compromise neither the quality of, nor the access to, care provided through state Medicaid programs.

Although the National Council is in support of the thrust of your efforts to control health care costs, we would like to comment on one aspect of the approach to hospital cost containment outlined in Section 2 of S. 505, namely its application to certain inpatient charges for only Medicare and Medicaid patients. We are concerned that this restricted focus on Medicare and Medicaid may result in reimbursement differentials between these public programs and other third-party payors which would serve to create barriers to access to care for the poor and the elderly. Further, this limited approach may not adequately address the problem of rising hospital costs, for hospitals may react to restrictions on Medicare and Medicaid payments by raising charges to other third-party payors. We would therefore recommend that any approach to contain hospital costs include all payors of hospital charges.

We would also urge that any national program to contain hospital costs not supercede programs at the state level which are effectively achieving the same goal of restricting the rise in hospital costs. Currently a number of states have in place hospital rate setting commissions that are successfully holding down hospital costs. A federal cost containment program should not interfere with the operation of these state programs nor should it preclude, or in any way restrict, the future development of similar programs in other states.

Along these same line, the National Council would like to express its support of the provisions of S. 505 which will allow states the flexibility to implement improvements in Medicaid program management and/or achieve savings in program costs through more economical practices. Additionally, the Council would like to particularly note its support of Section 24 of the bill which would prohibit an individual's transferring of assets for the purpose of gaining Medicaid eligibility. Although under current law some states have been required to grant Medicaid eligibility to individuals who have just divested themselves of large sums in order to become

eligible, public knowledge of these instances, in spite of their legality, has resultedin damage to the credibility of the Medicaid program. Passage of Section 24 will prevent the occurrence of such abusive situations and should therefore allow the Medicaid program to direct more of its resources to serving its intended population.

Again, on behalf of the National Council of State Public Welfare Administrators, I thank you for the opportunity to present the Council's views on these most important issues. If the Council can be of any further assistance to the Senate Finance Committee, please do not hesitate to contact me.

STATEMENT OF ELMER CERIN IN BEHALF OF THE AMYOTROPHIC LATERAL SCLEROSIS SOCIETY OF AMERICA

This statement is in behalf of amyotrophic lateral sclerosis (ALS) patients and other chronically disabled individuals and recommends changes in the provisions of S. 505, Medicare-Medicaid Administrative and Reimbursement Reform Act of 1979. It is recognized that because of the stringent monetary restraints in the cost of total changes in medicare and medicaid provisions, only the less costly changes are now being considered. Nevertheless, since the eligibility requirements are so fundamental in the application of medicare, it is suggested that the Congress begin considering the need to redefine the scope of home nursing service, as set forth in section 1861(m) of the Social Security Act, as amended.

The immediate question is what would be the proper vehicle for advancing the beneficial purposes in two primary health bills now under the consideration by the Congress and thus provide benefits for the seriously disabled, to which they are presently denied under existing medicare regulations. These bills are S. 350, Catastrophic Health Insurance and Medical Assistance Act, introduced by the Chairman of this Subcommittee, and the Domenici-Packwood bill, S. 489, Medicare Home Health Amendments of 1979. Since it would not be proper or effective to try to introduce these proposed changes at the hearings on these two bills, it becomes essential that this proposal is introduced at this hearing on changes in the medicare program.

The pertinent sections that are affected in the medicare regulations are No. 5, subpart L, conditions of participating home health agencies, sections 405.1201 (a)(1), 405.1221 (a) and 405.1221 (d). The suggested changes would delete the word "skilled" and substitute the word "professional" and, where appropriate add the phrase "homemaker-home health aide". These changes would broaden the application to the care of ALS and other seriously disabled individuals for whom medical science has not yet discovered or developed a cure. ALS is a terminal neurological disorder wherein the motor neurons of the brain and spinal cord are damaged and consequently the muscles go out of control and become paralyzed. This disorder attacks mature individuals in the 40 to 70 age range, in the prime of their lives, and usually terminates in three to four years. Since there is no therapeutic treatment, only trained health aides are needed to care for the terminally ill. But such trained personnel are now essential to prolong the lives of ALS patients and make existence a bit more bearable for the chronically disabled. The employment of registered nurses will only become necessary when the cause and cure of ALS are found.

In order to limit the scope of this definition of nursing care, it is suggested that it include only the chronically disabled who are homebound or bedfast and who require round-the-clock service. It is appreciated that this broadening of the definition of nursing care can be abused by making such service available to individuals who can be better served by family members, friends, volunteers, and community assistance, rather than through the employment of trained health aides. The proposed application would be severely circumscribed and be made available only to cases that are completely dependent upon others and who require the assistance of trained health aides, either professional nurses or trained homemaker-home health aides. Furthermore, such service would be available for only one eight-hour shift for five days of each week. Such arrangement would permit the breadwinner of the family to obtain employment and thus help to meet the cost burden incurred in providing the nursing and medical care as well as household needs.

Since both S. 350 and S. 489 are tied to Medicare eligibility provisions, the benefits that they would provide would be restricted to skilled nursing care. No matter how seriously ill are the ALS and other chronically disabled patients, no benefits would be extended to them unless Medicare is broadened to provide professional nursing care instead of the severely limiting skilled nursing care. Whereas both S. 350 and S. 489 seek to expand Medicare coverage, as presently written both bills would provide no help in assisting ALS patients and their families in coping with the astronomical costs that are incurred in providing necessary care. While the

underlying intent of S. 350 is to develop a mechanism to assure all Americans that bankruptcy would not overcome them because of the devastating effects of serious illness or injury, the evident fact is that ALS patients and other chronically disabled would not be benefitted one whit unless medical science discovers the cause and cure for their illnesses. As long as custodial home care is the best that can now be offered, such service does not qualify for Medicare benefits.

In short, a catch-22 situation exists: A dread disease without a present cure does not qualify for Medicare benefits since skilled nursing care is not needed to care for the terminally ill patient. Thus, it is imperative to redefine the level of nursing care so that ALS patients and other seriously ill patients become eligible for home nursing services. To control possible abuse, it is recommended that the Medicare benefits be limited to home health care for the seriously disabled requiring trained nursing care. Accordingly, this change from skilled to professional nursing care and the introduction of the homemaker-home health aide concept would expand medicare benefits to a small portion of our very sick population who truly require such assistance in order to prevent total financial ruin.

One additional comment concerning physical therapy coverage merits discussion. Under current Medicare regulations physical therapy treatments at home are included in the benefits, provided such therapy is restorative or rehabilitative. However, if such treatments are palliative or assist in maintaining the patient's health, no Medicare benefits are allowed. That such therapy improves the muscle tone, strengthens the patient's ability to better cope with the disorder, and indeed prolongs life does not constitute sufficient basis, under current Medicare regulations and interpretations, to designate physical therapy for ALS patients as being eligible for Medicare benefits. It would appear reasonable to conclude that such physical therapy would be considered as falling within the Medicare benefits under the home health care services provided by Part B.

Since my wife's condition is fast deteriorating, it is unlikely that we would be receiving any benefit, either service or financial, from the adoption of the foregoing recommended changes in the Medicare program. But other ALS patients and their families as well as other chronically disabled individuals will continue to face the spectre of heavy expenses and eventual bankruptcy. It is recognized that total coverage of their home health care costs would substantially increase Medicare appropriations, yet, as noted above, a humane solution is possible by allowing for the payment of home nursing care on a one shift per day basis so that the family breadwinner can bring in funds to pay for the medical and household expenses. Unless such steps are taken to help the ALS and other chronically disabled patients, the families of such patients will continue to face bankruptcy, even under the provisions of S. 350.

I thank the Subcommittee for granting me the opportunity to express the concern and interest of thousands of ALS patients and their families. The adoption of the changes, proposed herein, would go a long way in making health care a right to a significant segment of our citizens who are grievously suffering from a dread disorder ALS as well as other chronically disabling diseases.

Statement of the American Society of Internal Medicine on the Medicare-Medicaid Administrative and Reimbursement Reform Act

The American Society of Internal Medicine (ASIM) believes it is important to address hospital cost reimbursement methods and supports the objective of containing hospital costs by promoting efficiency in the hospital setting. We believe that S. 505 is the best approach yet proposed in Congress to address the problem of hospital cost inflation. We particularly applaud those features of the bill that offer positive incentives for efficiency while recognizing the differences in individual hospitals. There are certain provisions in S. 505, however, that we feel merit specific comments and recommendations on our part.

Section 2—Criteria for determining cost of hospital services

This section would establish an initial incentive system for reimbursing "routine hospital costs" under federal health programs. Hospitals would be classified according to bed size, type, and other criteria; cost would be determined for each classification through a uniform accounting and reporting system; and a per diem rate for routine operating costs would be determined for each hospital. A new Health Facilities Cost Commission would be created to develop recommendations for Congress on how a permanent reimbursement could be established and on the possible application of the reimbursement system to providers of service other than hospitals.

ASIM generally supports the provisions of this section. We recognize, however, that in order to provide the desired flexibility for dealing with individual institutions, the program must necessarily be complex. If it is enacted, the development of regulations and their implementation will be critical to the success of the program, and we sincerely hope the Secretary of DHEW will be responsive to input from the private sector during the process. It is equally important that the new Health Facilities Cost Commission be responsive to the input of health care professionals, physicians as well as administrators, particularly as it develops recommendations for expanding the prospective reimbursement system to non-hospital settings that are presently reimbursed on a cost basis. The best way to assure the necessary degree of physician input, we believe, is to require that a specific number of seats on the Commission be filled by practicing physicians.

ASIM is pleased that S. 505, as presently worded, is limited to reforming only the Medicare and Medicaid reimbursement system and excludes ancillary services from the definition of "routine operating costs." We believe that any effort to broaden this bill by requiring changes in the reimbursement methods used by non-governmental insurers, or including hospital services that are not covered by the proposal as presently worded, should not be considered until the efficacy of the proposed incentive system has been demonstrated in actual practice.

Section 3—Payment to promote closing and conversion of underutilized facilities

This section would provide for reimbursing certain classifications of hospitals for capital and increased operation costs associated with closing down or conversion to approved use of underutilized bed capacity or services. ASIM supports this section.

Section 5—Agreements by physicians to accept assignments

ASIM is aware of widespread concern over the reluctance of many physicians to accept assignment for all Medicare patients. We support positive reforms to reduce the differential between Medicare payments and physician charges, and welcome efforts that could minimize the administrative costs to physicians who treat Medicare patients.

We do not believe, however, that offering increased incentives only to a category of "participating physicians" will be effective in attracting more physicians to the assignment option, as this section proposes to do. First, the disparity between Medicare payment and physician charges in many cases is so great that we do not think the incentives identified would convince many physicians to accept assignment on all patients and thereby give up their right to bill patients directly. Second, if the objective is to save administrative time and cost by increasing acceptance of assignment, we believe offering incentives to all physicians to accept assignment on their patients would accomplish much more.

For example, if it is cost effective to offer the multiple billing option to encourage assignment, it should be offered to all physicians who have some assignment patients. If, as we suspect, multiple billing would save taxpayers money by itself, regardless of whether assignment is accepted or not, then we believe that this payment system should be put into effect immediately under the current billing and payment procedures, so that all physicians could submit multiple claims for all Medicare patients.

The one dollar "administrative cost-savings allowance" is arbitrary and its effect would vary from physician to physician. For example, for physicians who see relatively few patients the one dollar amount would provide little incentive. For all physicians this amount is insignificant when compared to the differential in reimbursement between acceptance and non-acceptance of assignment. Adoption of this provision would probably be beneficial to low-quality, high-volume type practices that specialize in Medicare patients in order to capitalize on the one dollar per patient incentive. Although a very small minority of physicians are likely to be involved in such practices, the result could be inferior care to a significant number of Medicare patients.

Section 6—Hospital-associated physicians

This section, although titled "Hospital-Associated Physicians," would establish a new definition for all reimbursable physician services under the Medicare program. The definition of physician services would exclude any service that a physician may perform as an educator, executive, or a researcher, or any patient care service unless the service was (1) personally performed or personally directed by the physician for the benefit of the patient; and (2) is of such a nature that the performance by a physician is customary and appropriate.

ASIM strongly objects to this redefinition of physician services. Whatever the intent of this definition, its vagueness may very well lead to regulatory interpreta-

tions that could place further limitations on services reimbursable under Medicare. We also believe that it is incorrect to separate the physician's role as educator and administrator from his role as a provider of patient care. Teaching and research have traditionally been regarded as intrinsic parts of medical practice, and the organized and complex structure of modern medicine frequently require tasks that can or should be performed only by practicing physicians. ASIM objects to this artificial division of the physician's role.

Section 7—Use of approved relative value schedule

This section would direct the Secretary of DHEW to establish a system for defining medical services and procedures under Medicare Part B. This system and a corresponding set of relative values would be developed by the Health Care Financing Administration (HCFA) with the advice of professional groups and other interested parties.

ASIM strongly opposes development of a new system of terminology by HEW and cannot support the bill if this provision is included.

For a procedural terminology system to be meaningful and equitable, we believe it must accurately describe the way medicine is actually being practiced. Such a system exists in Current Procedural Terminology, Fourth Edition (CPT IV) We support its adoption as a nationwide uniform system to define physician services and procedures.

We believe the medical profession is in the best position to describe most accurately what it does. The American Medical Association, with the active participation of ASIM and other specialty societies, has worked long and hard since 1960 to develop precise definitions of medical services and a corresponding coding system. First published in 1966, CPT is more widely accepted than any other system. Its use is endorsed by the Health Insurance Association of America, 36 state medical associations, and 16 national specialty societies. CPT has been adopted as the preferred system for the CHAMPUS program and is accepted under Medicare and Medicaid.

The major criticism of CPT has been its infrequent updating. With the recent publication of CPT IV, a mechanism for systematic and continuing review and updating has been established. This will insure the timely inclusion of new procedures of proven clinical value, as well as the elimination of outdated procedures. Directing DHEW to develop another system would require the expenditure of unnecessary effort and government funds.

Section 8—Teaching physicians

ASIM believes that delaying the implementation date of section 227 of P.L. 92-603, as this bill proposes to do, is appropriate, but would prefer outright repeal of section 227. As we have argued in the past, section 227—when implemented—will create inappropriate distinctions between Medicare beneficiaries and other patients regarding the delivery of their care, thus creating a situation directly contrary to the intent of Congress when it enacted the Medicare program. Furthermore, we believe that section 227 could have very negative effects on medical teaching programs across the country by exacerbating the financial pressures already faced by many of these programs. Short of repeal, however, we certainly support delaying the implementation of section 227.

Section 16—Visits away from institutions by patients to skilled nursing or intermediate care facilities

This section allows a Medicare patient in a skilled nursing facility or in an intermediate care facility to make visits outside the institution without such visits being regarded as indicating conclusively that the patient is not in need of the facilities' services. This is highly commendable. If more regulations which affect patient care were similarly flexible to allow application on an individual patient basis, physicians would find federal health programs much less objectionable.

Section 20—Ambulance service

This section would provide Medicare coverage for ambulatory service to hospitals other than the nearest hospital if the nearest is not adequately equipped and staffed to provide the necessary treatment. This solves only part of the identified problem with coverage for ambulance service. While it addresses the obvious need for adequate facilities, it ignores the desirability of having the patient treated by his personal physician. When treatment is provided by another physician, unnecessary repetition of tests and longer hospital stays often result, increasing the cost of medical care. It is recognized that there are instances which preclude taking a patient to the hospital where his physician has privileges (i.e., when there is an unreasonable distance to travel or when there is an emergency requiring prompt

treatment). However, it is often expensive to deny a patient treatment by his personal physician in the absence of such conditions.

Section 23—Disclosure of aggregate payments to physicians

This section would prohibit the release of names of physicians who have been paid large amounts for treating Medicare or Medicaid patients except as required by other laws, i.e., the Freedom of Information Act. We interpret this to mean that the Secretary cannot routinely provide such lists, but still must comply with the request under the Freedom of Information Act.

Although we applaud this provision as a step in the right direction, we urge you to extend it to completely prohibit the release of physicians' Medicare program payments. Past experience indicates that little is accomplished by such lists other than unfairly implying wrongdoings by many honest physicians.

Section 27—Payment for laboratory services under medicaid

This provision would permit states to purchase laboratory services for Medicaid recipients through a competitive bidding process. We foresee this creating several problems that negate, in our opinion, any cost savings that might accrue through competitive bidding.

Because the services provided by different laboratories are rarely comparable, it would be difficult, if not impossible, to develop criteria for awarding bids to the lab that offers the best quality service at the lowest price. Instead, because of overriding cost considerations, we believe bids would be awarded to labs offering inferior services, and Medicaid patients would receive lower quality care. This undercuts the very objective of the Medicaid law by establishing a separate system of laboratory service delivery to the poor.

Contracting with a limited number of laboratories would also unduly restrict access of Medicaid patients to lab services. Because physicians' office labs would be unlikely to win contracts through the competitive bidding process, physicians would be unable to perform lab tests for their Medicaid patients. If they continue to collect specimens, some patients would be required to make a return trip to the office to learn of the results and prescribed treatment. However, because Medicaid payment for collecting specimens often makes it uneconomical to do this alone, some physicians would be forced to send patients to independent or hospital labs to have specimens collected. Medicaid patients, who are generally less mobile than the rest of the population, would often be required to travel farther distances to find a lab under contract.

Emergencies and other situations sometimes require that test results be obtained immediately and this would not always be possible from the lab under contract. So, apparently, regulations will have to be issued allowing for reimbursement to non-contract labs under certain circumstances and further complicating both reimbursement and claims review.

Collectively, independent labs already represent one of the most competitive components of the medical care system. This competition results in improved services and fairly stable prices. However, under competitive bidding, most contracts would presumably go to high-volume, automated labs. And physicians forced to send specimens for Medicaid patients to these labs might well find it convenient to use the same labs for non-Medicaid patients. This would force many small labs out of business, destroy the competitive balance, and ultimately result in higher prices and fewer incentives to develop new processes.

We believe that physicians are in the best position to select the laboratory that will provide the best services to each patient. To mandate separate lab services for Medicaid patients can only serve to further remove them from the mainstream of medical care delivery, making them "second class" patients.

We urge that the competitive bidding provision be eliminated from S. 505.

Section 28—Confidentiality of PSRO data

This section would place strict restrictions on the release of PSRO data that identifies an individual patient, practitioner, provider, supplier, or reviewer. ASIM strongly supports this provision. The confidentiality of PSRO data is essential to the success of peer review, and we welcome legislative initiatives to protect the privacy, candor, and confidentiality of the PSRO program.

Section 31—Development of uniform claims forms for use under health care programs

ASIM supports the use of uniform national Medicare-Medicaid claims forms. We would like to point out, however, that the American Medical Association has developed a standardized claims form that has been endorsed by Blue Cross/Blue Shield, the Health Insurance Association of America, ASIM, and many other medical

societies, and is accepted by Medicare and Medicaid in many states. The AMA model is already used in many areas, and we believe that is is unnecessary and wasteful for DHEW to develop a different standardized form when the AMA model form is already available.

Section 34—Study of availability and need for skilled nursing facilities under medicare and medicaid

We support this section, which directs the Secretary of DHEW to conduct a study of the availability and need for skilled nursing facilities. As an organization of predominantly primary care physicians, we are familiar with the lack of urgently needed skilled nursing facilities in many localities. This section, which attempts to address this problem, is highly commendable.

STATEMENT OF THE AMERICAN SOCIETY OF INTERNAL MEDICINE ON THE HOSPITAL COST CONTAINMENT ACT OF 1979

The increasing cost of medical care delivered in hospitals is a concern to all citizens—patients and physicians alike. The American Society of Internal Medicine (ASIM) agrees that it is necessary to address hospital cost reimbursement methods and supports the goal of cost containment. To that end, we support the medical community's voluntary effort to contain hospital costs, an effort that we believe has already been quite successful in slowing hospital cost inflation. We cannot, however, support the proposal for standby mandatory controls set forth in the Hospital Cost Containment Act of 1979, S. 570.

Mandatory controls, we believe, will adversely affect the quality of medical care provided to the American public and will undermine the private sector's highly successful voluntary effort to hold down hospital costs. At a time when real solutions to the complex problem of hospital reimbursement methods are urgently needed, S. 570 proposes a simplistic, short-term approach to hospital inflation that—in the long run—will prove to be counterproductive.

As an organization composed predominantly of practicing physicians, we are most concerned about the effects of controls on the quality of hospital care provided to our patients. As we have stated in the past, it is inadvisable to consider separately the attributes of our health care system—quality, availability, and cost. Indeed, it is imperative that they be considered together if we are to plan rationally for the future.

But S. 570, in its zeal to find a quick "answer" to rising hospital costs, fails to adequately consider the consequences—to the quality of care provided to the public—of imposing controls on the hospital industry. By demanding that hospitals adhere to an arbitrary limit of 9.7 percent in order to avoid controls, S. 570 in essence advocates the rationing of medical care to the American people. It would require hospitals to make trade offs in quality and availability in order to reduce costs. The one percent allowance for intensity of service and improved technology is far too restrictive. It fails to recognize that implementation of medical technological advances and increases in the availability of services demanded by the public cannot be accomplished without substantial increases in cost. The public may decide it wants to sacrifice quality and availability in order to save money. But, certainly, the options should be presented to the American people in this, their true, context.

It is also unlikely that, in the long run, S. 570 will really succeed in holding down hospital costs. For the time being, mandatory controls may contain hospital costs. But as this nation's experience with mandatory controls in the early part of this decade dramatically demonstrated, a surge of "catch up" inflation must result whenever controls are finally lifted. Sometime in the future, we will pay the price in inflation for controls imposed now.

Considering the consequences of placing controls on the hospital industry, it is difficult for us to understand the rationale for continuing to advocate controls—particularly when the private sector's voluntary effort has accomplished so much in containing costs without denigrating the quality of patient care. In the year since the voluntary effort was organized, the rate of increase in hospital expenses has declined more than 2.5 percent; Medicare hospital outlays as projected in the fiscal year 1978 budget are expected to increase only 12.5 percent this year, compared to 17.1 percent the previous year; and the medical component of the Consumer Price Index (CPI), as a whole, increased less during 1978 than the all items component of the CPI.

In short, the voluntary effort is working. But the threat of federal controls will not be an added incentive to hold down costs, as proponents of S. 570 have argued. On the contrary, there is no surer way of guaranteeing the failure of the voluntary

effort than to enact this bill. To do so would convey a clear message to the private sector that despite their accomplishments to date, the government has already decided, long before all the facts are in, that the voluntary effort won't work and mandatory controls will be necessary. Under those circumstances, it is unreasonable to expect that the hospital community would continue to work as hard to control costs as it has since the inception of the voluntary effort. In other words, the government's expectation that the voluntary effort cannot work will become a self-fulfilling prophecy.

CONCLUSION

As a physician organization, we are attempting to stimulate a meaningful awareness of costs among our members. Through a series of articles—"Saving Dollars & Lives"—in our national publication, The Internist, we have provided our members with specific suggestions on how they can control costs in the hospital and their practices. We request that three of the articles in this ongoing series—dealing with the ways that physicians can hold down the costs of laboratory services, attack costs in hospitals, and help reduce the costs of treatment in intensive care units—be included in the official records of these proceedings as an example of a practical voluntary approach to cost containment.

However, as physicians, we will never be able to accept cost as the sole or determining factor in decisions about medical care delivery. We support voluntary efforts that control costs while maintaining the quality of medical care, and favor long-term programs that address hospital cost reimbursement methods. The American Society of Internal Medicine, however, opposes passage of S. 570. We will oppose any proposal to contain hospital costs through arbitrary limits set on revenues or capital expenditures, regardless of how and when these limits would be triggered.

Saving Dollars & Lives

Cost Containment in Practice

The ICU: Top-dollar care

by William M. Wilder, MD

In this article Dr. Wilder, a member of ASIM's Task Force on Cost Containment, explains the physician's responsibility to consider the costs of ICU care and explores ways to stabilize and even reduce them.

The ICU is one area of the hospital where costs can get out of hand and bills can be ruinous to a patient's financial situation. However, there are ways in which physicians can affect the expense resulting from a stay in an intensive care unit.

First, we should be concerned about who should be admitted to the ICU. Every ailment that is now admitted to an intensive care unit formerly was taken care of in some other area of the hospital. Many such patients could still be cared for outside an expensive ICU; internists should be alert in identifying those who could do just as well in a less expensive area of the hospital. One of the ultimate considerations is, what will this patient's quality of life be after intensive care unit management? If the outcome would appear to be unaffected by the area of the hospital in which the patient is assigned, then the cheaper one should be utilized.

Second, the length of stay in any area of the hospital, and especially the ICU, must be monitored. Once the acute problem has stabilized and the crisis has subsided, the patient's management in the ICU becomes one of skilled observation rather than skilled care. At that juncture, the patient should be moved to another area of the hospital where the observation could be just as intense, but the expense would be quite a bit less. That extra day or two in an ICU "just to be sure" may account for a large amount of the rising cost of ICU care.

> **"That extra day or two in an ICU 'just to be sure' may account for a large amount of the rising cost of ICU care."**

Unnecessary care

Third, in analyzing ICU care, one must look at the individual elements involved in the total expense. Each attending physician should feel that it is his obligation to be certain the patient's dollars are spent wisely and that no study or procedure is carried out unless it will lend some positive aspect to the management of that particular case. One suggestion is that price lists be posted in all areas of the hospital, especially the ICU, stating the cost of lab tests, EKG procedures, X rays, and other special studies and procedures. With this as an ever-present reminder, the attending physician will be less quick to order tests and procedures if he weighs the potential value against the expense. It is likely that testing represents the biggest area of house staff overutilization, one that results in unduly high bills for the patient. It is the responsibility of the attending staff to point out to those in training that cost considerations may be just as important as scientific or technical considerations in ordering tests and procedures. In many hospitals, ICU nurses have the prerogative of ordering a diagnostic study (e.g. lab, X ray, or EKG) if they feel it is indicated and the physician

is not on the scene It is therefore the responsibility of nursing supervisors to educate their staff members about expenses incurred by admission to the unit, as well as by those services ordered for the patient after admission

Patients' insistence on ICU

We are caught in an era of expanding knowledge, scientific procedures, and gadgetry. The media have dramatized the ICU level of care and many patients (and their families) often feel that they have not received all the hospital has to offer until they have been involved in the ICU arena Noth ing could be farther from the truth This attitude puts the physician in direct conflict between third parties who would like to see ICU expenses reduced, and patients and families, who sometimes demand that their particular case be hospitalized in the ICU When this is the case, physicians must reassure patients and families that expensive ICU care is not necessarily more beneficial than less expensive care elsewhere

All the above situations bear watching by the attending physician and there are perhaps other things that could be done by an attending physician to fur ther reduce the cost or decrease the utilization of an ICU In the long run every attempt to lower the number of admissions, shorten the length of stay, and reduce the internal cost to the patient in an ICU will help lower costs We can each help curtail the escalation of expenses which is now prevalent We should also feel obligated to pass on this concern about cost control to those in training to nurses, and to our patients □

February 1979

Saving Dollars & Lives

Cost Containment in Practice

How to attack costs in your hospital

The logic is compelling:

Since we are now in a cost containment era, one brought about by spiraling health care expenditures; and

Since hospital care accounts for the major share of health care costs, and

Since "doctors' orders" are the principal agent for hospital charges;

Therefore, doctors, working through their organized medical staff, should now take steps to help contain costs.

The steps

Commitment

The first step is to achieve a formal hospital-wide commitment to the concept, not only from the medical staff, but from other segments of the hospital family.

It is likely that the medical staff, through its board or executive committee, will find cost containment an easy notion to support. However, the board in its endorsing statement and in defining a charge to the implementing committee will undoubtedly wish to insist on the corollary concept that the containment effort must stop short of any infringement on the quality of care.

The hospital's trustees will also be likely to endorse the notion easily; the governing body's only caveat will be to instruct the chief executive officer to make sure that the hospital's balance sheet continues to balance.

The hospital administrator's endorsement may be harder to win. Although he may willingly subscribe to the concept, he may be — inappropriately — worried that in today's irrational Catch 22 cost charges reimbursement "system," even rational cost containment measures may result in ultimate fiscal disservice to the institution.

The local and parochial internal interests of hospitals must be viewed in the light of the current national scene. At this writing, it is still unclear whether cost containment will be put in place by legislative fiat (a "cap" on the nation's hospitals' operating and capital expenditures) or through a voluntary private-sector effort conceived — and perhaps jawboned — by the AMA, AHA and FAH (Federation of American Hospitals). Whichever approach prevails, cost containment will be the order of the day. It will have to be put into effect at the local level and the different perceptions and objectives of different hospital factions can best be settled by deciding to collaborate and to create and operate the program together.

Organization

It follows that the organizational committee charged with carrying out the hospital's cost containment efforts should include members of the trustees and administration. But a convincing argument can be made that the principal membership should come from the medical staff and indeed that the committee should be a duly constituted arm of that staff. Virtually all hospital procedures and services for which charges are made are ordered or rendered by staff members.

The chairman will likely be a senior physician above reproach and suspicion. He or she will need to be innovative, indeed creative, since there is little

---

This article is the second in the "Saving Dollars & Lives" series, which is intended to provide internists with practical suggestions on what they can do to help contain costs. Material for the article was brought together by ASIM's Task Force on Cost Containment, and the article was written by *Internist* Editor William Campbell Felch, MD, who is also chairman of the American Hospital Association's Committee on Physicians.

Future articles in this series will deal with cost containment in the physician's office, cost containment as related to the patient, and cost containment as related to insurance carriers. The Task Force would like to receive members' ideas on how internists can help trim medical costs and suggestions for future articles in this series. Write to Hugh S. Espey, MD, ASIM, 703 Market Street, Suite 535, San Francisco, California 94103.

Members of the Task Force on Cost Containment are Chairman Hugh S. Espey, MD, Quincy, Illinois; Norman Deane, MD, New York City; Michael C. Perry, MD, Columbia, Missouri; William H. Todd, MD, Long Beach, California; and William M. Wilder, MD, Shreveport, Louisiana.

"... a cost containment program is similar to a medical audit program: the objective is to identify deficiencies ... and to put into place remedial or corrective efforts."

published experience in this field and since varying local situations will require different solutions

As an early order of business, the committee will need to review its charge, define its objectives (perhaps in fiscal as well as procedural terms), identify the strategies it will employ for achieving those objectives, and devise an evaluative process for determining success or failure. Naturally, the committee will also have to decide on its operational processes, including such matters as frequency of meetings, keeping of minutes, submission of reports to policy bodies, informing rank-and-file members, and the scope of remedial measures.

The plan

To a considerable degree, a cost containment program is similar to a medical audit program: the objective is to identify deficiencies in process (in this case, excessive costs) and to put into place remedial or corrective efforts

Categories of concern

Instead of patient disease categories, the aim here is to identify areas of cost excesses. Since there does not yet exist sufficient information about what such areas are and what the causes of the excesses are likely to be, there is no opportunity for expert delineation of preset criteria. Instead, the committee will have to decide for itself, considering local circumstances in its hospital, what operational elements offer the greatest likelihood of causing excess costs — and therefore the greatest potential for effecting cost savings

While the per diem cost of hospital stays would appear to be a likely area to attack, it is probable that most hospitals already have effective utilization review systems for preventing unnecessary admissions and for controlling length of stay.

The committee will therefore undoubtedly wish to examine other aspects of hospital care in some systematic way One method is to review care by department — surgery, medicine, pediatrics, etc. — to search for cost-elevating processes in each Another way is to focus on specific service areas, ancillary care is an especially ripe subject since charges are usually high and tests are often ordered by physicians without regard to cost and sometimes with insufficient attention to real needs Still another technique is to break down a patient's course in the hospital into sequential parts and analyze each for possible unnecessary costs admission (were the results of pre-hospital tests performed elsewhere accepted?), routine tests (are they all important screens or just there through tradition?), admitting orders (are sleeping pill orders for expensive drugs?), etc A final way is unstructured, the committee simply blue-skies to identify areas in which cost excesses are likely to occur

Whatever the method, it is likely that committee members will come up with a number of areas in which the possibility of cost savings will arise The help of administration will be needed to provide hard data about costs and charges.

Remedial action

The first step is to create an attitudinal change among medical staff members, to instill an awareness of costs cost consciousness The commitment by staff leadership will start the process, it can be reinforced by presentations at staff meetings, dissertations in staff newsletters, etc

A related step is to give information to staff members about specific costs cost education Copies of a patient's itemized hospital bill can be copied for the attending physician The charges for lab tests, radiologic procedures and other ancillary services can be printed on requisition slips or posted at nursing stations

The third — and hardest — step is for the staff or a committee or a department to make a specific decision not to use certain expensive procedures or to make the commitment to select certain less costly alternatives cost control Such decisions are difficult and are better taken with input and possibly by vote from rank-and file staff members, imposition from above can stimulate resistance and poor cooperation

Evaluation

If at all possible, some yardstick of achievement should be established, so that staff members can measure the success of their efforts While the change in before and after costs by category would be the most valid assessment, the accounting necessary to achieve this may be too complex for the average hospital Simpler, less rigorous assays of costs savings can be devised that will give at least crude estimates of success

In the last analysis, the most important element in hospital cost containment is attitude If the rank-and file members of a hospital medical staff understand the importance of the effort, and if they are willing to make the commitment to accomplish it, it is likely that significant savings can result — W C F □

Saving Dollars & Lives

Cost Containment in Practice

One result of lab tests: High costs

by William H. Todd, MD

This fifth article in the Saving Dollars & Lives series, prepared by ASIM's Task Force on Cost Containment, focuses on the problem of getting a rein on the amount of money spent on laboratory tests and special diagnostic procedures. Cost "unawareness" in this area is a major problem—an alarming number of physicians, nurses, pharmacists, and technicians have no idea about the costs of such tests.

It is noteworthy that patients themselves know little about how much individual procedures cost. It is a paradox that in this day of advertising, discount stores, end-of-the-month sales, competitive interest rates, and the "best deal" from auto dealers, no "consumer" even asks the cost of a CAT scan. Of course, many people are convinced that cost consciousness would be produced in patients overnight if they had to pay the bill, even a 20-percent co-payment. Every primary care physician has witnessed the anxious reaction of patients when outpatient diagnostic studies are proposed. "Put me in the hospital, Doc," they say, "so my insurance will pay."

"It is a paradox that in this day of advertising, discount stores, end-of-the-month sales, competitive interest rates, and the 'best deal' from auto dealers, no 'consumer' even asks the cost of a CAT scan."

Mandatory cost awareness

Until co-payment prevails, our best chance of reducing the cost impact of laboratory and special procedures is to educate physicians and allied health personnel. This can best be achieved if a program for increasing cost awareness is made mandatory for all hospital personnel involved in patient care. In addition, it would be helpful to establish a system of documentation of hospital cost awareness programs—perhaps like that for documenting CME credit hours—as well as to make cost-awareness education a requirement for hospital accreditation.

A second approach, one being employed in a number of hospitals, is to post the charge on each procedure report, on the notion that such a display will heighten cost awareness. In addition, the posting of charges where the public can see them may help awaken patients to their responsibility. It is interesting to note that some hospitals have experienced a drop in bed day occupancy rates after posting room charges.

"Until co-payment prevails, our best chance of reducing the cost impact of laboratory and special procedures is to educate physicians and allied health personnel."

While inappropriate utilization of laboratory and special procedures by physicians is often related to lack of knowledge of costs, there are other causes. For instance, in the teaching setting, house staff physicians frequently order studies out of intellectual curiosity, with no direct patient

benefit. Teaching rounds are often "chart rounds," in which each physician participant (or for that matter, the pharmacist or nurses) makes a contribution by suggesting a more sophisticated test. The traditional clinicopathological conference approach has undoubtably contributed to the perpetuation of this problem-seeking type of "rounds;" the identification of procedure costs and yield would be of great value.

Evaluate yield vs. cost

Below is a list of questions relating to situations that practicing internists face every day in which consideration arises about ordering lab tests and procedures. The intent is not to challenge the worth of the services but to ask consideration of their yield in relation to cost:

—Are serial EKGs and three cardiac enzymes daily really necessary for chest pain problems? Total cost: $160–$180

—Do we need so many sputum cultures? Are we not usually just culturing saliva and tracheal flora? Cost: $40

—Is IPPB of any real value in respiratory problems? If so, is q.i.d. that much better than b.i.d.? Cost: $8–$10 per treatment

—Does a lung scan yield much information if arterial blood gases are normal? Cost: $150

—Must we do tomography with every IVP?

—Is a "clean catch" urine culture of value in females?

—Is a urine culture necessary in the absence of pyuria?

—Are platelet counts necessary if the estimate of platelets on smear is "adequate?"

—Does lipoprotein electrophoresis tell anything useful if the patient's serum is clear and the cholesterol and triglyceride values are known?

—Is a head CAT scan necessary for all headache problems?

—Is a spinal tap the final neurologic study to do?

—Do we always need an echocardiogram to differentiate a physiologic murmur from a "floppy valve?"

—Is the yield from annual proctosigmoidoscopy and barium enemas in an asymptomatic patient better than serial studies of stools for occult blood?

—Do we sometimes order studies in place of a good history and physical?

—Do we order studies without reviewing old data?

—Do we use the threat of a malpractice suit as an excuse to practice defensive medicine? Could we cope with the malpractice problem simply by asking the patient if he or she wants to spend $1,000 for a headache workup, documenting our thorough explanation, applying "tincture of time," and waiting to see if the headache proves transitory or not?

"Could we cope with the malpractice problem simply by asking the patient if he or she wants to spend $1,000 for a headache workup, documenting our thorough explanation, applying "tincture of time," and waiting to see if the headache proves transitory or not?"

"Teaching rounds are often 'chart rounds,' in which each physician participant . . . makes a contribution by suggesting a more sophisticated test."

Now is the time to act

The above list is not all-inclusive and could be expanded by any practicing internist. But just making lists and having a casual awareness is not enough. All physicians should be active participants in cost containment discussions, should organize and promote seminars for their staff members, and should encourage their hospitals to consider posting charges of laboratory tests and special procedures. Recent government meetings on the subject have asked that physicians lead the way in cost control. If we don't take positive action soon, it will be too late. □

TESTIMONY TO SENATE FINANCE COMMITTEE FROM THE CALIFORNIA HEALTH FACILITIES COMMISSION

The California Health Facilities Commission strongly supports S. 305, Senator Talmadge's proposed legislation to reform the hospital reimbursement system. The inclusion of incentives for efficiency is essential if hospitals are to operate as cost-effective enterprises. However, the Commission believes that the proposed reforms in the medicare and medicaid programs should be extended to Blue Cross, commercial insurance firms and out-of-pocket paying patients. We have always stood for reductions of cross subsidization between private and public payors and for the principle of equal pay for equal service. The Commission firmly believes that increases in overall hospital expenditures can be contained by linking annual adjustments in target rates of hospitals to general rates of inflation, as envisioned in the administration's approach to cost containment.

The California Health Facilities Commission is a State agency, currently operating the Nation's oldest uniform hospital accounting and reporting system. We are the principal data broker for hospital and long-term care information in California. The Commission has sought for the last 4 years to obtain legislative authority to review and approve hospital budgets, subject to clear efficiency criteria. We believe that this requires implementing an efficient and equitable reimbursement system across all payor groups for all California hospitals. With appropriate action in Washington, we can achieve that goal in California this year.

The proposed approach in S. 305 is long overdue. There is no doubt that hospitals differ a great deal in the efficiency with which they provide health services. The wage and case mix adjustments, and the bonus and penalty provisions incorporated in S. 305 constitute a major step forward in reforming the hospital payment system. Whatever payment system is finally adopted, it should explicitly recognize the key significance of short lengths of stay in determining target reimbursement rates. We are particularly pleased with the incorporation of incentives within medicare and medicaid payment rates for the closure and/or conversion of excess hospital capacity. In California, we have an estimated excess capacity of almost 20,000 hospital beds.

The Commission believes that three points should be strengthened:

Exemptions should be granted to States that already have or currently are in the process of obtaining prospective budget review programs. We agree that the Federal Government should pay for a portion of the start-up costs of state agencies implementing such prospective budget review programs, mandatory budget and rate review programs with incentives for efficiency should be conducted by independent agencies of State government.

The provisions of S. 305 should be extended to all hospital payors, effective cost containment should not be limited to beneficiaries of Federal programs. Cross subsidization of public patients by private patients amounts to a form of double taxation and should be reduced, if not eliminated. It is recognized that the hospital industry is not particularly competitive. There does not seem to be a good reason for restricting incentives to cost-effectiveness solely to the medicare and medicaid programs.

A linkup can be made between S. 305 and annual increases in total hospital expenditures through placing constraints on annual adjustments in target rates. Such constraints could conceivably be related to increases in gross domestic product deflator or components of the consumer price index. There is a need to link up efficiency reforms to measures to contain inflation of hospital expenditures.

Thank you.

COALITION OF INDEPENDENT HEALTH PROFESSIONS,
Office of the Chairman,
Rockville, Md., March 20, 1979.

Hon. RUSSELL B. LONG,
Chairman, Committee on Finance,
Dirksen Senate Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: The Coalition of Independent Health Professions (CIHP) appreciates this opportunity to testify on the crucial issue of hospital cost containment legislation. Our testimony will explain the interests of the member organizations of the coalition, review pending proposals for hospital cost containment and make specific suggestions for the best possible legislation to control hospital costs.

CIHP is a coalition of the ten following professional organizations: The American Occupational Therapy Association; the American Physical Therapy Association; the

American Society for Medical Technologists; the American Speech-Language-Hearing Association; the National Rehabilitation Counseling Association; the American Association of Pastoral Counselors; the National Association of Social Workers; the American Dietetic Association; the American Association of Bioanalysts; and the American Optometric Association.

The coalition collectively represents over a quarter million health care professionals providing services such as the following: Optometric services; occupational and physical therapy; speech, hearing and vision services; laboratory testing; dietetic services; rehabilitation counseling; and social work.

All these various organizations maintain high educational and training requirements for their members; some accredit clinical service facilities, such as hospital clinics; some accredit university training programs; nearly all certify the competency of professionals in their field. All organizations publish scientific or professional journals for their members.

The interest of CIHP in these proceedings arises from the fact that any hospital cost containment legislation could possibly affect the services delivered by our members. CIHP agrees with the President that hospital expenses are rising too fast and that many Americans are crippled as much by the cost of treating illness as by illness itself. We agree that strong hospital cost controls are needed. As you know, many organizations will make just such a statement and then say, "but our services should not be touched!" We will not repeat that refrain. Our organizations are willing to bear their part of the burden, but we do want to assure that the cost containment procedures are: (a) well thought out from both the cost and public health perspectives; and (b) implemented in a way that permits participation by those segments of the health care delivery system which are affected by the controls.

The President's proposal will evaluate increases in hospital costs which are incurred in inpatient care. We believe that this is preferable to previous proposals which would have been based on hospital routine operating costs. The effect of this provision is to encourage greater use of outpatient care. We believe that this is a sound distinction from a public health point of view. Outpatient care involves health services without the additional overhead of maintaining beds and support services for institutionalized patients. From the strictly cost perspective, outpatient care has not been identified as one of the inflationary factors pushing up hospital costs.

The President's plan would set a national voluntary limit based on (1) an inflation allowance for the cost of goods and services purchased by hospitals; (2) an allowance for population growth; and (3) an allowance for new services. This structure allows for the voluntary limit to expand within bounds of the general inflationary pressures beyond the control of the hospital sector.

Furthermore, states with their own cost control programs or states where the total increase in hospital costs is within the national voluntary limit would be exempt from the mandatory controls, should the voluntary limit be exceeded.

The mandatory program would apply to individual hospitals who would be given an allowable rate of increase in total inpatient revenues per admission. Again, low cost outpatient care would not be affected. Ech hospital would be granted an inflation allowance to cover its own market basket price increases including an allowance for the actual rate of increase in nonsupervisory wages occurring in that hospital. We would request that Congress carefully detail what is intended by that latter allowance. Legislation considered in the 95th Congress would have provided an allowance for increases for nonsupervisory personnel arising from collective bargaining agreements. This provision could have the effect of encouraging many of our members to join in unionization efforts. Under the NLRB, professionals who are not physicians or nurses are deemed to be a separate bargaining unit. While the issue of collective bargaining is left up to the individual practitioners who comprise the membership of our component organizations, we do feel it our duty to express to Congress what the effect of its proposals would be. If allowance for salary increases due to wage agreements achieved through collective bargaining becomes law, increased unionization among certain professions will no doubt result.

By the same token, limiting allowances to only low paid personnel will penalize many moderately paid professional employees. The bulk of our memberships, though highly educated, are not highly paid. And we believe that these of our members who receive salaries in the teens or mid-twenties should not have to pay the price for either inefficient administration or increases in costs that are out of their control. We propose that the allowance for wage increases for nonsupervisory personnel should not be limited to those covered by collective bargaining agree-

ments. This would avoid the ambiguity of the term "nonsupervisory" employees and would have no effect, one way or the other, on unionization.

We note that in its press release of March 1, 1979, the Senate Finance Committee Staff addressed itself to the specific question of reimbursement for outpatient hospital care. The Coalition of Independent Health Professions recognizes that there is indeed a problem with accounting techniques designed to pass the inflated charges from certain areas of service along to other more cost-effective services. This is an issue where oversight is warranted; however, any legislation which attempts to deal with this problem should be carefully drafted to insure that it does not come to serve as a deterrent to the alternative of outpatient hospital care or to the concept of community health centers and other free-standing clinics.

We are also concerned with the proposed approach to "stand-by" limitation for medicare-medicaid on allowable increases in ancillary hospital costs. Once again, we refer to the account juggling technique which can so effectively be used to administratively deal with inflated areas by "skimming" these accounts and applying the excess to more cost-efficient centers.

We are concerned that ancillary services not be restricted without a showing that excessive rises in the costs of these services are actually attributable to their delivery. The burden of effective cost containment should be equitably shared by the entire spectrum of health care professionals to the extent that excessive increases are actually attributable to the services in question.

Senator Talmadge's Medicare-Medicaid Administrative and Reimbursement Reform Act would establish a Hospital Facilities Cost Commission which would conduct continuing studies, investigations, and reviews of the reimbursement of hospitals for the care they provide. We believe that this Commission is an important component for continuation of cost control efforts. Cost containment legislation should provide that representatives of those services affected be permitted to participate in its implementation.

Under the President's bill, there would be a 15 member commission; 5 representing hospitals, 5 representing entites that reimburse hospitals, and 5 others. The proposed composition should specifically recognize the fact that a large part of the reimbursement program is incurred by nonphysician health professionals. It is naive to assume that hospital administrators, physicians or educated consumers will be sensitive to reimbursement programs affecting our members. Who on the Commission will be concerned if rehabilitation services in hospitals are eliminated in the name of cost containment so that unnecessary but lucrative surgical procedures may continue? Who on the Commission will be concerned that independent clinical laboratories will not be able to compete with hospital laboratories because of reimbursement policies? Who on the Commission will be an advocate for outpatient or home health care? Who will advocate use of appropriate nonphysician providers?

More importantly, basic fairness and the importance of involving all of us in the process of controlling health care costs means that the Commission should include at least two health care professionals, and that neither of these professionals should be physicians, nurses, or hospital administrators. We wish to make clear that hospital cost containment can broaden, not restrict, health care. No better example of this is available than H.R. 13097, which passed the House of Representatives in the 95th Congress. This bill would have applied $100 million in expected hospital cost savings to broaden the scope of benefits under Medicare. CIHP realizes that extension of benefits under Medicare or national health insurance will only occur under a system that limits costs and cuts waste and inefficiency. The expansion of home health care, development of preventive care programs and greater use of nonphysician health professionals will only come about within a system that is under control. We would urge this Committee to act quickly to transfer some of the savings from cost containment to the expansion of medicare benefits. Mr. Chairman, although CIHP was formed in 1970, this marks the first time that it has submitted a collective statement to the Congress. We expect this to be just the beginning of a long and active dialogue between CIHP and the Congress concerning health care policies.

Sincerely,

JAMES J. GARIBALDI, *Chairman*

STATEMENT OF THE COLLEGE OF AMERICAN PATHOLOGISTS

Mr. Chairman and Members of the Committee, the College of American Pathologists welcomes the opportunity to submit testimony on S. 505, the Medicare-Medicaid Administrative and Reimbursement Reform Act.

The College is a non-profit medical specialty organization of physicians with headquarters in Skokie, Illinois. We represent nearly 8,000 physicians who practice the medical specialty of pathology. College Fellows are certified by the American Board of Pathology.

Our members practice in hospitals, in independent medical laboratories, in medical schools, in military institutions, and in various facilities of the Federal, State and local governments. In addition, our members work in medical laboratory research institutions and in industries producing medical devices and in vitro diagnostic products.

During the hearings last year on S. 1470, Mr. Chairman, you commended the College for the positive statement we presented and complemented the College for our "cooperation and the spirit of cooperation which you have demonstrated with this Subcommittee and the Subcommittee staff."

We come before you this year, the third time we have submitted testimony on Medicare-Medicaid reform and cost containment, with that same spirit of cooperation. We hope we can again reach substantial agreement on areas of concern to both us and this Subcommittee.

The College supports a number of the principles embodied in S. 505. This Committee, in cooperation with private-sector health care organizations, can fashion a bill that will benefit the patient and the health care delivery system.

Last year the College presented to this Committee its position on the reimbursement of pathologists. It is important to repeat that policy statement.

The College: (a) Reaffirms existing College policy, that all pathologists' services are physicians' services and are an integral part of the practice of medicine; (b) Supports the definition of physicians' services that is contained in the Social Security Act (Section 1861(q)); (c) Continues College support of multiple approaches to contractual relations between pathologists and institutions; (d) Reaffirms College support of relative value scales that include suitable professional components for all pathologists' services as a satisfactory mechanism for reimbursement, and further, such relative value scales should include pathologists' services when performing autopsies; when providing quality control in the pathology department; when providing professional direction and supervision of departments of pathology; and when participating in educational programs related to patient services; and (e) Supports the use of appropriate relative value scales as well as other suitable reimbursement mechanisms for pathologists, in lieu of percentage agreements between pathologists and institutions.

The percentage contract is a standard arrangement in many areas and provides the basis for equitable arrangements for certain physicians practicing in hospitals. The concept of the percentage arrangement antedates the passage of Medicare by a considerable period of time. As Medicare evolved, so did the percentage contract. In fact, it was encouraged by the Social Security Administration as a desirable method of reimbursement. The regulatory authority was and still is charged with assuring that the services ordered by physicians are of high quality and that the charges made and fees paid for such services are inherently reasonable. The College has consistently recommended to its members that contractual arrangements between pathologists and hospitals should be fair to both parties and should not in any way interfere with the pathologists' ability to practice medicine in the best interests of the patient. The College has presented a number of uncontested studies that clearly show charges to patients are not in any way related to the pathologists' contractual arrangements.

It should be clear from this history and policy statement that we do not hold up any type contract as the "best" form of reimbursement. We support all reasonable and equitable methods of compensation. In lieu of the percentage contract, we have been willing to accept equitable alternatives such as fee-for-service with a professional component present for all clinical pathology procedures. We will return to this important point later in our testimony.

We would now like to address an issue that strikes all of us: rising costs.

Hospital cost containment

Mr. Chairman, the College was one of the first major specialty organizations to support the proposals developed by the Voluntary Effort on Hospital Cost Containment.

We are fully aware of the many complicated factors that affect the cost of health care and thus we cannot support simplistic proposals that purport to offer an easy solution. We are opposed to the concept of a mandatory cap placed on hospital expenditures. A mandatory cap, even when held in a stand-by status if a voluntary effort does not work, as proposed in S. 570, will not solve the dilemma of rapidly rising hospital costs. The experience this nation has had with mandatory wage and

price guidelines should be sufficient reason to seriously question the advisability of enacting legislation having mandatory cost controls hanging like the sword of Damoclese over this nation's hospitals. Our patients deserve better.

As we stated earlier, we strongly support the Voluntary Effort. We have communicated with our members the need for all physicians to cooperate in assuring the proper use of our health resources.

We have backed up our words of encouragement with solid recommendations to assit pathologists and others working toward this end. Recommendations are offered which could lead to a better understanding of the appropriate utilization of clinical pathology laboratory services and of the charges for such services. The College urges local and state voluntary effort cost containment committees to study these recommendations with the possiblity of including some or all of them in programs of cost containment developed by the committees.

We are proud to be the first major medical specialty to have developed cost containment recommendations for specific areas of medical care. These recommendations, in some form, are being used by a number of State and local cost containment committees. The national Voluntary Effort Committee has commended us on our effort and the American Medical Association has informed us that our recommendations will be included in their cost containment package being sent to all State medical societies.

Because of the importance we place on this policy position, we are including the six points of our program in our testimony and attaching a copy of the entire document to our written statement. The College recommendations are as follows:

1. *Pre-Admission testing.*—CAP Recommendation: State and local cost containment committees should consider supporting pre-admission laboratory testing programs for appropriate elective hospitalizations in an effort to reduce length of stay.

2. *Review of standing orders for laboratory services.*—CAP Recommendation: Each hospital should have a committee of its medical staff, which includes the hospital pathologist as a member, to review the appropriateness of all standing orders for laboratory services.

3. *Laboratory utilization.*—CAP Recommendation: (a) A continuing medical education program should be established at each hospital which should include guidance on the proper utilization of laboratory services; (b) Regular medical audits of patient care should include a component which carefully reviews the ordering of lab tests.

4. *Laboratory charges.*—CAP Recommendation: Voluntary cost containment committees should make an effort to emphasize to physicians the need for an awareness on their part of the charges generated by the ordering of commonly performed procedures, including laboratory tests.

5. *Role of training programs in teaching cost effectiveness.*—CAP Recommendation: Resident training programs should expose physicians in training to the appropriate utilization of the laboratory and to the charges resulting from that utilization.

6. *Common purchase of laboratory supplies.*—CAP Recommendation: Hospitals within a locality or region should investigate the joint purchase of high-volume laboratory supplies to receive volume discounts.

As you know, Mr. Chairman, the Blue Cross and Blue Shield Associations recently announced the phasing out of payments for "admission batteries" for medical (non-surgical) admissions to hospitals when the tests are not directly ordered by a physician. Blue Cross and Blue Shield also announced their intention to recommend to their member plans that routine payment be phased out for 26 diagnostic laboratory procedures now considered "outmoded, unnecessary, unreliable, or of no proven value."

The College of American Pathologists was consulted by Blue Shield and Blue Cross on the medical appropriateness of the 26 diagnostic procedures being phased out. These procedures were reviewed by the Committee on Guidelines for the Appropriate Utilization of Laboratory Procedures (GAULP) of the College, and comments were subsequently forwarded to the Council on Medical Specialty Societies and then to Blue Shield and Blue Cross.

The actions of the Blue Shield and Blue Cross Associations and the College's concurrence with the phasing out of routine payment for these procedures, are in keeping with both organizations' commitment to voluntary cost containment.

Mr. Chairman, the Voluntary Effort has had initial success in reducing the rate of increase of hospital costs. We strongly believe that effort should be allowed to continue. With the combined efforts of the hospitals, the physicians, and the health insurers of this country, meaningful reductions can and will occur. The College is dedicated to that effort. We urge others to so commit their organizations and members.

Our actions in attacking cost containment issues demonstrates our sensitivity to inflation, efficiency in the delivery of care, and real costs in the delivery of that care. We have also been active in another area of concern to this Committee, Medicare-Medicaid fraud and abuse.

Fraud and abuse

Mr. Chairman, when the bill that became the Medicare-Medicaid Fraud and Abuse Act (P.L. 95-142) was before Congress, the College submitted testimony in support of its concepts.

We continue to believe that many of the abuses and inequities the Committee perceives to exist in government health care programs can be corrected through proper implementation of P.L. 95-142.

The College has participated with the Department of Health, Education and Welfare Inspector General's office in implementing provisions of the Act. We have published in our official magazine, Pathologist, an article explaining the plans of Project Integrity as they relate to the clinical laboratory. We urged our members to cooperate with the persons carrying out this program. We continue to offer our cooperation in efforts to uncover and correct instances of fraud and abuse in the health care system. Those of our profession and specialty who violate the law should be brought to justice.

We were, and we remain, concerned by the tendency of some, in and out of Government, to arbitrarily reduce patient care utilization of the clinical laboratory or to develop rigid "cookbook" laboratory profiles into which the individual patient must be wedged. Exceptions to the rigid profiles are, in the minds of those urging curbing of utilization, at best, abuse—at worst, fraud. The College strongly believes this rigid approach to be counterproductive and not in the best interests of the patient.

The concept of what constitutes appropriate utilization of laboratory procedures is a complex question. Through the College's Committee on Guidelines for the Appropriate Utilization of Laboratory Procedures, we are addressing that issue.

We have also offered our cooperation to the National Council on Health Planning Subcommittee on Productivity and Technology, a group which will address the complex question of proper utilization of health and medical procedures and technology.

Care must be taken in assessing what was improper utilization and what may be called overutilization. We hope the Government, in its zeal to bring benefit and cost concepts into line, does not oversimplify this complex issue, as it is attempting to do with the complex issue of the cost of hospital care.

Mr. Chairman, the College has been very responsive in areas of concern of this Committee. When we came before you three years ago to testify on S. 3205, you urged us to come forward with concrete proposals to address such issues as cost inflation and fraud and abuse. We believe we have done so. Our record over the past three years speaks for itself. We also gave this Committee firm recommendations on ways to address the sensitive issue of the reimbursement of pathologists. We worked with you and the staff of the Committee on an equitable compromise. Yet, problems remain.

We preface our remarks on physicians' reimbursement reform with the caution that in this era of extreme cost sensitivity, changes in reimbursement methods which abrogate systems that have been in effect for some time should be made with care, for the unintended consequences may be worse than the perceived problem.

Section 6—Physician reimbursement reform

Mr. Chairman, this section of your bill proposes to: (1) redefine physicians' services as contained in section 1861(q) of the Social Security Act; (2) redefine what constitutes pathology services as provided by a physician; and (3) limit reimbursement to a physician who is compensated under what is known as a percentage arrangement. We will address each point in sequence.

Redefinition of physicians' services

The College opposes any redefinition of physicians' services as is suggested in section 6(a)(1) of the bill. We support the existing definition as stated in section 1861(q) of the Social Security Act: 'The term "physicians' services" means professional services performed by physicians, including surgery, consultation, and home, office and institutional calls.

We believe that it is not appropriate to address a reimbursement problem by trying to arbitrarily change the time-honored definition of physicians' services. Such change will be at the expense of all in the health care system—the patients, the providers, the insurers, and the Government.

Section 6 proposes to amend existing law by stating that a service is a physicians' service except any service that a physician may perform as an educator, an executive or a researcher; or any professional patient care service unless the service (a) is personally performed by or personally directed by a physician for the benefit of the patient, and (b) is of such nature that its performance by a physician is appropriate.

Although this change appears under the heading of hospital-based physicians it must be perfectly clear that the proposed change would affect all physicians because of its location in the statute. The impact on many physicians by such a redefinition would be profound even though its implications may not yet be widely appreciated in the medical community. Physicians employing physicians' assistants, nurse practitioners, operating room and obstetrical technicians, laboratory and X-ray technologists and technicians, anesthetists, respiratory technicians, dieners, pathology assistants, and EKG, EEG, EMG, etc.—all such physicians ultimately would be affected.

The proposed redefinition of physicians' services has been put forth as a cost containment measure. In fact, DHEW in its Fiscal Year 1980 Budget estimated that redefining hospital-based physicians' services to be only those personally performed and personally directed would save $55 million. Although we have had no access to the Department's supporting data, we must question this proposed savings. It is possible that the cost to the program may increase by changing to a cost-based system forcing pathologists to be more concerned with what they do with their hands rather than what they do with their minds.

The College is of the opinion that the redefinition as it appears in subsection (a)(1) would seriously impair the administration of the Act. Defining the term "personally performed by or personally directed" would inevitably lead to a complex maze of regulations. For example, we wonder how these regulations would define "personally directed" in an equitable fashion assuring optimal patient care. We also believe that inevitably, complex regulations would result in so much red tape as to impair the quality of physicians' services provided to patients.

The redefinition is not a cost containment measure. It is a major reordering of the nature of the practice of medicine which we believe to have a secure foundation in history. It is a "reform" that is in reality a revolution. The practice of medicine will change dramatically. Historically, all activities of physicians customarily recognized as part of the physicians' practice have been reimbursed as a physicians' service. We submit that this is indeed the case today. A physician is practicing medicine not only in his role administering individual patient care, but also in his medical role as a physician/patient educator, researcher into patient problems and supervisor of the clinical pathology laboratory.

We wholeheartedly support the American Medical Association, which stated in its testimony (June 7, 1977) on S. 1470:

"The writers of regulations, armed with this proposed statutory language, could arbitrarily change the practice of medicine as recognized today to the detriment of both the patient and the profession.

"Whatever its intent, a legal definition which states that a physician acts as a physician only when directly treating a patient and when performing services only a physician can perform will ultimately lead to confusion in the Medicare program and further dismemberment of health care.

"Furthermore, the physician as educator, researcher, or administrator does not cease to be physician; indeed, since the earliest days of the medical profession, teaching and research have been recognized as intrinsic parts of the practice of medicine. As medicine has become more organized and technologically sophisticated, administrative tasks have developed which can be performed most effectively only by a practicing physician.

"We protest strongly any artificial division of the physician's role."

Mr. Chairman, we strongly urge the Committee to recognize what this redefinition is—a restructuring of the practice of medicine—not a simple cost containment measure. Thus, we strongly urge the deletion of section 6 from this bill.

Pathology services

Subsection (a)(3) proposes to specifically redefine pathology services in a manner very similar to the general redefinition of physicians' services as discussed above. Our preceding comments apply quite well to this redefinition of pathology services, for it proposes to arbitrarily restructure what is and is not a physician's service in the delivery of clinical pathology services.

Much of this testimony which we presented on S. 3205 and S. 1470 and which is a part of those hearings, described what a pathologist is and what he does. We will not repeat this in detail today. However, a brief summary of those views appears appropriate.

Pathology is that speciality in the practice of medicine that deals with the causes and consequences of disease and with the diagnosis, treatment and prognosis of patients, using primarily laboratory methods developed from the biological, chemical and physical sciences.

As the basic science most closely related to clinical medicine, and the clinical discipline closest to basic science, pathology is often called the bridge between the basic sciences of anatomy, biochemistry, genetics, microbiology, phsiology, and pharmacology, with such clinical disciplines as internal medicine, surgery, obstetrics, and gynecology and pediatrics.

Separation of the services provided by pathologists to patients and other physicians is inappropriate.

We of course recognize that payment for didactic classroom teaching and basic research is not one of the objectives of the program. When we speak of patient care, we speak of providing laboratory data and clinical pathology consultation essential for the assessment, diagnosis, treatment and management of disease in the individual patient. When we speak of education, we speak of the need for the pathologist to educate the attending physician in a consultative role on patient-based matters. When we speak of research, we speak of the development or refinement of procedures for daily use to improve the care of the individual patient.

As these functions are normally provided concurrently during the pathologist's daily practice, they are inseparable.

Because it is a large and complex field, pathology practice is usually subclassified by the following two major categories: (1) Pathology, which deals with the gross and microscopic structural changes caused in tissues by disease; and (2) Pathology, which is concerned with the functional change produced by disease as reflected in blood, urine, and other body fluids and tissue.

The close interrelationships between these areas consolidate the specialty in practice.

There is actual medical judgment and the potential for medical judgment in every pathology service.

For example, the autopsy is medically indispensible. It is a procedure that must be performed by the physician. We refer you to our testimony submitted on S. 1470 (June 7, 1977) and on S. 3205 (July 29, 1976) which comments extensively on the importance of the autopsy and its recognition as a physician's service.

The statement that supervision and quality control are "appropriately performed by non-physician personnel" recognizes only a small part (the manual-technical portion) of the responsibilities often performed personally by technical personnel, but does not recognize that the policy and procedure setting, standardization, evaluation and action initiation must be the medical responsibility of the pathologist director of the laboratory. This is especially critical for the hospital laboratory. Because a non-physician can under certain circumstances perform designated delegated quality control and supervisory functions, this fact does not change the existence of or the nature of the physician's service in quality control and supervision and the clear patient-related services that these represent. This is in itself a cost containment program. Years ago, all services offered by a pathologist were personally performed by him. What do you think the cost would be today if this type of service were still required?

We believe that the unique services provided by pathologists as the medical director of the clinical pathology laboratory are most appropriately provided by a physician. Who would want anyone other than a physician evaluating the quality control data pertaining to a test required by you or a member of your family on an emergency basis when release of a misleading result or withholding of an accurate critical value from your physician could lead to a delay or some inappropriate treatment.

This situation is clearly recognized in section 6(a)(2), anesthesiology services, where the difficult-to-define term, "personally performed," is stated to mean, among other things, "personal participation in the most demanding procedures in this plan * * * and assuring that a qualified individual, who need not be his employee, acting under such physician's direction, performs any of the less demanding procedures which the physician does not personally perform."

This situation exists in the clinical pathology laboratory. This is what a pathologist does. This committee must recognize that what holds true for anesthesiology, as quoted above, holds true for the pathologist in the clinical pathology laboratory.

There is strong evidence to support the CAP position that there is a professional (physician's) component in every laboratory procedure. This evidence is based on not only actual daily practice, but also legislative and regulatory history.

In every-day practice, the pathologist must correlate clinical data, test results, and other data to determine a diagnosis for a patient. The requirement for this decision-making transcends the arbitrary division between personally performed or personally supervised.

This is why clinical pathologists review abnormal results and, by various techniques, the routine statistical quality control procedures in their day-to-day work (e.g., the College of American Pathologists' Quality Assurance Service). These services are not always obvious but they are physicians' services nonetheless.

Because of their medical training and experience, pathologists can see warning flags in subtle abnormalities, which take on meaning not only in a single test but in the context of multiple tests.

Mr. Chairman, all fifty states of this Union have successfully defined medical practice in their laws. None of those laws require a physician to perform every medical function personally.

But as a physician engaged in the practice of medicine, the pathologist is held accountable by law for the services performed by those he employs, supervises or engages to perform medical services based on his medical judgment.

We believe that the definition of physician services should remain as presently stated in the Medicare law. Singling out any group of physicians for special treatment would be a radical change from Congress Medicare policy.

If laboratory services are appropriately recognized as containing a physician's component, then a common complaint expressed by many—there is no review over pathologists' fees—could be answered effectively. Through the process known as direct professional component billing, the pathologist joins his office-based colleagues in being subject to usual customary and reasonable fee charge screens, thus applying existing mechanisms mandated by law to monitor the reimbursement of pathologists. It should not, however, be the objective of the program to restrict a pathologist's reimbursement, regardless of the quantity or quality of the services that pathologists provide.

The College has consistently supported the concept that there should be multiple avenues available to physicians and their institutions to develop contractual arrangements which are sufficiently versatile to accommodate the many varied local conditions. For this reason, it has been difficult to classify these arrangements and compare them—just as it has been difficult to compare institutions. These problems were clearly seen in the Arthur Anderson & Co. study on hospital-based physician compensation (DHEW/HCFA/Office of Policy, Planning, and Research Contract No. 600-76-0055). This difficulty was further compounded by requirements of the Federal Government, some of the carriers and intermediaries, and the several State licensure boards, that a hospital list for its pathologists (or the pathologist record for himself) the breakdown of his time between such categories as teaching, research, supervision, etc., without there being a clear-cut, acceptable set of definitions available to all who were attempting to cooperate. The result has been that there was widespread variation in the interpretation of these categories by capable people, resulting in considerable variation in the subsequent apportionment of reimbursement responsibility between the Federal trust funds and the Medicare carriers. This paper distribution of funds in no way changes the responsibility of a pathologist and the services he provides to patients.

The professional component method for compensation of pathologists has been subject to some of this variation. Considering past history, this is understandable. The College believes that the total function of a pathologist as a physician providing services to patients should be included in this professional component. We have communicated to this Committee the basis of professional component development and implementation. We do not believe that non-patient-related education or basic research should be included as a physician's service under Part B of Medicare. The College has plans to communicate to its members through its Professional Relations Committee and through the mechanisms of its publications, meetings and seminars, the position of the College with recommendations that these guidelines be given careful consideration when developing a contract. By these methods, including clear descriptions of our testimony on Medicare reimbursement reform, we hope to lessen these variations and to facilitate the operation of the program and the processing of third-party claims.

The provision of clinical laboratory services has had a number of interpretations over the years, both legislatively and in regulation. It is clear,however, that the existence of a physicians' component in each clinical pathology procedure is recognized.

Although there was some controversy over how to treat hospital-based physicians during the time surrounding the passage of Medicare in 1965, the legislation which

finally passed placed hospital-based physicians with their clinical colleagues, under Part B, to a large extent because of the strong sentiment in Congress against any major disruptive effect on the contractual arrangements between physicians, hospitals and patients. The details on managing the Medicare program were yet to be determined by regulation, but the issue had clearly been joined in Congress and those who favored treating hospital-based physicians the same as all other doctors prevailed.

Further, a review of the legislative history suggests that no major discussion seems to have taken place concerning any distinction between a physician's service to an individual patient, and a physician's service benefitting patients in general. It further appears that pathology services were without qualification assumed to be "physicians' " services.

The Committee bill also makes it clear that items, supplies, services of aides, etc., that are incidential to physicians' personal services would be covered in the hospital, clinic, home, or office and regardless of whether the bills are rendered by the hospital, the physician, or both. For example, the change would make it clear that a laboratory test would be covered whether performed in the physician's office or whether the physician sends the specimen to an independent laboratory and regardless of whether the physician or the laboratory bills the patient. If the test is performed in an independent laboratory, standards contained in the Committee bill, which are described below, relating to laboratory services of independent laboratories would apply * * *.

(Senate Report (Finance Committee) No. 404, June 30, 1965, p. 42.)

In addition, there appeared to be a consensus that both sides of the hospital-based physician reimbursement issue wanted to avoid influencing physicians' contractual arrangements. Thus, Senator Douglas (reflecting the view of a number of Senators) at the hearings stated: "In summary, the amendment would permit reimbursement under the basic hospital plan for the hospital services of radiologists, pathologists, anesthetists, and psychiatrists only where the specialist receives payments for his services from the hospital rather than rendering his own separate bill to the patient. Nothing in the amendment interferes with coverage of his services under the voluntary plan (Part B) if he renders individual bills, nor does the amendment take one side or the other in what the arrangement is to be between the hospital and the specialist."

The Committee Reports published after enactment confirm the Congressional intent that hospital-based physicians should be treated the same as office-based physicians. As stated in the Conference Report of the House Ways and Means Committee: "Scope of Services-Specialists: The House excluded physicians' services in the field of pathology, radiology, psychiatry or anesthesiology from basic hospital insurance benefit—but provided for their payment under the supplementary voluntary medical insurance program * * *. The Conference adopted the House version."

The intent of Congress appears to have been that pathology services are to be reimbursed as a Part B service regardless of the mode of billing, a legislative result endorsed by Congressman Hall from Missouri: "I am particularly delighted that in amendments 70 and 141 the position of the House prevailed, and that the professional services involving involuntary servitude for certain medical specialists was removed."

Provisions that appear in the regulatory implementation of Medicare lend strong credence to the proposition that there exists an identifiable physician component in each clinical pathology laboratory procedure.

The Secretary, DHEW, in section 1871, was directed to develop "such regulations as may be necessary" to carry out the administration of the program. To this end, the Secretary promulgated a number of reimbursement principles.

Recognizing the great difficulty of applying the required procedures to the high volume of individual clinical pathology laboratory procedures (as compared to volume of surgery, for example) the regulation writers provided for an optional method of calculating the "provider component" and the "professional component" of pathology services.

Significantly, this approach recognizes the presence of a professional component—"an identifiable service requiring performance of the physician in person." This very important principal is reflected in 42 CFR 405.483(c)(2): (2) With respect to pathology services, for example, an individual entitled to Part B benefits under Title XVIII of the Social Security Act (in connection with a hospital stay, or in connection with a series of out-patient diagnostic tests) will, on the average, have multiple laboratory procedures which in the aggregate permit the assumption that at some point with respect to at least some of the laboratory services there has been "an identifiable service requiring performance by a physician in person."

The regulations also specifically recognize the hospital-based physician's right to bill his Part B charges directly. Principal 6 provides that "where the physician bills the patient directly, costs of operating the hospital department which are borne by the physician will be reflected in his reasonable charges which are compensable under the supplementary medical insurance program (42 CFR 405.486(a))."

Mr. Chairman, the College believes there exist both "real world" and legislative/regulatory-history reasons for the recognition of a physician's component in all clinical pathology laboratory services.

There are many ways this physician's component may be computed. One method is a system of relative value schedules. Another method is fee-for-service billing with an identifiable professional (physician's) component. In both instances, it is necessary to allow for local and regional variations.

It must be emphasized that these methods of reimbursement, which the College supports, do not involve a disguised percentage arrangement.

The physician's component is a part of every item of clinical pathology laboratory service. The physician's component is not necessarily a uniform "across-the-board" fraction, but is determined separately for each item. Items requiring a higher level of personal involvement, observation, and/or interpretation by the pathologist will have a high physician's component. Conversely, items requiring a lesser level of personal involvement, observation, and/or interpretation by the pathologist will have a lesser physician's component. Whatever the physician's component, it must include the pathologist's contribution toward maintaining professional and technical standards. Even in the case of services with a lesser physician's component, there is no way of foretelling which particular service will require more individual attention and special interpretation by the pathologist beyond his usual involvement in establishing procedures, evaluating methods, judging the competence of technical personnel, determining abnormal results outside expected norms, and other medical services. Thus, every procedure performed in the department of pathology, including the clinical laboratories, involves an actual as well as a potential consultation by the pathologist. We would again state that the requirement in S. 505 of what constitutes personal services in anesthesiology, as discussed earlier in our testimony, also clearly applies to the clinical pathology laboratory.

Mr. Chairman, because of what we believe to be clear legislative history supporting our position, we urge that provisions redefining physicians' services and pathology services be deleted from your bill. Last year, during the markup on S. 1470, these provisions, then contained in section 12, were deleted from the bill. The reasonableness of our arguments was evident at that time. We believe they are still reasonable and we urge the Committee to take a similar action by striking section 6 from S. 505.

We would now like to turn our attention to the question of the percentage arrangement.

Mr. Chairman, last year during hearings on S. 1470, we attempted to set the record straight—the College does not hold up the percentage contract as the most desirable method of pathologist reimbursement. In fact, the College has a policy statement presented earlier in this testimony stating that we suggest a multiplicity of contractual arrangements.

Compensation arrangements between pathologists and institutions vary widely, depending upon local settings. Each is custom-made to meet the varying needs of the pathologist, the institution and the patient population.

Limitation on percentage arrangements (section 6(b)(2) plus (c) plus section 19)

Section 6 of S. 505 also proposes to limit Medicare reimbursement in situations where percentage arrangements are used. Section 19 restricts contractual arrangements based on income or receipts. We note with approval the exceptions to this restriction of arrangements which promote "efficient and economical operation of the health service."

The key factor in any of these arrangements is that they are agreeable to each of the parties involved. And whatever the reimbursement method, their job descriptions and responsibilities are mutually agreed upon by the pathologist, the medical staff, and the hospital administration; and then the entire professional and contractual arrangement is reviewed and approved by the hospital board of trustees.

No single form of contractual arrangement can fit every situation. The CAP believes that any type of contract is acceptable, providing it does not interfere with, or impair, the free and complete exercise of medical skill and judgment, or does not tend to deteriorate the quality of medical care.

None of which alters the fact that the rate charged for a particular unit of hospital service, including a pathology service, can vary widely from institution to institution. Rates for specific laboratory procedures must be evaluated as part of the

study of the per diem charge, per illness charge, and patient mix not exclusively on the basis of the service itself.

During the recent past, many stories have appeared in the press alledging unreasonable reimbursement to pathologists on percentage arrangements. Examples have been cited by this Committee. DHEW contracted with Arthur Andersen & Co. for a study, the results of which alledged unusually high incomes for pathologists on percentage arrangements as compared to other forms of compensation.

As pathologists, we have doubts as to the validity of the results of that study by DHEW. Thus, we have contracted to have a comparison done between the DHEW study and a study contracted for by the College several years ago. Our study used a larger data base. We believe our study holds fewer biases than the DHEW study. Preliminary results (final report not yet available) suggest the following:

(1) Like those of the Arthur Andersen study, the CAP data indicate salary arrangements are associated with lower average FTE earnings than percentage arrangements, but the magnitude of the differential is very much smaller in the CAP sample data. Moreover, the size of the differential is as would be expected, still smaller when contributions to fringe benefits are added to cash payments.

(2) Owing to data limitations, it is not possible to confirm or deny the Arthur Andersen finding that salary arrangements and teaching status are closely associated with each other.

(3) Results were obtained from the CAP sample which directly conflict with the Arthur Andersen conclusion that pathologists in small hospitals tend to earn more on a FTE basis than those in medium and large hospitals. Moreover, estimates of the difference in average earnings per FTE in large hospitals is negligibly different from that for medium-sized hospitals.

(4) The necessary data is not available from the CAP sample to explore the Arthur Andersen conclusion that earnings are higher in hospitals which get a greater share of their revenues from cost reimbursement, and that FTE earnings "are closely associated with the gross and net revenues of the departments in which they work." However, these are neither implausible nor surprising results.

(5) There is considerable basis to doubt the validity of the Arthur Andersen conclusion that pathologists in the West make almost double the earnings of those in the Northeast. Moreover, average earnings in the West appear to be lower than in the North Central and South. Finally, on this score, the CAP survey data shows a notable similarity of earnings cross regions, albeit with a smaller, but notable, disadvantage for those in the Northwest.

(6) The single most important difference in the results of the two surveys is the smaller differences in earnings by almost any distinguishing characteristic—e.g., type of arrangement, region—exhibited by the CAP survey in comparison with the much smaller Arthur Andersen survey.

The College believes the foregoing adds credence to the position that it is not the type of compensatory arrangement that is the cause of these apparent inequities but rather application of the compensatory arrangement.

Nevertheless, we recognize the deep concern of this Committee over increasing health costs. It is possible that the percentage arrangement, utilized in situations where government and third party payors mandate cost reimbursement, may lead to unreasonable reimbursement to a pathologist.

However, it is difficult to determine what level of compensation is unreasonable in the absence of knowledge of the quality and quantity of the services provided. It is possible that the public perception of pathologists has been unfairly altered to one of a physician who is a businessman first and a doctor second—We know that is not the case and we believe this Committee knows that a pathologist is first and foremost a physician concerned with the well-being of the patient. We also recognize that pathologists must be good businessmen in order to assist in the voluntary effort to control hospital costs.

Mr. Chairman, in keeping with the sense of cooperation we mentioned earlier, we offer to this Committee a course of action that would: (1) Delete section 6 as it now appears in the bill; (2) Remain consistent with College policy which states that the College will accept equitable alternative forms of reimbursement in lieu of the percentage arrangement; and (3) Allow for the development of a system where pathology and pathologists' fees are reasonable and subject to the same type of review as all other physicians as might be done through appropriate review of global and/or professional component billings.

First, we urge the Committee to delete section 6 of the bill.

Second, the College refers the Committee to section 19 of S.505 which would restrict the use of contractual arrangements based on income except in those circumstances where the Secretary will develop regulations establishing exceptions

to the prohibition if the reimbursement is reasonable and the percentage arrangement—"(1) is a customary commercial business practice; or (2) provides incentives for the efficient and economical operation of the health service."

We would be pleased if section 19 were removed from the bill. Authority to achieve intended goals exist in present Medicare regulations. However, because of the changes in several features in section 19 which are improvements over the original section 40 of S. 3205, we would not oppose retention of section 19.

Third, we urge the Committee to include in the form of Committee Report language on this bill a statement recognizing the right of pathologists to employ multiple forms of reimbursement, including fee-for-service professional component billing for all clinical and anatomical pathology services.

Mr. Chairman, we believe this course of action we offer is a significant step in physician reimbursement reform. It will not lead to incalculable problems for the Medicare program and the physicians of this nation, as would the provisions of section 6 as presently contained in S. 505.

Lease arrangements: Section 19 and section 6(b)(1)

Mr. Chairman, we believe that features of section 6(b)(1) and section 19 are internally inconsistent and would have an adverse effect on the lease arrangements and Mutual Working Agreements (MWA) which have, in appropriate circumstances, allowed pathologists and hospitals to provide quality services to patients in a fashion desirable to all. In section 6, although appropriate lease arrangements are recognized ((b)(1)), compensation would be limited to that which would have been reimbursed had an employment relationship existed. This provision would effectively interfere with the freedom to contract for one's services. Further, it would markedly decrease flexibility for the program and curtail availability of services, especially in some rural areas. Furthermore, this could and probably would increase the costs to the institutions because of the necessity of compensation for all aspects of the physician's reasonable requirements including deferred compensation, all varieties of insurance (life, health, workman's compensation, malpractice), vacation benefits, etc., which are now provided by the pathologist under the lease arrangement. In this regard, we are very pleased that there is mention in section 19(b) that exceptions to the restrictions on percentage and lease arrangements may be recognized.

We believe it would be prudent for the Government to continue to allow for leases and MWAs as is presently permitted in 42 CFR 405.486(a). In this fashion, the total (global) fee for the clinical pathology laboratory service will be clearly identified and available for review by third party payors in a fashion similar to all other physicians.

The lease arrangement has received considerable bad press because of its unfortunate linking to Medicaid Mills. The lease arrangement we speak of bears no resemblance to those methods employed by Medicaid Mills. To our knowledge, most pathologists who have a lease or MWA are not on a percentage-of-the-charges basis. We repeat that a lease or a percentage arrangement with a pathologist is in no way comparable to that situation alleged to have existed between lay-operated laboratories and Medicaid Mills.

The lease arrangement is the most effective means of providing laboratory services to numerous hospitals in this country. For the benefit of those who may not understand the need for this type of arrangement, the following points may be of help:

1. *Regionalization.*—Lease contracts enhance the opportunity to reduce costs and charges by regionalization of specialized pathology services within groups of intitutions and/or pathologists, thereby facilitating cost accounting and minimizing economic barriers which might exist.

2. *Small Institutions.*—Lease arrangements, especially when facilitated by regional cooperative agreements, will accommodate the needs for provision of services to small hospitals. A significant percentage of the seven thousand acute-care hospitals in the United States have fewer than one hundred beds. These are in need of clinical pathology consultation and specialized services which can be provided in many instances most appropriately and economically on a lease-based, fee-for-service arrangement. Development of transportation, communication and courier mechanisms can bring the patients in small hospitals comprehensive pathology services of high quality.

3. *Clerical and Billing Costs.*—These costs can be minimized if the volume of the clinical pathology laboratory develops to a significant degree. This is often facilitated by cooperative regional arrangements combining laboratory facilities and services on a shared or cooperative basis among several institutions, some of which may be small.

4. *Taxes.*—The entire pathology department is maintained on local, State, and Federal tax rolls. The amount varies but does contribute to the local economy by paying appropriate sales and/or property taxes as do other independent practitioners of medicine.

5. *Hospital Control.*—It is often stated that hospitals lack appropriate controls under lease arrangements. This does not actually occur in practice. Pathologists are physicians on the medical staff with specified privileges, responsibilities, and duties. Quality and quantity of the medical services provided are under constant internal surveillance. In addition, the administration, board of trustees, and staff physicians can all act as "patient advocates." This is not a myth; it operates as a fact. In addition, a review with the patient, doctor, or hospital is promptly set in motion if the patient feels that the pathology fees are inappropriate for the services provided. Finally, contractual arrangements can be varied locally as appropriate to provide for adequate control without interfering with professional judgment.

These points touch upon the many advantages of a lease arrangement. It would appear appropriate for the Secretary to approve lease-type arrangements under circumstances where a lease promotes regionalization of certain services; facilitates the availability of a wide variety of medical and nonmedical professional personnel; assists a hospital in maintaining the total fees for clinical pathology laboratory services well within the guidelines established for a region; or facilitates provision of services in locations and settings for which such services are not available or would not be available under alternative methods of arrangement and/or compensation. In addition, provisions should be included for continuation of presently existing lease arrangements which have been deemed acceptable by local medical staffs, boards of trustees, intermediaries and carriers, and others, and would thereby be deemed "ordinarily" acceptable under the general guidelines. It would seem inappropriate for the Secretary of DHEW to become involved in receiving requests for permission to provide pathology laboratory services under a lease arrangement and act on such requests on an individual basis. Many areas of local professional and fiscal review presently exist to ensure the appropriateness of such arrangements. Our recommendation above would be consistent with the existing Medicare law which states:

"Section 1801. Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person."

Mr. Chairman, we will now comment briefly on several other sections of the bill.

One hundred percent reimbursement for pathology services: Section 6(d)(3)

Section 6(d)(3) offers a proposal that appears to restrict to those physicians accepting assignment the established procedure for reimbursing in-patient pathology services at the 100 percent payment level.

We must oppose this restriction for the same reasons that prompted the Congress to amend the Medicare law in 1967 so as to clearly provide for 100 percent reimbursement for pathology and radiology services to hospital in-patients, provided by physicians specializing in pathology and radiology. (See Senate Finance Committee Report No. 744, 1967.)

The problem is presently dramatized in those areas where fiscal intermediaries have arbitrarily reintroduced 80 percent reimbursement limits for clinical pathology laboratory services provided to hospital in-patients when referral to an off-premises reference laboratory is required, while continuing 100 percent reimbursement for work performed in the hospital's own laboratory. If the Committee so desires, we will provide details on this situation.

This arbitrary interpretation of Medicare regulations is especially discriminatory against patients in small hospitals. We urge that this practice be eliminated.

Criteria for determining reasonable cost of hospital services: Section 2

Mr. Chairman, earlier in this testimony, we expressed our support of the Voluntary Effort. We also presented what pathologists are doing to contain hospital costs.

Although we approve of many of the concepts put forth in your hospital cost containment proposal, we fear its implementation would create an unmanageable bureaucratic problem. We agree that physician services such as those provided by a pathologist should be excluded from "routine operating costs." We also agree that laboratory services should be classified as "ancillary services."

We also fear that the limiting of cost increases to general economic indicators will lead to insensitive rationing of health care. Cost control measures must reflect productivity and the increasing technology of health care.

We are pleased to see section H (i) and (ii). These exceptions recognize changing concepts in hospital care. For example, there are indications that a rapid, complete diagnostic work-up may lead to shorter lengths of stay. One recent study from Strong Memorial Hospital in Rochester, New York, ("Annals of Internal Medicine" 90: 243-248, 1979) indicates that decreasing laboratory charges may be related to physician education and an increase in automated battery testing.

The College believes the creation of a Health Facilities Cost Commission is a commendable action. However, we are concerned that the proposed Commission membership does not clearly indicate physician participation. Physicians should be deeply involved in the operations of any such commission.

In subsection (e), authority is given to the Commission to secure any data necessary. The College believes language should be included to indicate that no physician or patient-identified data may be collected by the Commission.

Agreements with physicians to accept assignments: Section 5

The College believes that the wording of this section creates a discrimination against hospital-based physicians, pathologists in particular. Subsections (c)(2) (B) & (C) specifically exclude pathologists who direct bill from benefits of the administrative cost savings allowance.

We would recommend that these discriminatory provisions be eliminated.

Use of approved relative value schedules: Section 7

The College strongly supports the use of relative value schedules. The procedural terminology developed should not be too rigid as to restrict scientific advancement. In addition, any RVS should be permissive enough to reflect variations in services such as is seen between inpatient and outpatients. We strongly urge that the Secretary be instructed to utilize the extensive work due on procedural terminology by major professional organizations.

The College has long been involved in the development of nomenclature for use in the clinical pathology laboratory. With the ever-increasing advancement and complexities in the provision of quality laboratory services, the need for a systematized, standard nomenclature increases. The College has taken the lead in developing such a system for the laboratory with the development of a Systematized Nomenclature for Pathology (SNOP). We will be pleased to work with the Secretary in the development of procedural terminology for pathology.

The College long ago recognized the value of appropriate use of relative value schedules. As far back as 1961, the College developed a relative value schedule for pathologists' services and updated this schedule several times. Its use by the College was terminated by a consent decree signed by the College with the U.S. Department of Justice.

The College welcomes the inclusion of relative value schedules as a basis for establishing a method of reimbursement for physicians. Further, the College maintains that such relative value schedules must contain a physician's component in every clinical pathology laboratory procedure.

Teaching physicians: Section 8

The College supports the extension of the implementation date of section 227, Reimbursement of Teaching Physicians, until October 1, 1979.

Furthermore, the College is on record as supporting the repeal of section 227.

Section 227 came about because of alleged practices uncovered in several teaching institutions. With the passage of the Medicare/Medicaid Fraud and Abuse Act (P.L. 95-142), the need for section 227 as a tool to combat abusive practices was eliminated. This law builds a number of safeguards into the system which would prevent those practices that resulted in the development of section 227.

Section 227 would exclude consultative services as presently provided by pathologists from qualifying as physicians' services. The implementation of section 227 could have the effect of making pathology, as is practiced in teaching institutions, a non-physician service. The creation of this class of pathologists and the schism it creates between academic pathologists and those in other institutions is totally unacceptable.

The proposed regulations are redefining physicians' services, and in doing so, classifying many pathology services as non-physician services may result in the restructure and downgrading of pathology departments in teaching institutions.

Certain surgical procedures performed on an ambulatory basis: Section 9

The College supports the recognition that regulations should facilitate provision of quality medical care in various settings for the benefit of the patient. However, the

College does oppose the required taking of assignments which is prejudicial to both the patient and the physician.

The development and administration of regulations that would be required to the use of an "all-inclusive" fee would be a serious bureaucratic problem. We strongly urge the Committee to reconsider this proposal.

Criteria for determining reasonable charge for physicians' services: Section 10

Sections (a)(1) (C) and (E) provide for the establishment of a lowest charge level for medical supplies, services, and equipment, and prevailing charge levels for each state.

Because of many factors involved in determining the cost of a clinical pathology laboratory service, it is inappropriate, if not impossible, to apply a lowest charge level to such a service. In some instances, the utilization of lowest charge levels for reimbursement may be appropriate for medical supplies and equipment such as hospital beds and wheel chairs. To group clinical pathology laboratory services with manufactured medical supply items, ignores the varying components present in the delivery of laboratory services. A good example of this problem is a recent proposal by the Health Care Financing Administration to include such complex and variable tests as hemoglobin electrophoresis and microscopic examination for parasites under the lowest charge level concept.

Laboratory services may vary in quality from one laboratory to another in a given locality. Determining the cost of such services is a very complex issue. If this determination is to be meaningful, one must evaluate all the elements of cost associated with the testing process and consider the cost and value of what happens as a result of that testing. The availability of services must be considered. In each element of cost, there must be recognition given to the professional input of medical direction, supervision and responsibility provided at all levels by the pathologists.

What elements of cost would be considered under the lowest charge level? Does the lowest charge level refer to only the actual physical performance of the test, or does it include the entire service provided, beginning with the test order and ending with the return of the final results to the patient's chart? The services required by patients vary considerably on the patient's location and medical condition. Costs of collection, preparation of tests and transmittal of results are costs which may or may not be included. For the same type of tests, the fee charged may legitimately vary depending on whether 9 A.M. to 5 P.M. weekday or 24-hour emergency availability is required. If the lowest charge level is to apply only to the physical performance of the test, it would not take into account other critical components of a procedure and is therefore incomplete. If the lowest charge level includes the whole spectrum of providing the laboratory service, then this section will create an administrative nightmare for carriers trying to develop the multiple fee profiles required.

It is our belief that the implementation of a lowest charge level system of reimbursement for laboratory services could result in the following:

Subjecting laboratory services to price comparison would be misleading. There are many factors such as availability, specificity, sensitivity, pickup service, reporting, overhead expenses, and others which must be considered. Clinical pathology laboratory services are not numbers generated by machines.

The lowest charge level wrongly places emphasis on procedures that can be automated rather than procedures that are appropriate. Test procedures are done by varying methods under varying situations. Some tests may be automated in one situation and not in another.

The administration of a lowest charge level method of reimbursement will be hopelessly complex.

Charge differentials would have to be developed depending on the specimen sources (arterial, capillary, venous), time of day, location of patient (rural, urban, suburban), patient's age, general availability of services and other factors.

The philosophy behind our discussion of concerns over a lowest charge level is in many ways appropriate to the development of prevailing charge levels for each state. Such prevailing fee development must take into account the location and circumstances under which the service is provided. Was it in-patient or out-patient? Was it routine or emergency? Did the laboratory obtain the specimen? Was it a preprocessed specimen?

We urge careful consideration of these points in developing prevailing charge levels for each state or its economic region. We also recommend elimination of laboratory services from the lowest charge concept.

Hospital providers of long-term care services: Section 13

The College is opposed to the mandatory cost reimbursement for ancillary services provided for in subsection (cc)(1)(B)(ii). This provision would encourage inefficiency

and the development of unecessary on-site laboratories. Extended care facilities often do not require full-time or even significant part-time pathology laboratory services. Services are often provided by a private practitioner of pathology through a hospital or independent laboratory. The concept of direct billing as presently provided for under the Medicare law must continue to maximize cost-savings and efficient delivery of care.

Disclosure of aggregate payments to physicians: Section 23

The College approves of and supports this section which would prohibit the release of reimbursement information on individual physicians.

Deductibles not applicable to expense for certain independent laboratory tests: Section 26

The College has been opposed to the implementation of section 279 since its inclusion in the Medicare program. The removal of the $60 deductible will not correct the basic problems presented by section 279—the difficulty in applying the mechanisms of a negotiated rate and the lack of resulting savings to the program.

Payment for laboratory services under medicaid: Section 27

The College is strongly opposed to the concept of competitive bidding. This provision in the past has led to restricted patient and physician rights, and slipshod and fraudulent work.

We foresee a serious degradation of quality in the delivery of laboratory services to Medicaid beneficiaries under competitive bidding. We strongly believe that a number of major problems would exist under competitive bidding: (1) competitive bidding ignores a primary aspect of laboratory services—quality—and concentrates instead on the sole criterion of cost; (2) competitive bidding could lead to a reduction in competition in a locality and resultant monopolistic practices; (3) competitive bidding could result in loss leader pricing situations and marketing strategies; and (4) competitive bidding could affect timeliness of services by increasing turnaround time which will inevitably increase costs for patient service.

It has long been the position of the College that the delivery of clinical laboratory services is the provision of medical services. The choice of a laboratory by an attending physician is a function of that physician in providing medical services to his/her patient. The physician-director of a clinical laboratory is dedicated to the provision of quality laboratory services at a reasonable cost to the patient; not "cost-effective" laboratory services at a reasonable level of quality. We believe that competitive bidding either forces a laboratory to provide the latter type of service or forces from the marketplace the laboratory unwilling to compromise quality. Thus, we fear that competitive bidding will be devastating to laboratories attempting to provide a broad spectrum of truly quality laboratory services.

Confidentiality of PSRO data: Section 28

The College strongly supports this provision. In order for the PSRO program to function appropriately, it is necessary that physician-patient identities and information remain confidential.

Development of uniform claims forms: Section 31

The College believes that uniform claims forms developed should be versatile, appropriate, and contain the minimum amount of information required.

In addition, any such form developed must allow for the use of attachments to provide for those circumstances where the inclusion of information on the uniform form is not possible.

We support the development of uniform claims forms when developed in consultation with physician and hospital organizations.

This concludes our testimony on S. 505. The College of American Pathologists appreciates the opportunity to submit our comments. We know they will receive careful consideration.

COLLEGE OF AMERICAN PATHOLOGISTS

Recommendations on the Voluntary Effort on Hospital Cost Containment

As approved by the Board of Governors of the College of American Pathologists, August 1978

The College of American Pathologists supports the Voluntary Effort on Hospital Cost Containment. This program is sponsored on a national level by the American Medical Association, the American Hospital Association and the Federation of American Hospitals, and now is being implemented on the state and local level.

In an effort to assist pathologists and others working toward the containment of health care costs, the College has set forth recommendations which it believes could lead to a better understanding of the appropriate utilization of clinical pathology laboratory services and of the charges for such services. The College urges local and state voluntary cost containment committees to study these recommendations with the possibility of including some or all of them in programs of cost containment developed by the committees.

The College will serve as a national repository for reference materials on the following recommendations. Materials will be made available on request.

I. PRE-ADMISSION TESTING

Laboratory testing prior to admission for appropriate elective hospitalization may reduce length of stay, which may reduce the total cost of the hospitalization. Patients should report to the hospital laboratory for their pre-admission laboratory testing. Upon admission to the hospital, test results would become a part of the inpatient record. To facilitate the inclusion on inpatient records of pre-admission testing done outside of the hospital, the testing laboratory should conform to the attached policy guidelines established by the College of American Pathologists.

CAP Recommendation: *State and local cost containment committees should consider supporting pre-admission laboratory testing programs for appropriate elective hospitalizations in an effort to reduce length of stay.*

II. REVIEW OF STANDING ORDERS FOR LABORATORY SERVICES

Each medical staff should have a committee of its members to review all standing orders, including standing orders for laboratory services. This committee may be the utilization review committee, medical audit committee, or some other committee which has the responsibility of peer review in their hospital. Standing orders which are not appropriate (in this context, appropriate refers to both overutilization and underutilization) contribute unnecessarily to the cost of hospitalization. The committee which reviews standing laboratory orders should have the hospital pathologist as a member. The committee should review both the standing orders for admission as well as standing orders (including "daily orders") for inpatients.

CAP Recommendation: *Each hospital should have a committee of its medical staff, which includes the hospital pathologist as a member, to review all standing orders for laboratory services.*

III. LABORATORY UTILIZATION

Frequently duplicate testing is done on patients who have been admitted to the hospital from the emergency room where initial laboratory tests were ordered. Efforts should be made to expedite the transfer of test results from the emergency room to the inpatient chart to avoid duplicate testing.

The medical staff should be sure that an analysis of laboratory test ordering by the medical staff is a component of the regular medical audit of total patient care.

The medical staff of an institution must have available to it a ready source of up-to-date information on appropriate procedures in laboratory medicine.

CAP Recommendation: a. *A continuing medical education program should be established at each hospital which should include*

guidance on the proper utilization of laboratory services. b. Regular medical audits of patient care should include a component which carefully reviews the ordering of laboratory tests.

IV. LABORATORY CHARGES

In caring for the patient, the individual physician decides the course of treatment which includes the ordering of laboratory tests. A physician obviously cannot be expected to know the charge for each item or service ordered for the patient. However, physicians should be aware of the customary charges for commonly performed procedures, including laboratory services.

Often the charges for laboratory tests may be determined not so much by the cost of providing the procedures, but by the hospital's need for revenue from the pathology department to finance other non-revenue producing services. Thus the laboratory charge frequently includes, in addition to the direct laboratory costs and indirect expenses, a component adequate to enable laboratory charges to help support non-revenue producing departments. The voluntary cost containment committee should educate itself and the members of the medical staff concerning this practice and the extent to which it alters laboratory charges in their hospital.

A recent study has shown[1] that, when corrected for inflation, direct laboratory costs *per admission* in both teaching and non-teaching hospitals were lower in 1976 than in 1972, showing that "pathology departments on both the practice and academic setting (have) achieved cost containment." Every pathologist should strive to continue to be sensitive to the direct laboratory costs which are, or should be, under his control. However, no amount of cost sensitivity in the laboratory can affect indirect costs or contributing margins, the most prominent of which is general inflation.

CAP Recommendation: *Voluntary cost containment committees should make an effort to emphasize to physcians the need for an awareness on their part of the charges generated by the ordering of commonly performed procedures, including laboratory tests.*

V. ROLE OF TRAINING PROGRAMS IN TEACHING COST EFFECTIVENESS

The overall concept of the cost of medical care must be taught to young physicians in their training programs. Resident physicians should be knowledgeable of not only the proper utilization of the laboratory but also should be aware of the resultant charges. In the past, emphasis has been placed on scope or completeness of the workup. This is appropriate provided the studies are required.

The following recommendation is consistent with the National Commission on the Cost of Medical Care's recommendation No. 38, as approved by the AMA House of Delegates.

CAP Recommendation: *Resident training programs should expose physicians in training to the appropriate utilization of the laboratory and to the charges resulting from that utilization.*

VI. COMMON PURCHASE OF LABORATORY SUPPLIES

Considerable savings can be realized by the purchase of laboratory supplies in large volume. Hospitals should investigate the possibility of combining their orders on supplies that are commonly used in order to receive the most advantageous discount. In those areas where a good working relationship between hospitals exists, common purchasing of high volume supplies should be investigated.

CAP Recommendation: *Hospitals within a locality or region should investigate the joint purchase of high volume laboratory supplies to receive volume discounts.*

---

1. Straumfjord, Jon V., Jr., Report of Committee on Quantification of Resources Need for Academic Clinical Laboratories to Association of Pathology Chairmen, 1977.

COLLEGE OF AMERICAN PATHOLOGISTS
POLICY STATEMENT

PRE-ADMISSION DIAGNOSTIC TESTING

A. A single high quality of pathology laboratory service should be available to all patients whether they are ambulatory or are admitted to a hospital.

B. Alternate responsibility for the determination of the acceptability of laboratory determinations for use by committees of a medical staff should rest with the individual medical staff involved.

C. Laboratory procedures performed prior to admission of hospitalized inpatients, which are to be included in the official hospital medical records, must be performed in a laboratory acceptable to the hospital medical staff and which meets standards at least as stringent as those of the hospital's laboratory and;

D. Laboratories providing laboratory procedures used by the hospital's Utilization Review Committee (or other similar committee) for the purposes of current review, must meet standards acceptable to the hospital's medical staff which must be at least as stringent as those of the hospital's laboratory and;

E. Laboratories providing laboratory procedures for these purposes must meet, where *applicable*, one or more of the following conditions:

1. Maintain standards at least equal to the CAP Inspection and Accreditation program

or

2. Maintain standards required for certification under title XVIII (Medicare Law)

or

3. Maintain standards required by the Clinical Laboratory Improvement Act of 1967

or

4. Maintain standards as required by the Joint Commission on Accreditation of Hospitals

or

5. Maintain standards as required by state licensure laws and/or regulations

and

F. These laboratories should provide test procedures as required to ensure that the medical staff can discharge its medical responsibility to its patients. Procedures should be performed within a medically appropriate time interval prior to admission, i.e., within 72 hours in most cases.

G. All physicians must assume the moral, legal, ethical and professional responsibility for the services they provide or which are provided under their direction.

H. Nothing in the implementation of concurrent utilization review should compromise the ability of hospital pathologists to provide laboratory services to patients.

AMBUCARE INTERNATION, INC.,
Coral Gables, Fla., March 20, 1979.

CHAIRMAN, SUBCOMMITTEE OF HEALTH,
Senate Finance Committee,
Washington, D.C.

DEAR MR. CHAIRMAN: As planners, developers, managers and consultants for ambulatory surgical facilities, Ambucare International, Inc. of Coral Gables, Fla., is deeply interested in the issue of medicare reimbursement. We have monitored since April of 1974, DHEW efforts to study whether services provided by ambulatory facilities results in more economic provision and more effective utilization of services.

The purpose of the study, "Comparative evaluation of cost, quality and systems effects of ambulatory surgery performed in alternative settings," was to determine whether legislative authority for the medicare program should be amended to permit reimbursement of facilities' fees to freestanding ambulatory surgical centers. Under current law, reimbursement of physicians' fees may be made for surgery performed in any setting, but payment of non-physician costs in a freestanding center is precluded. Present law recognizes only hospitals, skilled nursing facilities and home health agencies as providers under medicare.

The study was originally scheduled for 2 years, but was subsequently amended and extended to the point where the study was not published until December 1977. We have attached a copy of the executive summary for your use.[1]

The study confirmed what we had already known. Costs for the same procedures in ambulatory surgical facilities were substantially lower than both hospital inpatient units (55 percent less), and hospital outpatient units (15 percent less). The quality of care was judged at least as good as that provided in other surgical facilities. The negative impact of these freestanding surgical facilities on the communities health care system was relatively minor and temporary, and overall the community appeared to suffer no harm.

We believe that the findings of the study support our contention that freestanding ambulatory surgical centers are capable of delivering quality surgical services to the aged at substantially lower costs. As an example of a procedure that generally falls within the medicare age group, is cataract extraction. There are approximately 400,000 cataract procedures performed annually. There is conservative savings of $700 for each procedure performed on an outpatient basis. If all cataracts could be performed on an outpatient basis, there would be a potential savings of $280 million! Obviously, not all Medicare age patients will be candidates for outpatient surgery for many reasons. However, our surgeons inform us that conservatively, more than half of their patients can tolerate outpatient cataract surgery.

It is estimated that between 20–35 percent of all surgical procedures can be performed on a same-day basis. The American College of Surgeons "Socio-Economic Factbook for Surgery 1978" lists 20.1 million surgical operations performed in 1976. The potential for savings is enormous!

Those of us managing free-standing ambulatory surgical centers have been involved in negotiations with insurance carriers the past 7 years to get them to change their reimbursement mechanisms such that they would not encourage inpatient institutionalized care. We have seen that insurance coverage that pays 100 percent of inpatient care and only 80 percent of outpatient care forces the patient and doctor to elect the more costly inpatient care for the mere reason that it involves less out-of-pocket costs to the patient. Most of the major insurance carriers have removed this regressive reimbursement mechanism from their health insurance policies, and pay outpatient facilities on parity with inpatient facilities. Medicare remains the only principle third party payor which does not reimburse freestanding surgical centers. We cannot understand why it has taken so long to consider payment for an alternative health delivery mode. This type of procrastination tends to remove any initiative to try innovative approaches to health care delivery.

Last year, the Senate added the provisions of (S.1470), Senator Talmadge's proposal "Medicare-Medicaid Administrative and Reimbursement Reform Act" to a tariff bill (H.R. 5285) in the closing days of the 95th Congress. The provisions of the bill would have allowed Medicare reimbursement on the basis of an all-inclusive, prospectively established rate to freestanding ambulatory surgical centers and to physicians performing surgery in their offices. Payments would have been made for selected surgical procedures the Secretary (DHEW) determined could be safely and appropriately performed on an ambulatory basis.

---

[1] Study made a part of the committee files.

Report No. 95-1111 of the 95th Congress which accompanied H.R. 5285 dated August 11, 1978, contained a description of "Certain Surgical Procedures Performed on an Ambulatory Basis" in Section 6. On page 17 of that report are the following two sentences that we believe are essential if the Congress intends to support this cost-saving, innovative delivery system:

"Similarly, reimbursement would be provided for the use of facilities in an ambulatory surgical center, without deductible or coinsurance, where the center accepts assignment."

"The deductible and coinsurance would be waived for the physician fees for services performed in connection with listed surgical procedures in hospital outpatient departments and other ambulatory surgical centers where the physicians accept assignment."

This bold concept that provides an incentive to the surgeons and the patient to have the surgery performed on an outpatient basis is what is needed to influence the procedure to be performed in as low a cost setting as practical.

I did not see this provision included in bills S.505 and S.507. We would request your consideration of provisions contained in section 6 of Senate Report No. 95-1111 of the 95th Congress which accompanied H.R. 5285 when you draft legislation to permit medicare reimbursement for free-standing ambulatory surgical facilities.

Thank you for your consideration.

DONALD O. GUSTAVSON,
Vice President, Planning and Development.

STATEMENT OF THE AMERICAN HEALTH CARE ASSOCIATION

INTRODUCTION

The American Health Care Association is pleased to submit the following comments on S. 505, the Medicare-Medicaid Administrative and Reimbursement Reform Act of 1979 introduced by Senators Talmadge and Dole, Chairman and Ranking Minority member of the Senate Finance Health Subcommittee. We consider this legislative proposal a positive and meaningful approach to improving the complex problems and reducing the excessive costs of the medicare and medicaid programs. AHCA commends Senators Talmadge and Dole for their efforts and particularly for their willingness to incorporate constructive suggestions made with respect to similar legislation considered in the 94th and 95th Congresses.

As the Nation's largest organization representing long-term care facilities, we will confine our statement to the specific provisions relating to long term care.

OPPOSITION TO REPEAL OF REASONABLE COST-RELATED REIMBURSEMENT

AHCA supports enactment of S. 505 but we wish to express great concern over a recent development which could have a substantial and adverse impact on both providers and beneficiaries of long term care services under medicare and medicaid. Committee staff has raised several alternatives designed to result in cost savings in health programs for consideration by committee members.

One of the alternatives would repeal section 249 of the 1972 Social Security Act Amendments requiring that State medicaid payments to providers of nursing home care be on a "reasonable cost-related basis." AHCA is unalterably opposed to the deletion of Section 249 and urges the defeat of any effort to include it on a hospital cost containment bill.

The requirement of "reasonable cost-related reimbursement was enacted by Congress in 1972 but did not go into effect until January 1, 1978. The 1972 Senate Finance Committee report specifically states why this requirement was adopted:

"Under medicaid, States have been free to develop their own bases for reimbursement to skilled nursing facilities and intermediate care facilities * * * Concern has been expressed that some skilled nursing facilities and ICF's are being overpaid by medicaid, while others are being paid too little to support the quality of care that medicaid patients are expected to need and receive."

"The committee bill would require States to reimburse skilled nursing and intermediate care facilities on a reasonable cost-related basis . . . This approach is preferable to the arbitrary rate setting currently in effect in some States which provide no incentives to facilities to upgrade the level of care provided."

Under this requirement States must use acceptable cost-finding techniques to determine reasonable reimbursement. Many States have developed innovative reimbursement methodologies—many in fact have moved to so-called prospective systems with incentives which are similar in principle to section 2 of S. 505. While we recognize that HEW has recently sought to impose restrictions on the State's

flexibility to devise appropriate payment systems, we do not believe it wise to jeopardize reasonable cost-related reimbursement plans developed as a direct result of Section 249. That is not to say HEW's efforts to pressure States should not be limited but this should be done while retaining the present system.

Repeal of "reasonable cost-related reimbursement" is wrong for three essential reasons:

(1) There exists little justification for abandoning a rational reimbursement concept (albeit a system which is not perfect and subject to HEW harassment) and returning to one which this committee found arbitrary and where the discretion granted the States in setting rates opens up the potential for abuse. For every State that retains or initiates a legitimate system (e.g., use of a rate setting commission) there may be another where the state adopts questionable procedures unrelated to the costs of providing quality care in order to cutback on medicaid dollars.

(2) No assessment can be made of the actual impact of "reasonable cost-related reimbursement" systems since the requirement has only been in effect for a little over a year. There is no evidence to demonstrate that this requirement has not met the dual objective of encouraging development of payment systems which would adequately reimburse providers while protecting against "windfall" profits or unjustifiably low payments. Indeed the facts would suggest otherwise, that satisfactory methodologies are being developed.

(3) The repeal alternative is being raised as a cost containment proposal with a potential savings estimated at perhaps $250 million. AHCA is convinced that in all but a few states, state legislatives and Medicaid agencies can look on repeal of section 249 as the signal for limiting payments for Medicaid services. The potential adverse consequences for the delivery of adequate care to patients in nursing homes is obvious. We do not believe the beneficiaries or the providers should be sacrificed without a full and complete understanding of the consequences.

We now turn to the specific provisions of S. 505.

PAYMENTS TO PROMOTE CLOSING AND CONVERSION OF UNDERUTILIZED FACILITIES

HOSPITAL PROVIDERS OF LONG-TERM CARE SERVICES

There has been considerable discussion in recent years of the feasibility of simultaneously solving the problems of too many hospital beds and too few long term care beds by converting existing acute care beds to nursing home beds. AHCA believes this concept has practically no validity in the case of patients requiring truly long term and multidisciplinary care, and only limited potential in the case of post-hospital convalescent patients. Such a conversion policy may be feasible and beneficial only in a small number of rural localities in the nation.

Section 3 of S. 505 provides for including in hospitals' reasonable cost payments, reimbursement for capital, and increased operating costs associated with the closing down or conversion to approved use (including long term care) of underutilized bed capacity or services in non-profit short-term hospitals. Section 13 of S. 505 establishes a simplified reimbursement formula which would assist rural hospitals in using acute care beds for needed long term care services.

As we have indicated, AHCA has a fundamental concern as to the ability of hospitals to provide the unique care and living arrangements required by persons needing long term care. We further question the premise that cost savings occur with a conversion policy as we believe that paying off the debt on the unneeded hospital space makes more sense than financing a conversion. Finally, we are quite concerned about the uncertain economic implications for existing nursing homes if a broad scale hospital conversion policy is undertaken without adequate controls.

For the above reasons, we would urge that a cautious approach is most appropriate and that any program to encourage conversion be carefully tested on a limited basis. We would, therefore, support the provisions set out in S. 505: The limitations of section 3 to not more than 50 hospitals and the reimbursement formula in Section 13 restricting applicability to rural hospitals with less than 50 beds which have been granted a certificate of need. In addition, we believe that reimbursement for medicare and Medicaid patients using "converted" beds be at rates established for long term care facilities. We also believe that it is essential that hospitals meet the appropriate standards set forth in the medicare and medicaid conditions of participation for nursing homes at least with respect to the converted beds.

FEDERAL PARTICIPATION IN HOSPITAL CAPITAL EXPENDITURES

AHCA supports the provision in Section 4 of S. 505 which makes clear that the capital expenditures limitation under Section 1122 of the 1972 Social Security Act

Amendments does not apply to simple changes of ownership of existing and operational facilities which create no new beds or services.

Section 1122 of the Social Security Act was added as part of the 1972 amendments as a means of coordinating the Medicare, Medicaid, and Maternal and Child Health programs with Federal and State health planning efforts.

Specifically, Section 1122 gave the Secretary the right to withhold payments to hospitals or nursing homes for expenditures attributable to capital projects or to the purchase of expensive equipment where a designated state planning agency finds the expenditures to be in non-conformity with statewide or area-wide health plans.

Section 1122 requires that a proposed capital expenditure (as defined in the law) must be reported to the designated planning agency at least 60 days prior to the date on which it is expected to be incurred. The agency must then make a determination as to whether the proposed expenditure is reviewable, and if so, whether or not it conforms with the standards and criteria contained in applicable health planning laws and regulations. Medicare and Medicaid payments can subsequently be reduced to an institution which either (1) failed to give required notice of a capital expenditure, or (2) was found to be in non-conformity with applicable health plans.

A significant problem has arisen in the implementation of this legislation. HEW has interpreted the present statutory language to require notice, review, and approval of simple changes of ownership of existing operational health care institutions—an outcome clearly unintended by Congress in 1972. As a result, many purchasers or lessees of facilities have been forced to jump through a meaningless bureaucratic hoop, and in some instances, purchasers have had a difficult time obtaining financing because of the uncertainty created. More unfortunately, many others, unaware of the requirement for prior notice, have had substantial Medicare and Medicaid reimbursement disallowed even though the facilities were in conformance with all planning requirements before and after the change of ownership.

AHCA believes Section 4 contains the necessary statutory clarification to establish the original intent of Congress that the sale or lease of an existing and operational health care facility would not be classified as a capital expenditure subject to review under Section 1122 where no new beds or services are created in the transfer of ownership. We would hope that the Committee would also suggest in report language that HEW take cognizance of this intent and forego making disallowances in those pending cases where health care providers may be liable for reimbursement penalties for failure to give timely notice to a planning agency of a simple sale or lease.

REIMBURSEMENT RATES UNDER MEDICAID FOR SKILLED NURSING FACILITIES AND INTERMEDIATE CARE FACILITIES

As the Committee knows, there has been controversy as to the ability of States to include a profit factor or incentive payments in their reimbursement systems for nursing homes participating in the Medicaid program. We believe the statutory language and legislative history of Section 249 of the 1972 Social Security Act Amendments which requires reimbursement on a reasonable cost-related basis is clear in permitting states to include such allowances. Unfortunately, HEW regulations issued to implement Section 249 were preceded by a preamble which implied that profit allowances, if adopted by a state, were to be restricted to a return on invested net equity. AHCA challenged the preamble limitation arguing that the limitation is not required by law and effectively prevents the establishment of incentive-based payment systems. As a result of litigation, "reasonable cost-related reimbursement" has now been construed by the federal courts and HEW to permit opportunities for the earning of profits.

We therefore strongly endorse the Committee proposal's intent to statutorily clarify that states have the option of including incentive allowances related to efficient performance in reimbursement formulas under Section 249. In view of the confusion which has existed, however, we believe it would be useful for the Committee to consider modifying the proposed language so as to specifically encourage flexibility in the development of payment systems and to assure that such systems are cost-effective and attract the capital investment necessary to provide sufficient nursing home beds and services. We, therefore, recommend that the Committee recognize in statutory language that incentive payments may include a profit factor or growth factor where the provider retains the difference between the actual costs and the established rate (whether based on "target" rates, ceilings, or a prospective class system). A statement to that effect in the statute would provide the certainty needed in this complex area.

MEDICAID CERTIFICATION AND APPROVAL OF SKILLED NURSING AND INTERMEDIATE CARE FACILITIES

The intent of Section 15 is meritorious—to foster uniformity in the application of federal standards in the certification and approval of long term care facilities in the Medicare and Medicaid programs. The proposal would transfer final certification authority for Medicaid only facilities from the states to HEW so that all skilled nursing and intermediate care facilities in Medicare and Medicaid would come under an HEW certification process. We remain skeptical that such a transfer will in fact result in uniform application of health and safety standards. The unnecessary complexity, paperwork, duplication of inspections by federal, state and local health, licensure, and other related and unrelated authorities seem doomed to continue as long as these agencies refuse to recognize standards and surveys on a reciprocal basis. Consolidation of certification and decertification authority under HEW may be a positive step if implemented to provide expeditions, consideration of certifications and foster application of uniform standards by the various surveying agencies.

AHCA supports efforts aimed at insuring prompt and fair resolution of disputes concerning the fitness of long term care facilities to serve as providers of care in the Medicare and Medicaid programs. While only a small number of facilities ever become the subject of a decertification action, it is vital that public confidence in the quality of nursing home care be maintained. We believe the vesting of final authority with HEW should improve the current situation and that the provision requiring a hearing prior to cutting off federal funds to the facility (except where there is a written determination of an immediate and serious threat to resident's health and safety) assures adequate safeguards for the rights of providers.

VISITS AWAY FROM INSTITUTION BY PATIENTS OF SKILLED NURSING OR INTERMEDIATE CARE FACILITIES

AHCA continues its endorsement of this provision which encourages visits away from an institution and recognizes the therapeutic value. A flexible policy on such visits can be an extremely positive step.

RESOURCES OF MEDICAID APPLICANT TO INCLUDE ASSETS DISPOSED OF AT SUBSTANTIALLY LESS THAN FAIR MARKET VALUE

AHCA believes the change proposed in Section 24 of S. 505 is long overdue and eliminates an area of abuse which has been an embarrassment to the Medicaid program and a fraud on the taxpayer.

The abuse occurs when individuals divest themselves of personal assets such as real property for the purpose of establishing eligibility for medical assistance.

This practice appears to be particularly widespread when nursing home care is required or anticipated to be required. Because of the present Federal law, it is literally possible for persons to give away substantial holdings to their children or to others on one day, and enter a nursing home at taxpayer's expense the next. The National Governors' Conference has referred to this problem in a number of its reports on the need for reforms in the Medicaid program.

At the root of the problem is the fact that a federal statute, Title XVI of the Social Security Act, outlines eligibility requirements for the Supplemental Security Income program. Thirty-five states have elected for good reasons to extend Medicaid benefits to all SSI-eligible persons. However, because the Federal statute does not prohibit a person from obtaining SSI eligibility through divestiture of his or her resources, states are also obligated to provide free medical care to such persons along with those whose financial need is genuine.

States which have endeavored to enact restrictions on this practice by state law have run afoul of the Supremacy Clause. We are pleased the proposal has addressed this problem and strongly endorse the approach taken.

We are concerned, however, that the specific proposal is too narrowly drawn in that it would apply to transfer of assets for subetantially less than fair market value for only the period of twelve months prior to Medicaid eligibility determination. We note that the President, in his budget message, has proposed a prohibition on eligibility for SSI or Medicaid for up to 24 months for applicants who within 24 months prior to application transferred resources without adequate compensation which, if retained, would have made the applicant ineligible for benefits. We recommend that Section 24 be amended to extend the restriction to a period of two years prior to application for Medicaid.

REMOVAL OF THREE-DAY HOSPITALIZATION REQUIREMENT AND 100 VISIT LIMITATION FOR HOME HEALTH SERVICES

Section 29 of S. 505 repeals the three-day hospitalization requirement for home health services under Medicare. We recommend that this provision be expanded to include elimination of the three-day prior hospitalization requirement for the use of skilled nursing facility care. We believe such a change would: (1) provide Medicare beneficiaries with greater flexibility in their long term care coverage, and (2) result in lowering overall costs for both the patient and the Medicare program.

The current restriction is arbitrary, unnecessary and burdensome. There are many individuals who are otherwise eligible for skilled nursing care but because they are not acutely ill or do not require the complete and costly diagnostic and therapeutic resources available in hospitals cannot be admitted to a SNF with Medicare eligibility. There are also those who abuse the program by arranging for unnecessary (and costly) hospital stays in order to become eligible for SNF Medicare benefits. In addition, there are individuals receiving hospital care who would benefit as much from SNF care but who are not transferred to an SNF because of the paperwork (e.g., transfer of medical records, treatment plan) and the lack of any financial incentives or disincentives (e.g., no cost sharing is required after first hospital and until the 61st day).

The above situations are encouraged by the three-day requirement. The removal of the requirement would recognize the legitimate needs of individuals who require only skilled nursing services and thus eliminate these artificial situations. Because the cost of Medicare covered services in an SNF is far less than the routine cost per day in a hospital, the potential for program cost savings are obvious. Direct admission to an SNF would also mean that an individual otherwise qualified for Medicare benefits would not be faced with a choice between spending substantial personal resources to pay for SNF care and seeking unnecessary hospital care.

To the extent that the three-day requirement was intended by Congress to assure that a medical evaluation of the individual's condition demonstrates the need for skilled nursing services, we believe that alternative means such as physician certification and concurrent utilization review can provide the necessary assurance and satisfactorily replace the hospital stay requirement.

STUDY OF AVAILABILITY AND NEED FOR SKILLED NURSING FACILITY SERVICES UNDER MEDICARE AND MEDICAID

AHCA is pleased to support Section 34 which would require HEW to conduct a six month study and investigation of the availability and need for skilled nursing facility services under the Medicare and Medicaid programs.

During the last Congress the Committee adopted a proposal to require that skilled nursing facilities participate in both Medicare and Medicaid but the Senate approved a change to require the study which now has been included as part of S. 505. AHCA opposed mandated dual participation for several reasons virtually all of which related to inadequacies of the Medicare program. These problems still exist—paperwork, lack of full reimbursement, low utilization of benefits, etc. Dual participation would not have solved these problems, only exacerbated them and created new ones—forcing some facilities to drop Medicaid participation so as to not be coerced into Medicare, others to alter basic philosophy and programming by adopting a short-term convalescent component incompatible with long term chronic care.

AHCA acknowledges that in recent years there has been a substantial reduction in the number of Medicare participating facilities and that in some areas beds have been unavailable for beneficiaries of the Medicare program. The reasons, of course, have been the very problems noted above. These problems need to be addressed and improvements made in the structure and operation of the program. If fundamental reforms can be made in the program, long term care facilities would participate in Medicare. We remain skeptical of the dual participation concept but we believe an effort by HEW to identify deficiencies in Medicare and propose legislative and regulatory changes can be a major forward step for both beneficiaries and providers and correct the shortage of Medicare beds. We believe the Committee's report language should clarify that the principal purpose of the study is to determine what problems exist in the Medicare and Medicaid programs which have led providers to choose not to participate. We also do question whether the six months time framework is sufficient to adequately fulfill this objective.

STUDY OF CRITERIA EMPLOYED FOR CLASSIFYING A FACILITY AS A SKILLED NURSING FACILITY

We believe Section 37 of S. 505 requiring HEW to review the criteria for determining whether a facility is a "skilled nursing facility" for purposes of renewal of Medicare benefits is meritorious.

Under present law, Medicare benefits are extended and limited by what is defined as a "spell of illness." In order to become reentitled to a new round of benefits, an individual must end one spell of illness and begin another. A spell of illness can only be ended by the lapsing of 60 consecutive days during which the individual is not an inpatient in either a hospital or skilled nursing facility.

Individuals often remain in a skilled nursing facility for long periods of time receiving intermediate or custodial care and are unable to become reentitled to Medicare benefits when needed because of the literal fact that they are inpatients of a skilled nursing facility. This long standing inequity deserves to be removed at the first opportunity.

CONCLUSION

Let me conclude by urging the Committee to proceed expeditiously on the mark-up and reporting of S. 505. AHCA believes that S. 505 is on target in its overall approach and concept. Although, as we have indicated, minor modifications would improve some of the particular provisions. Our major concern is that regarding repeal or modification of Section 249 requiring reasonable cost-related reimbursement for facilities participating in Medicaid. For the reasons already expressed, AHCA opposes repeal of Section 249 without a thorough evaluation of its effectiveness and the consequences of deletion.

We again wish to thank the Chairman for eliciting the cooperation of the many groups affected by this legislation. The results are evident. S. 505 is realistic and constructive legislation which recognizes that the deficiencies in current programs must be corrected before any attempt to expand benefits can be seriously contemplated.

HOSPITAL ASSOCIATION OF RHODE ISLAND,
Providence, R.I., March 20, 1979.

MICHAEL STERN,
Staff Director, Committee on Finance,
Washington, D.C.

GENTLEMEN: Hospital Association of Rhode Island, on behalf of its 16-member voluntary hospitals, opposes S 570, the Hospital Cost Containment Act of 1979, notwithstanding the fact that it might exempt our State.

We acknowledge that the visible congressional concern (which we share) over rising health care costs helped give impetus to the now successful voluntary cost containment effort. But, it would be our considered judgment, from reading S. 570 and from the recent track record of those who would be charged with its implementation, that its enactment would create a "trigger-happy" situation most likely to result in untimely death of one of the only effective industrywide private-sector antiinflation programs in this country. The 8-year Rhode Island experience convinces us that combined effort of hospitals, major third-party purchasers, physicians and others at the state and local level can produce results far exceeding anything possible under Federal controls.

There is mounting evidence that the 9.7 percent "trigger" in S-570 is unreasonably low for some states, regions and hospitals, and that excessive discretion is given the HEW secretary, likely leading more quickly to over sweeping and killing voluntary effort than the Congress intends.

Standby wage/price controls are called inflationary by most economists, and S. 570 would add inflation by being costly to administers. We urge that it not be enacted. Request our comments be in the hearing record on the bill

WADE C. JOHNSON, *President.*

STATEMENT OF THE NATIONAL COUNCIL OF HEALTH CARE SERVICES

Mr. Chairman, members of the Subcommittee, I am Jack A. MacDonald, Executive Vice President of the National Council of Health Care Services. The National Council represents a select group of proprietary multifacility nursing home firms. Members of the National Council own and/or administer more than 80,000 beds in

long term care facilities throughout the country. Members of the National Council are also involved in other health related services such as hospitals, psychiatric, rehabilitation and day care centers.

We appreciate this opportunity to submit a brief statement concerning S. 505.

First, we would like to commend Senator Talmadge and the Committee members for taking the initiative reflected in this bill to correct and, hopefully, reform the Medicare and Medicaid programs. We strongly support the intent of S. 505 as reflected in the title of the bill, "Medicare-Medicaid Administrative and Reimbursement Reform Act of 1979." That title effectively delineates the two areas which are the cause of the major problems of the Medicare and Medicaid programs.

Solutions to the problems in these two areas must be found before the adoption of any national health insurance program. If we do not solve these problems now they will be magnified tenfold under any national health insurance program.

Mr. Chairman, your efforts and those of your colleagues are vitally important in meeting that need. We offer our support to the Committee in that effort.

I. INTRODUCTION

The present diffusion and confusion in the administration of the Medicare and Medicaid programs has created a regulatory quagmire which has prevented the effective operation of the two programs. It has also created problems in the enforcement of standards which, in many instances, have led to the abuses noted by various critics of the health industry. These problems involve eligibility criteria for beneficiaries, the delivery of services, certification of providers, and payment for services rendered under the programs.

The past administrative formats of the Medicaid program and the Medicare program have been costly and ultimately detrimental to the provision of quality health care at a reasonable cost. As the Chairman pointed out in his statement introducing S. 505, it is time to change from a payment system which he characterized as, "The more you spend—the more you get paid."

While there is a strong need to restructure the administration and the payment systems of the two programs, there is also a counter-balancing need to stabilize the Medicare and Medicaid standards for beneficiaries and providers. In this area, the changes made as a result of the Social Security Amendments of 1972 (Public Law 92-603) need to be examined and evaluated as to their impact before any new major revisions are made involving the skilled nursing and intermediate care facilities under the two programs. Mr. Chairman, in our opinion, this can best be achieved under the format proposed by S. 505 in Sections 34 and 37.

II. SPECIFIC COMMENTS

Section 2: It is our understanding that this section, as proposed in S. 505, only pertains to hospitals. As a result, it would not preclude the use of Medicaid payment systems for nursing home services which have been developed by states pursuant to Section 249 of Public Law 92-603.

As the Chairman is aware, the regulations implementing Section 249 have caused a significant restructuring of the state Medicaid payment systems which need to be evaluated prior to any wholesale change in those systems. A number of new payment systems for skilled nursing and intermediate care facilities have been developed under this provision that should not be encumbered by the system outlined in Section 2 of S. 505 or the concept of expenditure or revenue caps which have been introduced in other legislation currently pending in Congress.

It is our recommendation that the Secretary should be strongly encouraged to utilize Section 249 of Public Law 92-603 to develop new, "improved methods" for prospective payment systems which contain costs for nursing home services for both the Medicaid and Medicare programs. The states have the flexibility under the Medicaid program to be innovative in getting away from the pitfalls of "the more you spend—the more you get paid" Medicare hospital syndrome which is not present under the Medicaid program.

We would recommend though that the Committee extend the application of Section 2 to cover Medicare certified skilled nursing facilities. It is our opinion that the methodology set forth in this section is more compatible with the systems adopted by the states for the payment of such services under the Medicaid program than the existing Medicare payment system. That is especially true regarding those states which have adopted prospective class rate systems for their Medicaid nursing home services.

Section 4: In regard to Subsection (p) of this section, we would offer our strong support of this provision. It addresses problems created by the interpretation and resulting regulations implementing the existing Section 1122(g) of the Social Secu-

rity Act. The Department of Health, Education and Welfare issued regulations (42 CFR 100.103(a)(1)) on November 9, 1973, which require that the purchaser of an existing facility must obtain approval for that purchase from the appropriate comprehensive health planning agency even though there is no change in service or bed capacity.

In the case of *Herbert L. Rogers* v. *David Mathews, Secretary of HEW,* the Department of Health, Education and Welfare acknowledged in its brief that they inserted the word "or" in the regulation between the statutory phrase "(i) exceed $100,000" and "(ii) changes the bed capacity of a facility with respect to which such expenditure is made." On the basis of that insertion, the Department of Health, Education and Welfare has attempted to exercise jurisdiction over the simple sale of existing facilities.

This interpretation has presented a severe problem and hardship for both the seller and purchaser of health facilities. It has resulted in some instances in the purchaser having a hardship in obtaining financing for the facility because of the fact that it is unknown whether the facility will be allowed to continue to be used as a nursing home.

The Department of HEW has even attempted to interject this requirement into transactions specified by bankruptcy court actions. This, we feel, is totally beyond the original intent of this Committee when it wrote Section 1122(g).

Section 13: Mr. Chairman, we would acknowledge the fact that there may be, at the present time, an excess of hospital beds in some parts of the country. However, we are concerned with the possible long-range results of this Section 13 of S. 505.

It should be noted that the shifting of excess hospital beds to another purpose could easily result in an excess of beds in that latter area. At the same time, it might be necessary at a later date to switch the hospital beds back to their original purpose which could result in a shortage in the alternative service area.

We would also point out that there is a significant difference in physical plant standards between hospitals and nursing homes. Nursing facilities are now being required to have more floor space available than hospitals for patients outside, as well as inside, their rooms for what the regulations define as general "activities of daily living." This is being done for the very valid reason that the nursing home patients require a setting which is attuned to their total needs . . . not just their medical problems. Hospitals are simply not designed to meet those needs without additional capital expenditures which we question as to whether that is in the best interest of containing health care costs.

This cost effectiveness question is one which, we would respectfully submit, has not been fully examined. It should be noted that the average per patient day cost in a hospital is now nearing $200.00 vs. approximately $34.00 in a free standing nursing home . . . or 488 percent higher. Given the fact that the fixed costs of hospitals, such as physical plant costs, are significantly higher than nursing homes ($15,000-20,000 in nursing homes vs. $65,000-70,000 in hospitals). The cost differential is really not subject to extensive reductions. Therefore, the use of those beds for nursing home patients will, in effect, result in a new government subsidization program for hospitals.

Therefore, we submit it is rather questionable as to whether the concept of this legislation is really cost efficient.

Section 14: It is our opinion that this section would clarify the intent to allow state Medicaid agencies the discretionary authority to include "incentive payments" in their cost related payment systems developed pursuant to Section 249 of Public Law 92-603. The original statutory language of Section 249, along with this Committee's report on Public Law 92-603, leaves little doubt that states were intended to already have that type of discretionary authority in the development of their state Medicaid payment systems.

This viewpoint was reflected in the final regulations issued by the Department of Health, Education and Welfare implementing Section 249. The regulatory language neither prohibits nor requires a state to include in its rate a profit, a growth factor or an incentive payment.

The Preamble to the final regulations, however, has confused the issue somewhat. On the one hand, it specifically recognizes the need for a profit for proprietary facilities; while, at the same time, tending to limit the flexibility of states to have a return other than one based on Medicare's concept of owner's net invested equity. The Preamble to the regulations however, also speaks favorably of a payment system developed by a state which provides for a return based on other than solely the owner's net invested equity.

This approach has been adopted by several states. In those instances, it has resulted in a more efficient and administratively simple payment system than that

Medicare program's approach. This section, we feel, would clarify the situation and encourage HEW to allow states more flexibility in the design of their systems.

We would, however, suggest that the Committee give consideration to clarifying the types of "incentive payments" which it envisages the states including. It is assumed that the Committee would wish to follow the direction set forth under Section 2 of S. 505 and we would, therefore, urge consideration of the following language: "Such allowances may include, but are not limited to, for example, retention of all or a part of the difference between an institution's actual costs and its prospective rate where the rate is established on a statewide, areawide, or other class basis. A variant of this approach may be employed where rates are established by formula on an institution-by-institution basis. In such cases, an institution may qualify for an incentive allowance by holding its actual costs below reasonable cost ceilings or target rates established by the state on the basis of cost comparisons among institutions and analyses of economic trend data.

In addressing ourselves to this section, we are compelled to address the tenth proposal contained in the Committee's "Press Release" of March 1, 1979, concerning the repeal of Section 249 of Public Law 92-603.

First, it is our view that Section 249 has served to stimulate the development of a number of innovative payment systems by the various states. These innovations would not have taken place within the administrative restrictions of the Medicare program's payment methodology. For that reason alone, we must compliment the Committee on its foresight in 1972 in attaching the provision to the Social Security Amendments of 1972.

However, we have recently witnessed increasing pressure being placed on states to adopt the existing methodology of the Medicare program. This pressure, if successful, will undermine the flexibility granted to the states to develop less costly systems of administering a payment system for skilled and intermediate care facilities.

Ultimately, this may well result in the application of the existing Medicare system of "the more you spend—the more you get paid" to the states and their Medicaid programs. Such a result, we submit, would be highly detrimental to the containment of long term health care costs.

We would, therefore, encourage the Committee to consider inserting in its report on S. 505 the reaffirmation of its intent that states have the flexibility to "develop other reasonable cost-related methods of rate setting" besides that of the Medicare program.

We would also urge, in keeping with our earlier comments regarding Section 2 of S. 505, the insertion of statutory language covering two points: a) language applying to Sections 2 and 25 to Medicare certified skilled nursing facilities; and b) language which protects the states from further incursions of the principles and methods of the Medicare program through regulations mandated by HEW. In that regard, we would suggest that the language of Subsection (b) of Section 249 of Public Law 92-603 be amended to read as follows:

"(b) Section 1861(v)(1) of such Act is amended by inserting after subparagraph (D) the following new subparagraph:

"(E) Such regulations may, in the case of skilled nursing facilities in any state, provide for the uses of rates, developed by the state in which such facilities are located, for the payment of the cost of skilled nursing facility services furnished under the state's plan approved under Title XIX (and such rates may be increased by the Secretary on a class or size of institution or on a geographical basis by a percentage factor not in excess of 50% to take into account determinable items or services or other requirements under this title not otherwise included in the computation of such state rates)."

As a result, Subsection (b) would provide an excellent opportunity to simplify the payment structure faced by nursing facilities participating in the Medicare and Medicaid programs.

The one remaining concern which we have with Section 249 is that of establishing an assurance that the cost of HEW's revisions in the standards for skilled and intermediate care facilities will be recognized by the states in their payment rates. This is a very real problem in light of the fact that HEW is currently revising all of the federal standards for nursing homes participating in the Medicare and Medicaid programs. These revisions will have a significant impact on the cost of the affected services which, if the facilities are not compensated for, could be economically disastrous for them.

We would recommend that if Section 249 is repealed that the Secretary be urged to delete from the Department's proposed revisions any change with any cost attached to it which is not specifically mandated by statute. If all of the preceding is

done, the Committee will realize their goal for cost savings while installing a more flexible and efficient payment methodology for nursing home services under the two programs.

Section 15: We would submit that the problem in the area of certification and enforcement of standards is not one of who should be certifying, inspecting and enforcing; but rather, one of unifying the standards and surveys under a single authority. There is presently no one authority empowered to say "yes" or "no" on a timely basis in response to a certification finding. As a result, this process can often be dragged out for an extended period of time.

It should be noted that skilled nursing facilities participating under the Medicare and Medicaid programs are, at the present, subject to more than 520 detailed federal requirements. These standards are surveyed and reviewed by different authorities, including, in some instances, duplicate federal and state survey teams reviewing a facility's compliance with the same standard. As was stated at the outset of our statement, there is a clear need to unify the certification process under a single authority and we strongly support any attempt to accomplish that task.

Based on our experience, this process can be accomplished most expeditiously at the local level. This approach would be compatible with the possible repeal of Section 249 which was discussed in the preceding section. It would not be appropriate to provide the states total flexibility in the payment area while mandating that HEW be able to set the standards of the service for which they pay the bill.

In a related issue, this section provides a means for the Secretary to distinguish between those facilities which, as a result of the certification surveys, are found to present an immediate and serious threat to the safety and health of the patients, and those facilities with lesser violations. We endorse the provisions in this section if the states hold the certifying authority for both programs, especially in regard to the facility's right to judicial review.

We also support the inclusion in this section of the certification procedure and authority for the intermediate care facilities as being the same as that used for skilled nursing facilities. This is necessary, we feel, since many skilled nursing facilities also participate as intermediate care facilities under the Medicaid program. Any other arrangement would not be administratively sound nor in concert with the expressed intent to consolidate the policies and administrative authority for the two programs.

Section 16: We would like to briefly comment that the concept reflected in this section is extremely important to both the nursing home patients and the facility. Patients should be encouraged to make visits to their families and not discouraged. The latter has been the practice, we are sorry to say, of the Department in the past. Even though they have recently liberalized their policy, we commend Senator Talmadge for clarifying the statute in regard to this issue.

Section 29: While we endorse this provision, we would urge the Committee to consider amending it to increase its potential cost savings. Specifically, we would suggest that it be amended to include the elimination of the three-day prior hospitalization requirement for skilled nursing facility benefits as reflected in S. 3507 introduced during the last Congress.

We believe that the potential costs of such a change would be more than offset by the reduced hospitalizations which would result. Equally important, it would also mean that those patients who are in need of skilled nursing care would be able to receive the care most appropriate to their condition without the imposition of an unnecessary and costly barrier of prior hospitalization.

HEW has in two reports recommended the elimination of the prior three-day hospitalization as an unnecessary barrier to needed services.

Two types of program savings would accrue as a result of a shift in utilization patterns from the elimination of the three-day prior hospitalization: patients who are unnecessarily placed in hospitals merely to meet the three-day stay requirement and, perhaps more significantly, those who require skilled care but who enter a hospital and then are never discharged into a skilled nursing facility.

The potential savings in eliminating unnecessary three-day hospitalizations are too easily dismissed by many individuals. Even eliminating a relatively small number of such visits could have a significant impact in terms of increased benefits for patients. The funds used to hospitalize three hundred patients for three days in a hospital would pay for their care in a skilled nursing facility for 20 days. Considering that the average length of stay as a skilled Medicare patient in a nursing home in 1976 was 24 days, the benefits of such a tradeoff are obvious.

A 1976 HEW report, Forward Plan for Health, endorsed elimination of the three-day stay by stating, ". . . it is probable that patients in need of only skilled nursing care, and who are now instead hospitalized are never subsequently transferred to an

SNF because of paperwork (e.g., transfer of medical records, treatment plan) and the lack of any financial incentives or disincentives (e.g., no cost sharing is required from the first hospital day and until the 61st day)."

In discussing the potential savings, the Forward Plan for Health goes on to say, "Since the average Medicare cost of a covered day in an SNF is less than one-third the routine cost per day in a hospital, the potential cost savings is obvious." When comparing the Medicare program's experience in hospital and SNF utilization and cost trends during the years 1968-1975, the differences are readily apparent:

1. Between 1968 and 1975, Medicare SNF admissions decreased 31 percent; hospitals experienced a 62 percent increase.
2. Admissions per 1,000 eligible beneficiaries decreased 43 percent in SNF's; hospitals experienced a 30 percent increase.
3. Average length of stay decreased 40 percent in SNF's; decreased only 16 percent in hospitals.
4. Number of days of care per 1,000 eligibles decreased 66 percent in SNF's; days of care in hospitals increased 9 percent.
5. In 1978, the cost per patient day was approximately $34 in a SNF vs. approximately $200 in a hospital.
6. The economic inflation rate for the seven years (1968-75) for SNF's was 99 percent (14.1 percent per annum); the economic inflation rate for hospitals was 270 percent for the same seven years (31.5 percent per annum).

According to a 1976 General Account Office report, this decrease in utilization was a result of stricter enforcement of the requirement that nursing home services be medically necessary. The GAO said in its report these were "costs avoided by Medicare," and, thus, enabled Medicare to "avoid paying for about 17 million days of nursing home care during fiscal year 1975."

While Medicare may have "avoided" paying for SNF care, it has not avoided paying for hospital care. The National Council of Health Care Services feels strongly that elimination of the three-day prior hospitalization would significantly reduce unnecessary hospital stays while expanding the benefits and options available to Medicare enrollees.

In light of the aforegoing, we urge the Committee to consider amending Section 29 to provide the elimination of the three-day prior hospitalization for determining eligibility for SNF services.

Section 34: The National Council strongly supports this provision. Senator Nelson has correctly identified an area which we feel needs to be carefully examined.

During the Senate's consideration of H.R. 5285, Senator Nelson, on the floor, stated that: "Many nursing homes are declining to participate in one program or the other, reducing the availability of skilled nursing facilities, and that (thus) there is a need to encourage greater participation."

He commented further that: "From all indications, the reason for declining participation in Medicare and Medicaid is unmanageable paperwork, slow collection on claims and a host of other administrative difficulties relating to red tape and bureaucratic inconvenience. It seems to me that it would be far more effective to aim reform efforts directly at those problems rather than try to coerce SNF participation with this kind of all-or-nothing condition."

Those statements are as significant today as they were at the time they were made.

Section 37: We firmly support the intent of this provision. The subject of this section, HEW's application of paragraph (2) Section 1861(a) of the Social Security Act, is one of the ways which has been used to avoid paying for services under the Medicare program.

HEW has been utilizing a definition for purposes of this section which does not limit itself to facilities designated as SNFs under its own artification program as noted in Section 1861(j) of the Social Security Act. This has resulted in a hardship for a number of patients, as well as a bureaucratic nightmare for the facilities providing services to them.

III. CONCLUSION

In conclusion, Mr. Chairman and members of the Committee, we appreciate the initiative which you and your staff have taken in holding the hearings and that Senator Talmadge has shown by introducing S. 505. The need for reforming the administrative and payment structures of the Medicare-Medicaid programs is clear. The National Council of Health Care Services feels that S. 505 represents a large step in that direction and, on that basis, we concur with the scope of the reform proposed in the bill.

If you have any questions concerning our statement, we will be happy to attempt to answer them.

SQUIRE, SANDERS & DEMPSEY,
Washington, D.C., March 16, 1979.

Hon. HERMAN E. TALMADGE,
Russell Senate Office Building,
Washington, D.C.

DEAR SENATOR TALMADGE: In anticipation of early hearings on S.505, introduced earlier this month by you and Senator Dole, we have been asked by the American Society of Anesthesiologists (ASA)—for which we act as legal counsel—to submit the following views for inclusion in the record.

As you know, ASA has previously testified in favor of certain substantive provisions of the Bill relating to definition of the reimbursement standards for anesthesiology services. While these provisions have been changed in certain minor and clarifying detail (Section 6(a)(2) of S.505), ASA continues to find these provisions satisfactory and reflective of sound medical practice.[1]

In the past few months, we have discussed with members of the Finance Committee staff certain additional clarifications which, although not practical for inclusion in the language of the Bill, nonetheless in ASA's judgment are required for a proper understanding of legislative intent. We have been requested by the staff to prepare proposed clarifying language for inclusion in any Committee Report on the Bill. We thus offer the following for the Committee's consideration:

Section 6(a)(1) of the Bill provides for the exclusion from Medicare Part B reimbursement of services performed by a physician "as an educator, and executive, or a researcher; or any professional patient care service" not involving personal performance or direction by a physician, for the benefit of a patient. It is not the intent of the Committee, by this language, to exclude from Part B reimbursement those services of a physician involving his personal performance or personal direction for the benefit of a patient, when simultaneously with performing those services, the physician is also engaging in a teaching function for others (e.g., resident physicians not in his employ) who are also participating in or observing the services as part of their educational experience.

Section 6(a)(2) of the Bill provides additional standards to the Act to govern Part B reimbursement for services by an anesthesiologist, in general limiting such reimbursement to those instances in which the physician either personally performs or personally directs the provision of anesthesia care in connection with surgical or obstetrical procedures. The Committee recognizes that anesthesiologists perform medical services to patients outside the context of a surgical or obstetrical procedure, and it is not the Committee's intent to affect reimbursement standards in these other contexts. The Committee also recognizes that many anesthesiologists practice in partnership or "group" form, and that more than one member of the group may permissibly provide the required services for which reimbursement is authorized, e.g., one physician in the group may make the pre-anesthetic evaluation, while another may actually anesthetize the patient.

ASA wishes also to state its support for the principles of Section 9 of the Bill, which create an express statutory basis under Medicare for rendition of surgical services in an ambulatory center. In point of fact, a large number of these centers have been established on the initiative of anesthesiologists. Many ASA members believe that these centers are to be strongly encouraged as a vehicle for rendition of surgical and anesthesia care, in proper cases, at a lesser facility-operation cost than that normally involved in a hospital setting. ASA believes, however, that Section 9 is not presently clear that two alternative means are to exist for reimbursement of an anesthesiologist or other non-surgeon physician who performs services in connection with a surgical procedure in such a center—either by participating (by agreement) in an all-inclusive fee paid to the center, or by separate normal Part B

---

[1] We note that these provisions are not included in that portion of the S.590, Clinical Laboratories Improvement Act of 1979 (introduced by Senator Javits on March 8, 1979) dealing with physician reimbursement principles. While ASA does not oppose these provisions in S.590, we strongly urge that if the Senate is going to deal with physician reimbursement principles, whether under S.590 or S.505, the entire provision on this subject of S.505 should be included. As you know, the provisions of S.505 dealing with anesthesiology services have been constructed with some care and have involved close consultation among ASA, the Finance Committee staff, and representatives of Medicare. The foreshortened provisions of S.590, if adopted, simply would not reflect the detailed understandings that have emerged from prior consultations on the predecessors to S.505.

reimbursement. We respectfully recommend that these alternatives be spelled out in the report of the Committee on S.505.

We have also been asked by ASA to reiterate its opposition to Section 7 of S.505, as currently drawn. ASA's objection to this provision is that it unduly and improperly limits the participation of a physician organization, in the development of a relative value schedule, to reacting to proposals by the Secretary. ASA believes that such a limitation erodes its constitutional right to petition the Government, a right which is confirmed in the decisions of *Eastern Railroad Presidents Conference* v. *Noerr Motor Freight, Inc.* 365 U.S. 127 (1961); and *United Mine Workers* v. *Pennington*, 381 U.S. 657 (1965).

In this connection, we respectfully refer you to the terms of a Consent Order recently entered into between ASA and the Federal Trade Commission (relating to ASA conditioning membership privileges on the mode of compensation received by a physician) which states as follows:

It is further ordered, That nothing in this order shall prohibit or limit the organizations and persons subject to this order from petitioning the government for a redress of grievances by:

A. Preparing or furnishing testimony, information, or advice to, or negotiating with, any government body or agency or furnishing drafts thereof to any organization which is preparing or furnishing testimony, information or advice to, or negotiating with, any government body or agency with respect to the same subject matter;

B. Advising its members and others of legislation, programs, policies, regulations, procedures, or interpretations of any government body or agency and soliciting their views thereon;

C. Informing members and others of any testimony, information or advice supplied to, or negotiations with, any government body or agency; and

D. Suggesting or recommending that members or others undertake the activities enumerated in subparagraphs (A), (B), and (C) above; but only as long as the activities enumerated in this part VI are not undertaken with the purpose or intent of achieving a result prohibited by part II of this order through means other than the action of a government body or agency.

We do not believe that the philosophical approach of Section 7 adequately recognizes the rights of organized medicine to initiate negotiations with the Secretary, concerning relative value schedules or other subjects of common concern.

We request that a copy of this letter be included in the record of the Subcommittee's hearings on S.505.

Respectfully submitted,

MICHAEL SCOTT.

STATEMENT OF THE AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION

This statement is presented by Michael F. Doody, President of the American Osteopathic Hospital Association, 930 Busse Highway, Park Ridge, Illinois 60068.

The AOHA maintains its Headquarters in Illinois, with an office in Washington, D.C. and represents the 208 osteopathic hospitals which are located in 28 states. These institutions serve as the primary institutional care facilities for those patients (individual consumers) who choose to receive their health care from one of the approximately 15,000 practicing osteopathic physicians in the country.

Osteopathic institutions and physicians are interested in the delivery of quality health care. Osteopathic physicians are largely providers who concentrate in the areas of general practice and family medicine. The majority of all practicing osteopathic physicians are engaged in the delivery of primary care. Osteopathic hospitals are cost conscious institutions whose primary objective is the delivery of quality health care in a cost-effective manner.

A large number of osteopathic hospitals are engaged in the teaching of interns and residents and as such represent an important community health resource. Many of our hospitals are located in rural or semirural areas and provide a very necessary community health service. In some instances the osteopathic hospital is the only hospital present within the community.

INTRODUCTION

Essential to a discussion of hospital costs is a thorough understanding of the nature of those costs and the causative factors behind their rise. Hospitals do not cause inflation. They must pay higher prices and wages for the goods and services they use in the delivery of patient care. Virtually all hospitals operate on tight budgets and quickly fall victim to rising costs.

The amounts hospitals must pay to meet operating expenses has risen steadily over the past several years. The major components of the rising costs include such things as energy (up more than 20 percent per year since 1973), food, premiums for malpractice insurance, labor costs, and government regulation. The hospital market basket is an expensive mix of goods and services the costs of which move at a greater rate than the overall Consumer Price Index, and it is a market basket especially hard-hit by inflation in the general economy.

It is commonly stated that the cost of hospital care has risen over the course of the past ten years at a far faster rate than the overall rate of inflation or the Consumer Price Index. However, those who make this statement generally fail to recognize that a patient day of care in 1979 is a far different product than a patient day of care in 1969. Hospitals are not producing a uniform product such as the steel or meat packing industries produce. The hospital product, a patient day of quality health care, is an extremely complex item to produce and it is a product which is constantly changing and improving.

Another factor which contributes to rising hospital costs is intensification of services in terms of sophistication of technology. Intensification is the result of the change in the mix of patients treated—we are able to treat many previously untreatable maladies—and a result of new technologies heretofore unavailable—open heart surgery, organ transplants, renal dialysis equipment and others. Such technological improvements in care have all contributed to increased per unit costs.

Volume is another major factor contributing to increased costs. We are living longer and therefore are more likely to contract illnesses which require greater care. We have expanded benefits, broadened coverage, and increasingly we have eliminated economic barriers to the utilization of the health care system. As a result, hospitals all over the country provide care for millions who cannot pay or who pay only in part.

The hospital customer, unlike other customers, rarely shops price. Once the decision is made to enter the hospital, he demands nothing less than the best the industry and its sciences can offer, even miracles. There is no patient demand for a cheaper model. And it must be remembered that it is the physician, not the hospital, who decides what tests, treatments and other procedures will be utilized.

Government regulation of the hospitals of this country has certainly been a major factor in rising costs. Hospitals have been experiencing a steady and excessive increase in reporting requirements, inspections, and regulations which, while aimed at improving quality, also have significant financial implications. Many of these requirements are duplicative and conflicting and, as a result, compliance all too often adds costs without commensurate improvements in the quality of care.

The following excerpt taken from the Statement—"The Complex Puzzle of Rising Health Care Costs: Can te Private Sector Fit it Together"—from the Executive Office of the President, Council on Wage and Price Stability, December 1976, highlights the problem of government overregulation. In the foreword (page iv) to the Members and Adviser Members of the Council on Wage and Price Stability, William Lilley, III, acting director, said in part: "It is all too apparent that right now, with current reimbursement programs and the ubiquitous and often conflicting morass of regulations, that the federal government, instead of being part of the solution, is part of the problem of rising health care costs. This sorry state of affairs has come about despite the best intentions of the government. To add yet another layer of cost-raising regulations, which would inevitably accompany any federal effort, would only be to compound the existing problem."

Hospitals are labor intensive. (More than 50 percent of the hospital dollar goes to salaries, wages and fringes.) As a result, hospital costs are particularly vulnerable to laws and regulations impacting on employees wages and benefits. The new increase in the federal minimum wage increased hospital costs by an estimated $2.8 billion in 1978; and the increase in Social Security contributions will cost hospitals hundreds of millions of dollars. This, by way of example, shows what laws and regulations can do to the hospital and its costs. Other examples include fire and safety codes; the regulations to implement Section 504 of the Rehabilitation Act of 1973; reporting requirements in such programs as PSRO, Hill-Burton assurance programs, and health planning data; the new clinical laboratory requirements; the proposed System for Hospital Uniform Reporting; and many other federal and state requirements.

Finally, there is one other area which we believe contributes to rising hospital costs—modernizing the hospital plant and maintaining its service capacity. These costs have risen rapidly too because of changes in the nature of facilities, construction inflation, and the increased cost of capital. The trend in construction has been away from wards toward semi-private and private rooms and toward replacing

obsolete facilities with modern ones which provide better treatment and patient safety. Construction costs are up both in terms of materials and labor. Finally, capital costs have generally increased because of the need to use debt financing, a result of the declining availability of grants and philanthropy.

Osteopathic hospitals have taken action to contain costs. Our hospitals have taken a variety of cost-cutting steps such as mergers, shared services, the development of ambulatory care programs, cost containment reviews, and many other internal management programs. In addition, there are a number of governmental and voluntary controls in existence such as accreditation procedures, reimbursement controls, certification of need for facilities and services, that are all directed at this same issue

S. 570 CONTAINING COSTS

The Administration's legislative cost containment proposal would establish a national limit for the rate of increase in hospital revenues for this calendar year. Hospitals would be asked to meet the goal, set at 9.7 percent, voluntarily. If hospitals fail to meet this goal, stand-by mandatory controls would become effective on January 1, 1980.

In arriving at its 9.7-percent target, HEW recognized that the increases experienced by hospitals are made up of three basic factors. These factors are: (1) Increases in the costs of goods and services hospitals must purchase; (2) increases in hospital utilization resulting from both an older and a larger population; and (3) increases resulting from improved medical technology and expansion of services.

The Administration proposal, however, is both unrealistic and counter-productive since the guidelines are based on erroneous projections in these three areas. First, the Department of Health, Education and Welfare is projecting a 7.9-percent increase in the hospital "market basket", those goods and services a hospital must purchase. Both the Congressional Budget Office and the hospital industry believe this increase will be closer to 9 percent.

The major reason for this difference is the uncontrollable portion of the so-called market basket. We estimate that between 10 and 20 percent of an average hospital's budget consists of wages and salaries that are not subject to the wage guidelines of the President's voluntary inflation program. About half of this figure falls under the minimum wage exemption and the other half may or may not be exempt under the tandem relationship guideline which can vary from institution to institution. Another 12 1/2 percent of the average hospital budget, in such areas as energy, food and interest rates, are also exempt from the guidelines. Therefore, between 23 and 33 percent of all hospital costs are exempt from the guidelines and these costs will rise faster than the target rate of 7.9 percent. We believe 9.1 percent is a realistic projection for this component.

Second, HEW projects that overall increases in population in 1979 will add 0.8 percent to the increase in hospital costs. However, this does not recognize the increase in the needs of the larger elderlypopulation, which is expected to increase 2.1 percent in 1979. It is our estimate that this factor will add an additional 0.3 percent to the projected increase in total population bringing the population factor to 1.1 percent instead of 0.8 percent.

Third, increases in services and advancements in technology, less increases in productivity, generally added an average of 4 percent to the annual increase in hospital costs. It is expected that 1979 will see an increase of 3.8 percent in this factor. A considerable portion of this increase cannot be eliminated in the short run because it is a result of activities begun many years ago. The HEW projection of 1 percent for this factor is unacceptable and would result in denying our patients the benefits of advancements in medical science.

To summarize:

HEW projects an overall increase in hospital costs of 9.7 percent.

Hospitals project an increase of 14 percent.

HEW projects increases of 7.9 percent in the market basket, 0.8 percent for population and 1 percent for technology/service improvements.

Hospitals project increase of 9.1 percent in the market basket, 1.1 percent for population, and 3.8 percent for technology/service improvements.

It should be noted that, in spite of the projected increase of 14 percent, hospitals are, through the Voluntary Effort, attempting to hold the actual rate of increase to 11.6 percent. It will be a difficult goal to reach, but we are firmly resolved to achieve it.

THE VOLUNTARY EFFORT VS. THE NEW GUIDELINES

The Voluntary Effort (VE) is the health care industry's program designed to contain the rate of increase in health care costs. It was created in November, 1977 as a coalition of major national organizations concerned about the cost, provision, and quality of health care services.

The basic goal of the VE is to reduce the gap between the rate of increase in total hospital expenditures and the rate of increase in the overall gross national product. The objective is to reduce, over a two year period, the rate of increase in total hospital expenditures by four percentage points. The 1978 goal was to reduce the rate of increase to 13.6 percent and in 1979 to 11.6 percent.

The final results from 1978 show a national rate of increase in total hospital expenditures of 12.9 percent. This compares to a 15.6 percent increase in 1977. It should be noted that this reduction was accomplished in spite of accelerating inflation in the general economy, and in the prices hospitals pay for goods and services they purchase.

The American Osteopathic Hospital Association agrees with the Administration and the Congress that the question of rising health care costs needs to be addressed. Related questions of intensification and utilization of hospital services need to be considered in any proposal aimed at controlling the inflationary rise in these costs.

What is needed is a clearly stated set of national health goals which expresses agreed upon public policy decisions regarding the level and scope of services, their cost, and the rate of growth deemed desirable by the nation.

The Administration proposal is designed to place a cap on the rate of increase in total hospital in-patient revenues per admission; it does nothing to control costs. There is no consideration in the proposal of the costs which hospitals incur as a result of rising prices for those items which are essential to the operation of an institution. Despite the insistence of the Administration to the contrary, this program is a form of wage and price control.

Singling out one segment of the economy for mandatory control while all others, including hospital suppliers, are subject only to voluntary guidelines, is patently unfair. The Washington Business Group on Health, made up of 160 companies, previously released a report on the health care cost containment experience of a number of major U.S. businesses. It concluded that capping hospital costs is not likely to reduce total expenditures on medical care. "We cannot support direct price controls," states the summary of the report; ". . . a limitation on the prices hospitals can charge, without adjustment for the costs they will incur, is unrealistic."

Any program which limits the revenues of one industry while that industry must pay whatever the market demands for supplies, services and employee wages is unworkable and inequitable. As mentioned previously, the portion of the average hospital's budget left uncontrolled by the Administration's voluntary program is very significant: between 23 and 33 percent.

Now for a few general comments about the formula utilized in S. 570 It is out belief that the in-patient revenue limit is inequitable in its intent, will be costly to administer and will have a long-term negative impact on the health care delivery system. Details of the indices used will not be available in sufficient time for proper budgeting by the institutions affected since all hospitals are now well into their fiscal years. Hospitals have made financial commitments for this budget year and it is fiscally unsound to impose new, restrictive requirements at this stage.

We concede that this program, if passed by the Congress, might result in short-term saving. However, the long-term consequences of controls applied exclusively to health care will lead inevitably to: cutbacks and reduced access to services; reduced quality of care; unemployment; and perhaps even to some hospitals closing their doors.

LONG-TERM REFORM PREFERABLE

S. 570, as it is currently designed is both unworkable and inequitable.

It is, in our view, far more preferable to provide for the development of permanent reforms in hospital reimbursement and to provide incentives for the efficient and effective use of hospital resources.

Such long-term reforms could be based on a classification system of hospitals similar to the one proposed in S. 505, the Medicare-Medicaid Administrative and Reimbursement Reform Act. Such a system would provide a meaningful method to differtiate between efficient and inefficient operations. It would recognize that institutions differ, and that:

There should be allowance for geographic wage differences

There should be allowance for an equitable exceptions process which recognizes atypical service and patient mix.

There should be exclusion of certain noncomparable and often uncontrollable costs—such as debt services, health manpower training, energy and malpractice—in determining target rates.

Permanent reforms should be phased in over a period of years to assure that such reforms are not damaging to a hospital's financial integrity and ability to meet community needs. The reforms should apply to all purchasers of care.

There is a need to devise new financial mechanisms that will encourage efficient management of our resources and contain rising costs without, at the same time, impairing the capacity of the health care system to meet patient needs. S. 570 fails substantially to address this issue.

CONCLUSIONS

The American Osteopathic Hospital Association is totally opposed to the enactment of S. 570. This legislation seeks to place a cap on hospital revenues without providing for restricting the prices of the expensive goods and services that must be purchased by hospitals to provide patient care.

In addition, we believe it would take a large bureaucracy to implement S. 570, resulting in greatly increased costs.

The appropriate alternative would be the development of long-term reforms based on a classification system similar to the one embodied in S. 505. Such a proposal would reward the efficient institution and penalize the inefficient; recognize the major differences between hospitals; prevent reductions in or the elimination of needed services; and assure continued access to services by those in need of them.

CHEVY CHASE, MD., *February 13, 1979.*

Mr. MICHAEL STERN,
Staff Director, Committee on Finance,
Dirksen Senate Office Building, Washington, D.C.

DEAR MR. STERN: In response to Senator Russell B. Long's recent call for comments on health cost containment (Senate Committee on Finance Press Release No. H-6 dated February 12), I would like to submit for the record and for the committee's consideration the attached article on "Carter, Cost Containment, Cough Drops, and Other Cold Remedies."

In this article, I comment on how the United States Government has encouraged, through its tax policies, the present broad coverage of private health insurance and how this has led to a distortion in the demand for health care.

As you know, payments by employers for health insurance premiums and other medical expenses are deducted as business expenses by employers and excluded from employee income. The exclusion from the employee income gives rise to a tax expenditure.

This provision of Federal tax law (i.e., the exclusion of employer contributions for medical insurance premiums and medical care) cost the U.S. Treasury approximately $7.6 billion in fiscal year 1978. This tax expenditure will increase to $9.6 billion in fiscal year 1980 according to a recent estimate prepared by the Treasury Department (see page 209 of the Office of Management and Budget Special Analyses of the FY 1980 Budget.)

This tax policy provides a powerful inducement to buy health insurance. It clearly encourages employees and unions to opt for more insurance instead of more wages. Furthermore, the existence of extensive health insurance gives the false impression to many individuals that health care costs are not really that high. After all, for many individuals today, the net out-of-pocket cost of health care appears quite modest because of the existence of such extensive health insurance coverage. Thus, patients and doctors are encouraged to utilize expensive procedures that cost more than they are really worth, and hospitals are induced to offer more complex and more sophisticated care.

It is my thesis that this national tax policy no longer serves the public interest. It is a key, but often unrecognized, ingredient in the soaring cost of hospital care. Before we have any hope of containing the rapidly rising cost of hospital cost, some modification in this tax expenditure policy must be made.

I do not call for an abolition of this tax policy. Rather I believe that we should look to approaches that would lead to the gradual reduction of the exclusion of employer contributions for medical insurance premiums and medical care.

Thank you for giving consideration to these views.

Sincerely,

WALTER J. UNGER.

Enclosures.

"Carter, Cost Containment, Cough Drops, and Other Cold Remedies"

Address to Midwest Pharmaceutical Advertising Club by Walter J. Unger February 9, 1978, Chicago, Illinois, Drake Hotel

Thank you, Chuck, and good evening ladies and gentlemen. It's a pleasure to be back here again with you.

When I was here a few months ago, *Al Mannino* was your guest speaker, and he talked about the *HEW Maximum Allowable Cost* program. I got the impression then that many of you are distinctively interested in the economic and political aspects of health care.

So this evening, I thought you might be interested in a brief discussion of President Jimmy Carter's *number one legislative priority* in the health field: the Hospital Cost Containment Act.

Now, as you know, the financial statistics of health care are indeed horrendous, if you're concerned about the national pocketbook, or wonderfully gratifying, if you regard the figures as evidence of how a nation looks after the health of its people.

In any case, *total national expenditures for health* rose from *$12 billion in 1950* to over *$160 billion last year*. Over the same period, per capita expenditures grew from $78 to $730, nearly a ten-fold increase.

And during the last quarter century, the percentage of the gross national product spent on health has almost doubled – from 4.6% in 1950 to 8.8% last year. The Office of Management and Budget estimates that if the rate of increase in recent years continues, the proportion of the GNP devoted to health will further increase to 9.6% in 1982.

All of these facts and figure are familiar to you, and I am sure they are of great concern to you as they are to me. We all want the health system to operate more efficiently, and the services it provides to be of the highest quality.

Nevertheless, many Americans are finding it difficult to tolerate health costs continuing to rise much faster than other prices in the economy as a whole. A growing troop of health analysts are saying that it simply can't go on like this.

HEW Secretary Joseph Califano has called the nation's health-care system "*very costly. . .virtually noncompetitive . . .obese*" and in need of "*profound reform.*" He has proposed to put an anti-inflationary 9% "cap" on the annual increase in hospital operating costs and limit hospital capital expenditures to $2.5 billion per year, less than half their current rate.

Needless to say, these proposals have not been warmly received by physicians and hospital administrators. Recognizing though that something must be done about the rapid rise in hospital costs, the American Hospital Association, the American Medical Association and the Federation of American Hospitals have organized a voluntary cost containment program of their own. Most Administration officials and many on Capitol Hill doubt that this voluntary effort will succeed, but at the same time it would be foolish to outrightly oppose any private sector initiatives.

The general public has shown very little interest in cost containment, especially where *cost* containment translates into *care* containment. The polls show that, by and large, Americans are satisfied with the medical care that they are getting. So it has been difficult for the Administration to generate much political support for its proposals.

In the Congress, the proposals have received relatively little attention. Two key committees that will have to act on the Administration's bill – the Senate Finance Committee and the House Ways and Means Committee – are both tied up with energy legislation and tax reform issues. Dan Rostenkowski has not even been able to muster a quorum of his health subcommittee members.

So with the Administration's proposals stalled in the Congress, I think it's now time to pause and reflect on whether the Hospital Cost Containment bill is the best solution to the predicament that we've gotten ourselves in.

The U. S. health care system is wonderously arrayed to defy economic sense. *Doctors order, hospitals provide, patients receive,* and *insurers pay* – all of which helps to explain why hospitals have been the most inflationary component of the health sector.

Imagine if you will a restaurant in which gourmet counselors ordered your meal from an extravagant menu that listed no prices. The check was taken care of by some faraway paymaster, who saw to it that the counselors got a generous share. If you can imagine this, you'll get a pretty good picture of the relationship that exists between physicians, hospitals, patients and the so-called third-party payers: health insurance companies and the Federal Government's Medicare and Medicaid programs.

About 90% of all hospitals' bills are now paid by some third party. Thus, each additional $10 of care costs the patient only $1 out-of-pocket. Under these circumstances, it is not surprising that patients and their doctors ask for the most sophisticated and expensive care available.

Mae West, in commenting on another precious commodity, once said: "Too much of a good thing is wonderful!" Hospital patients tend to take the same attitude when it comes to medical care. Many can be heard saying: "When it comes to my health, no expenditure is too great."

Clearly, there is little incentive for either the patient or his doctor to economize when the net out-of-pocket cost appears so modest. Such extensive insurance coverage results in a distortion in the demand for health care:

- Patients and doctors are encouraged to utilize expensive procedures that cost more than they are *really* worth, and
- Hospitals are induced to offer more complex and more sophisticated care.

No one in particular is to blame for this situation, but it is true that the Federal Government has encouraged, through its tax policies, the present broad coverage of private health insurance.

As you know, individuals can deduct from their taxable income about half of the premiums they pay for health insurance. And more importantly, employer payments for insurance are excluded from the taxable income of the employee as well as the employer.

These tax policies now cost the U. S. Treasury more than $6 billion a year in lost revenues and provide powerful inducements to buy health insurance. They clearly encourage employees and unions to opt for more insurance instead of more wages.

This key ingredient in the soaring cost of hospital care has been largely ignored in the current debate. Not very many politicians seem to recognize the problem, or if they do, how it continues to fuel the inflation in health care costs. If we are really serious about cost con-

tainment, then some modification has to be made in these tax policies.

It is important to recognize that *many other Federal policies have also contributed to an expansionary health care system*

The government has invested heavily in *biomedical research* to find new cures and treatments. Scientific discoveries have obviously changed the technological possibilities in hospitals.

Federal policies have resulted in a substantial expansion in the supply of *health resources*. Federal programs have encouraged the training of tens of thousands of physicians, dentists, nurses and other health professionals and paraprofessionals. Just since 1960, the number of health-related jobs has leaped from 2½ million to almost 5 million. These people represent 6% of the civilian labor force.

Partially as a result of 3 decades of direct Federal assistance for hospital construction through the Hill-Burton program, the number of short-term hospital beds has doubled since 1950 to almost 1 million today. Furthermore, since the enactment of Medicare and Medicaid in the mid-1960's, the number of nursing home beds has also more than doubled to about 1.3 million.

The Medicare and Medicaid programs caused a dramatic increase in the Federal Government's participation in health care financing. In 1965, the Federal share of total health spending was 12%; today, the Federal share is 29% or almost 2½ times greater.

Uncle Sam now pays for:

- 39% of all hospital expenses,
- 32% of all nursing home expenses,
- 19% of all physician services, and
- 5% of all drug expenses.

Last year, the Federal Government picked up $50 billion of the $160 billion total national tab for health. And as everyone here knows, the impact of Federal involvement in health affairs goes beyond its spending.

Federal regulations and guidelines, sometimes associated with spending programs and sometimes not, have had a dramatic effect on the health system. Food and drug laws, Professional Standards Review Organizations, health planning and health manpower, as well as other programs concerned with the protection of the environment and occupational safety and health *have* and *will have* an *enormous impact* on the performance of the health industry and the resulting benefits and costs to the American public.

Given the Federal Government's increasing role in health affairs, is there any wonder why we are spending much more today on health care?

Of course, the expanding Federal role in health affairs has been beneficial in many respects:

- Access to medical care is improving;
- We are beginning to achieve equity in delivering medical care to the poor and to minority groups, and
- There have been some real gains in American health.

For example, death rates have been falling for the last 7 years when adjusted for our aging population. Impressive gains have been made in infant and maternal mortality. And the death rates for coronary heart disease, stroke, diabetes and peptic ulcers have all declined.

But as Dr. John Knowles, president of The Rockefeller Foundation, put it: "There exists a profound national concern that, despite a massive increase in health expenditures together with a marked expansion in health workers over the past decade, *the nation's health has improved less than it was promised or expected. The benefits have not appeared to justify the costs*" To make matters worse, broad indicators of social pathology, including drug abuse, illegitimate births, divorce rates, crime, violent behavior, learning difficulties, and psychological problems... tell us that the nation is not as healthy as it should be."

New approaches must be sought to attack the problems of sedentary living, alcoholic overuse, reckless driving, obesity, smoking, suicide, drug abuse, fad diets, promiscuity and carelessness. The traditional health care system has not had, and cannot have much success in modifying these habits.

Many people are now seeing health education as a means to improving the nation's health and containing costs. But as we all know, it is difficult to get people to change their lifestyles in order to stay healthy. Persuading people to forego immediate pleasures for a future benefit is a tall order. Consequently, the results of health education are not apt to be very impressive. Nevertheless, I feel that even limited success in health education programs justifies the effort.

To summarize, I have spoken of the need to hold down medical costs. I have noted the major role that the Federal Government has played in creating an expansionary health care system. And in pointing out these inflationary Federal policies, I have attempted to show how these are inconsistent with the Carter Hospital Cost Containment bill.

Finally, I have suggested that health education programs – by showing people how they can assume responsibility for their own health – might contribute to the improvement of our health while saving on medical costs.

In conclusion, I believe that we should alter those Federal policies that are clearly inflationary and expand our health education efforts *before* we slap direct controls on the health care system. To do otherwise would be like assuming that cough drops could aid a smoker with emphysema or that antibiotics could benefit someone who has just come down with a cold. In each case, they're the wrong medicine.

Thank you.

Walter J. Unger is a Washington-based free lance consultant to a number of health care organizations. His office is located at 8506 Lynwood Place, Chevy Chase, Maryland 20015. Telephone: (301) 654-8511.

RÉSUMÉ 1—WALTER JAY UNGER

Education

Master of Business Administration degree from the University of Southern California (June 1969) with emphasis in finance, management and marketing.

Bachelor of Science degree cum laude from the University of Southern California (January 1967). General program of studies in business administration with major in finance.

Business experience

Counselor to a wide variety of health care organizations on management, financial and marketing problems and on the development of fund raising, public relations and Federal relations programs, January 1978 to present.

Special Assistant to the President, Institute of Medicine, National Academy of Sciences, Washington, D.C., 1973 to 1977.

Director of Planning, Office of Health Sciences Development, University Affairs Department, University of Southern California, Los Angeles, 1970 to 1973.

Administrator, Good Hope Medical Foundation, Los Angeles, California, 1969 to 1970.

Supervisor and Agent, Provident Mutual Life Insurance Company, Los Angeles Agency, 1965 to 1969.

Other data

Graduate, Economics Institute for Health Care Policy Officials, sponsored by the Law and Economics Center of the University of Miami School of Law, 1977.

Active member, Alpha Kappa Psi national professional business fraternity; held various offices including president of the Los Angeles Alumni Chapter in 1972-73.

Graduate, IBM Customer Executive School on Hospital Information Systems, San Jose, California, 1970.

Successfully completed all qualifying examinations for the Chartered Life Underwriter diploma, 1969.

Listed in Who's Who in Government, 3rd edition.

Married, no children, excellent health.

NEW DIRECTIONS FOR HEALTH PHILANTHROPY

(By Walter J. Unger)

Here are eight areas in which foundations could make major contributions to America's health and well-being.

The many changes that have occurred during the past decade in the nation's health picture provide new opportunities for philanthropy to contribute to the health and well-being of the public.

These changes are worthy of health philanthropists' attention:

First, our total spending on health care as a nation was $139 billion in 1976, more than three times what we spent a decade earlier and double what we spent in 1970.

Second, philanthropy provided $4.4 billion for health causes in 1976, up 67 percent from $2.6 billion a decade earlier. When this 5 percent annual growth in health philanthropy is compared to the 12 percent annual growth in total national health care expenditures, it is clear that philanthropy's role in the health field—from a financial viewpoint—is declining.

Third, the federal government's participation in health care financing has expanded dramatically. Primarily due to Medicare and Medicaid, introduced in the mid-1960's, the federal share of total health spending jumped from 12 percent in 1965 to 30 percent in 1976. The federal government allocated $42 billion for health care last year—nearly 10 times as much money as was donated by private sources.

Fourth, private health insurance—practically nonexistent at the end of World War II—now pays for more than 26 percent of all health care costs.

With the federal government and private health insurance picking up more of the tab for the health care bill, American's out-of-pocket expenditures for health care, when adjusted for inflation, have actually declined. It is not surprising, then, to learn that we are "seeing the doctor" more frequently than ever before in our history.

To meet the demand for health services, the health care industry now employs 4.8 million people, making it the largest industry in the country. Slightly more than one American worker in 20 is employed in the health field.

But numbers alone don't tell the entire story. Other changes have been taking place, too, that are difficult to quantify.

Noted scientist and author Lewis Thomas, president of the Memorial Sloan-Kettering Cancer Center in New York City, points out that "the general belief these days seems to be that the (human) body is fundamentally flawed, subject to disintegration at any moment, always on the verge of mortal disease, (and) always in need of continual monitoring and support by health-care professionals."

As a result of this new attitude in our society, "the health care system is being overused, swamped by expectant overdemands for services that are frequently trivial or unproductive . . . The general public seems convinced that contemporary medicine is able to accomplish a great deal more than is in fact possible." Unfortunately, Dr. Thomas notes, "the public is not sufficiently informed of the facts about things that medicine can and cannot accomplish." He warns us that "we are in some danger of becoming a nation of healthy hypochondriacs."(1)

In spite of many improvements in our health status, "we seem to be doing better but feeling worse."(2) As Dr. John Knowles, president of the Rockefeller Foundation, put it: "There exists a profound national concern that, despite a massive increase in health expenditures together with a marked expansion in health workers over the past decade, the nation's health has improved less than was promised or expected. The benefits have not appeared to justify the costs. To make matters worse, broad indicators of social pathology, including drug abuse, illegitimate births, divorce rates, crime, violent behavior, learning difficulties, and psychological problems . . . tell us that the nation is not as healthy as it should be."(3)

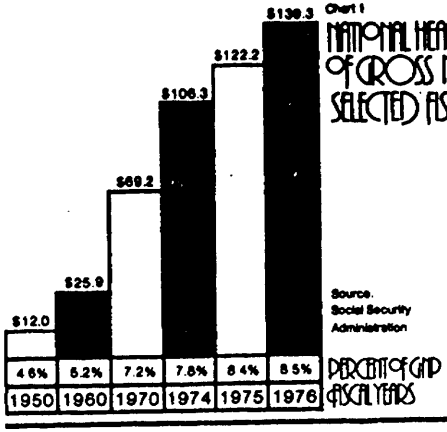
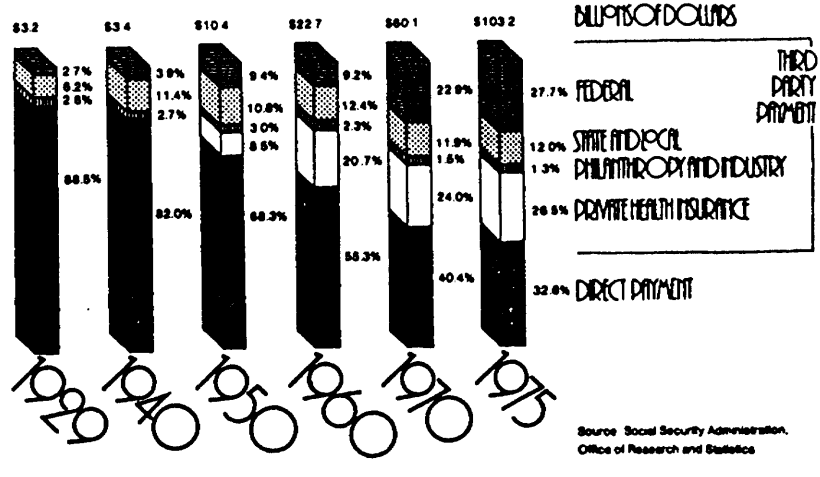


Chart 1

NATIONAL HEALTH EXPENDITURES AND PERCENT OF GROSS NATIONAL PRODUCT SELECTED FISCAL YEARS, 1950-76

DISTRIBUTION OF PERSONAL HEALTH CARE EXPENDITURES BY SOURCE OF FUNDS SELECTED FISCAL YEARS, 1929-75

Chart 2



Source: Social Security Administration, Office of Research and Statistics

In essence, we have created new problems in the very progress of solving old ones. Robert Maxwell summed it up nicely:

"Mastering our environment, we endanger ourselves by polluting it. Becoming affluent, we subject ourselves to the stresses of a crowded, fast-moving world—and at the same time allow ourselves to slip into a dangerously sedentary way of life, eating, drinking, and smoking to excess. Achieving mobility, we kill and maim each other with our motor cars. Relieved of much physical ill-health, whole vistas of mental distress open before us. And when by the standards of the less fortunate, we are relatively free from definable mental or physical ill-health, we become less able than our ancestors to endure minor complaints."(4)

These fiscal and social changes that have occurred provide a climate appropriate for new directions in health philanthropy. New approaches need to be taken. Yet one is constrained to ask: Will philanthropy respond to the new challenges and act responsibly?

Lamentably, there are some signs today that health philanthropy is tradition-bound.

According to estimates made in 1975 by the American Association of Fund-Raising Counsel, (5) about $1 billion—about one-quarter of all health philanthropy—is donated annually for personal health care services. At a time when most Americans have some form of health insurance and real out-of-pocket health expenditures are actually declining, it would seem to be inappropriate for such a substantial share of health philanthropy to be spent in this manner.

Furthermore, another $900 million is given annually to health agencies that tend to take a disease-by-disease approach to the human condition. More often than not, these funds provide health services when they should be invested in basic research to uncover underlying causes of disease. "Regrettably," too, as Dr. Thomas notes, "no agencies exist for the celebration of the plain fact that most people are, in real life, abundantly healthy. No one takes public note of the truth of the matter, which is that most people in this country have a clear, unimpeded run at a longer lifetime than could have been foreseen by any earlier generation."(6)

Finally, 20 percent of all health philanthropy—three quarters of a billion dollars annually—is spent on hospital construction. It would appear few donors realize that nationwide we have an excess of some 100,000 hospital beds. There are few places in the country other than some rural and inner-city areas where there are shortages of beds.

Private money is less needed today for hospital construction because these costs are being borne increasingly by federal and other third-party depreciation reimbursements. In addition, tax-exempt bonds have become a major source of hospital construction financing. These bonds are exempt from federal [and sometimes state and local] taxes, and they enable a hospital to borrow construction funds at a substantial discount, thereby minimizing construction costs.

In short, too many health philanthropy dollars flow toward providing services rather than toward investment in the health care system of tomorrow. Too much goes for purposes that are now being heavily supported by the federal government and other third-party payors. Too little goes for innovative projects.

Here are some areas where philanthropy could make important contributions toward the advancement of Americans' health and well being:

LIFESTYLES

There is an urgent need to raise the public's consciousness that lifestyle has become a prime health hazard in this country. A vast amount of our ill health is caused by the way we live and by the lifestyles we've adopted. John Knowles has declared that "the next major advances in the health of the American people will result from the assumption of individual responsibility for one's own health."(7)

New approaches must be sought to attack the problems of sedentary living, alcoholic overuse, reckless driving, obesity, smoking, suicide, drug abuse, fad diets, promiscuity and carelessness. The traditional health care system has not had, and cannot have, much success in modifying these habits.

A couple of promising possibilities are health education and research. Philanthropy should support far more extensive health education programs, emphasizing individual responsibility and the relation between benefit and cost.* Philanthropy also should support increased behavioral and biological scientific research that would improve our knowledge of the role of human motivation in health needs, psychosomatic illness, family planning, aging and other sociobiological phenomena.

---

*Such an effort could be tremendously helpful, for example, in countering the often just plain bad advice people get about what they should eat, how much sleep they need, or how to deal with stress, much of which comes through the mass media in the form of news, features, or even advertising.

ENVIRONMENT

We need to increase our awareness of environmental hazards and our ability to assess genetic differences among individuals in their adaptation to the environment. We should be expanding our efforts at improving food supplies and removing hazards from the physical environment.

Within the past few years, we have come to appreciate that environment has an effect on cancer. Such factors as smoking, synthetic compounds in our food and water, air pollution, and exposure to industrial and commercial chemicals are known now to cause an estimated 70 percent to 90 percent of all cancer. But our information is meager and the need for definitive research urgent.

And yet if we explore more broadly and obtain a better understanding of the nature and extent of different specific risks, we will then have to answer complex social, economic and psychological questions. We will have to find ways of removing dangerous substances from our environment while somehow reconciling the conflicting interest of various groups that have a stake in the problem.

ETHICS

We need to pay more attention to ethical issues in health care.(8) Our technology in many instances has outstripped our basic humanity. Faced with a scarcity of financial resources, advances in sophisticated and costly medical technology have placed us in the difficult situation of having to decide who can receive treatment. Increasingly, as Victor Fuchs pointed out, we will have to answer the question: "Who Shall Live?"(9) In other words, do patients have the right to unlimited use of expensive medical techniques and at whose expense? Must doctors sustain the lives of their patients as long as technology permits regardless of the quality of the life that is prolonged?

Furthermore, we are faced with other complex ethical issues like abortion, death with dignity, human experimentation, and psychosurgery.

OLDER AMERICANS

In our youth-oriented culture, it is frequently overlooked that ours is an aging society. Older people are the fastest growing segment of our population. Persons in retirement, or nearing it, now constitute more than 15 percent of our total population.

Old age in America is all too often plagued by poverty, chronic illness, a sense of uselessness, isolation and loneliness. The high rate of suicide among men over 65 speaks loudly of misery and despair. Regrettably, society's generally negative attitude about aging and the social structures that we have built encourage isolation and segregation of older people. Philanthropy should be paying far more attention to solutions to these problems than it is.

For example, philanthropy could assist innovative projects that would benefit the elderly by providing home health services, homemaker services, nutritional services, day care and foster home services, community mental health center outpatient services, professional counseling, legal counseling, barrier-free housing, and gerontological teaching and research.(10)

Furthermore, there is a need for the recognition that most older persons are in fairly good health, can care for themselves, and live alone or with a spouse. These self-sufficient individuals represent a large and underutilized resource for our nation. We need to assist them in finding something useful to do in society and to encourage them to enter second careers or new careers on a paid or voluntary basis. In addition, then, we need to reassess our policies toward mandatory retirement.

CARING

Our health-care system today provides too little time to meet the important functions of caring. Frequently, patients simply need someone to compassionately listen to their problems, to sympathize with them and to help them work out their difficulties. We need to find a better way of providing person-to-person contacts to help relieve anxiety in cases where patients are not suffering from major illnesses, but either think they are or simply don't know what's wrong with them.

Many people visit doctors for advice about living: What should their diet be? Should they take a vacation? What about a tranquilizer for everyone's inevitable moments of agitation and despair? We should be trying to develop improved ways for handling these questions through new types of counseling services.

We also need more counsellors to work with such problems as teenage pregnancy, venereal disease, drug abuse and alcoholism. And we need to find better ways for providing for patient follow-up. Was the treatment regimen followed? Are there any

questions about what to do? These are matters for which we need trained health guidance counsellors.

PLANNING

We need to find better ways for enlisting hospitals, medical schools and other health facilities in a serious planning process to avoid excess capacity and needless duplication of facilities, to promote the efficient sharing of expensive equipment, and to consolidate residency-training programs in order to avoid duplication and to ensure the minimum size required to sustain a high quality effort. The need for such planning is critical.

It is wasteful and unnecessary, for example, for every hospital to expend half a million dollars to purchase a new CAT scanner, a sophisticated X-ray and computer diagnostic tool. There are enough of these scanners in southern California to serve the entire western United States.(11)

COST EFFICIENCY AND EFFECTIVENESS

We should make a greater effort to encourage the development of well-designed, large-scale tests to determine the effectiveness of medical technology and to evaluate new methods of patient care. At present, there is no satisfactory means for evaluating new types of laboratory tests and new technological devices to be sure that their benefits are worth the cost.

Similarly, expensive new procedures are being introduced every month without satisfactory proof that they bring lasting improvements to our health. For example, thousands of people have already received coronary bypass surgery at a cost of at least $7,000 to $10,000 each. Up to four million persons are potential candidates for this procedure, and under provisions of a form of proposed National Health Insurance they might succeed in having these operations performed at total cost to the nation of $20 billion. Although some comparative studies have been made, controlled reliable clinical trials have not yet been performed to determine whether the operation has any significant effect on preserving human life.

REFORMING THE HEALTH-CARE SYSTEM

H.E.W. Secretary Califano, in a recent speech to the American Medical Association delegates, said:

"We know that any long-term strategy for reform in the health system must:

Provide alternatives to costly institutional care—whether in hospitals or nursing homes;

Encourage the substitution of general primary care for more costly specialized care wherever that is possible without lowering quality standards;

Expand and make more efficient the use of less expensive health care personnel;

Stress prevention and early treatment—especially among children—to avoid unnecessary illness, disability and death.

"For too long, all of us in health care have been using our affluence to cure problems, rather than our ingenuity and self-discipline to prevent them. We have not been willing to confront the hard fact that resources are limited. We must find new methods to provide quality health care to all Americans at a reasonable cost."(12)

In addition, we need to examine ways in which the health-care system can be designed, or redesigned, for use when it is really needed and when it has something of genuine value to offer. We need to understand why Americans are preoccupied with disease in spite of evidence that we are, as a nation, abundantly healthy. We should be investing far more dollars in health services research and development than we are at present.

The challenge to do better is substantial. And yet my experience in Washington tells me that the federal government will be quite slow in adopting new solutions. Enlightened leadership is not likely to come from private health insurers because they lack the necessary incentives to change the status quo.

Clearly, there are major opportunities today—as there have been in the past—for philanthropy to provide the necessary and important funds for innovation and experimentation in the health field. Philanthropy must not be bound to traditional ways of doing things. Rather it should be providing seed money, risk money and flexible kinds of support so vitally needed to allow us to address the new health problems that we face today. In so doing, philanthropy will be acting in the public's best interest, and it will—at the same time—be building ample support to justify its continued preferential tax status.

REFERENCES

1. Lewis Thomas, M.D., "On the Science and Technology of Medicine" in Doing Better and Feeling Worse: Health in the United States, edited by John H. Knowles, M.D. (New York: W. W. Norton & Co., 1977 or Daedalus, Winter 1977 issue of the Journal of the American Academy of Arts and Sciences).

2. This phrase was coined by Aaron Wildavsky, president of the Russell Sage Foundation and until recently dean of the Graduate School of Public Policy at the University of California, Berkeley.

3. John H. Knowles, M.D., introduction to Doing Better and Feeling Worse: Health in the United States, op. cit.

4. Robert Maxwell, Health Care: The Growing Dilemma (needs vs. resources in western Europe, the U.S., and the U.S.S.R.) a McKinsey & Company Survey report, New York, June 1974, page 7.

5. American Association of Fund-Raising Counsel estimate. See Giving USA: 1975 Annual Report, pages 33-39.

6. Lewis Thomas, op. cit.

7. John H. Knowles, M.D., "The Struggle to Stay Healthy," a Bicentennial essay for Time magazine, August 9, 1976, pages 60-62.

8. See Daniel Callahan, Ph.D. (founder and director of the Institute of Society, Ethics and the Life Sciences at Hastings-on-the-Hudson, New York), "Health and Society: Some Ethical Imperatives" in Doing Better and Feeling Worse, op. cit.

9. Who Shall Live? Health Economics and Social Choice by Victor R. Fuchs, Ph.D. (New York, Basic Books, 1974).

10. Consult:

(a) Care of the Elderly: Meeting the Challenge of Dependency (New York: Grune and Stratton, 1977).

(b) The Elderly and Functional Dependency, a policy statement by a committee of the Institute of Medicine, June 1977.

(c) Our Future Selves, A Research Plan Toward Understanding Aging of the Department of Health, Education and Welfare, National Institute on Aging, 1977.

(d) Why Survive? Being Old in America by Robert N. Butler, M.D. (New York: Harper and Row, 1975).

11. See Computed Tomographic Scanning, A policy statement by a committee of the Institute of Medicine, April 1977.

12. Joseph A. Califano, Jr., "What's Wrong with U.S. Health Care," speech to the American Medical Association House of Delegates, June 19, 1977 in San Francisco. Reprinted in the Washington Post, June 26, 1977, page B3.

ABOUT THE AUTHOR

Walter J. Unger is a private consultant to academic health centers, hospitals and other health care institutions. His experience in financial planning, fund raising, public relations and government relations includes 4 1/2 years of service as the Special Assistant to the President of the Institute of Medicine, a branch of the National Academy of Sciences in Washington, D.C., where he designed a resource development program that raised $5.5 million from philanthropic foundations and others. He also served for 1 year as the administrator of the Good Hope Medical Foundation in Los Angeles and for 3 years on the health sciences development staff of the University of Southern California where he received a bachelor's degree in business administration in 1967 and a MBA degree in 1969. His office is at 8506 Lynwood Place, Chevy Chase, Maryland 20015. Telephone: (301) 654-8511.

Statement of the American Dental Association

We appreciate this opportunity to discuss various aspects of this complex legislation which would make major changes both in the administration of, and the methods for determining levels of reimbursement under, the medicare and medicaid programs. The dental profession was active during the development and initial implementation of these programs and currently provides a significant amount of services under each of them. We are vitally concerned with problems which have developed with these programs and with the efforts which are and will be made to resolve these problems. Above all we are concerned that these programs provide the best care possible to eligible persons.

The dental profession has a very direct interest in the provisions of Section 35 of S. 505. Our comments will be directed primarily to that provision, although we also will comment on other provisions in the bill as well as other areas which we believe

should be addressed in order to make the medicare and medicaid programs more equitable.

Coverage under medicare of certain dentists' services (Section 35)

This provision addresses a very significant deficiency in the current administration of the medicare law relating to the provision of covered services which legally can be provided by both physicians and dentists. Under medicare there are certain services which dentists are specifically authorized to provide. Dentists are reimbursed for the provision of these services. However there are other covered services which dentists are authorized by state licensing laws to perform but which, if provided by a dentist, are not paid for under the medicare program even though physicians are routinely reimbursed for providing the same services.

Section 35 would amend the medicare law to provide that those services which a dentist is legally authorized to perform and which are covered under the medicare program would be paid for by medicare when provided by a dentist as they would be if a physician had performed them. This provision would not authorize additional medicare benefits. It simply makes the system of reimbursement for covered services more equitable. For example under the medicare program only certain oral surgery services currently are covered if performed by a dentist. However dentists often are involved in other related activities such as diagnosis and treatment of oral infections. Such activities currently are covered if provided by a physician. Section 35 would clarify the law so that such procedures also would be covered when performed by a dentist. Most importantly, it should be pointed out that not only is the current narrow interpretation of the law inequitable for the dentist, it also denies a covered benefit to those elderly patient beneficiaries who choose to have such services provided by a dentist.

We strongly urge adoption of the provisions of Section 35, including the attached technical amendments which would improve the language of Section 35. These technical amendments do not in any way alter the intent or substantive effect of this provision.

We also urge adoption of an additional amendment which would correct a current inequity in the medicare law relating to reimbursement for hospitalization which is necessary because of the severity of a patient's dental condition. The medicare law provides reimbursement for the costs of hospitalization which is necessary for the performance of a dental procedure if the dental procedure is a covered service. However in cases where the dental procedure is not covered under the medicare law, but hospitalization is necessary because of the severity of the dental procedure, eligibility for reimbursement of these hospital expenses is extremely restricted.

It is important when providing services to elderly individuals, even those who are in good physical health, that adequate medical backup be available. In many cases, because of the severity of the dental procedure which is to be undertaken, it is necessary that an aged patient be hospitalized in order to provide the proper level of support.

In cases where the dental procedure itself is not covered, however, medicare will not reimburse for the costs of hospitalization unless the hospitalization is required for the management, control, or treatment of a specific preexisting medical condition. While it is appropriate that hospital expenses be reimbursed in such situations it is equally important to the medicare beneficiary that such expenses also be covered in cases where, in the judgment of the dentist performing the procedure, hospitalization is necessary because of the severity of the dental treatment to be performed. We have attached an amendment to accomplish this objective and we urge its adoption by the Subcommittee. The amendment would not expand dental benefits but would assure coverage for necessary hospitalization.

Agreement by physicians to accept assignments (Section 5)

The provisions of Section 5 of S.505 are restricted to doctors of medicine or osteopathy. These provisions authorize certain administrative and financial incentives to participating physicians, who would be defined as physicians who agree: (1) to accept assignments for all claims made for treatment of individuals under Part B of medicare, and (2) that the reasonable charge as determined under the medicare law would be the full charge for services. We feel that the incentives offered in this Section to participating physicians may be attractive to certain providers. At the same time, we are opposed to the requirement that this provision apply to all claims or to none at all. A mandate that all claims be on an assignment basis could further reduce, rather than increase, the level of acceptance of assignments by physicians. Payment of adequate reimbursement would provide greater incentives for the acceptance of assignments.

Criteria for determining reasonable charge for physician services (Section 10)

Before discussing the provisions of S. 505 which address reimbursement to individual practitioners under medicare and medicaid, we want to stress that provisions for reimbursement to dentists under these programs should be consistent with provisions for the reimbursement of physicians.

The American Dental Association is well aware of problems which have been raised because of different payment levels for services which are provided in metropolitan areas as opposed to payment for those same services when provided in rural areas. The medicare reimbursement mechanism, which is loosely based on the usual, customary, and reasonable (UCR) fee system, which is supported by the American Dental Association, has divided the nation into regions for which reimbursement levels are determined. Most states contain more than one region. Although it is true that an argument can be made that a single program should pay the same amount for any given services no matter where provided, it is also true that costs for providing those services do differ from one area to another, even within a single state.

We believe that the usual, customary, and reasonable fee system reflects differences in reimbursable amounts, based on provider costs and other similar factors, between urban and rural areas. While preferring the UCR system, we feel that the system being used in the medicare program which is inequitable in many ways, does reflect these differences in the costs of providing services. We do not feel that it is appropriate that the lid which is proposed by S. 505 in Section 10 be adopted. Although this Section would not automatically grant uniform payment for services regardless of where they are provided, it would dictate allowable reimbursement levels under the medicare program on a basis which is unrelated to the usual, customary and reasonable charges made by health care providers in the area.

Disclosure of aggregate payments to physicians (Section 23)

Section 23 would prohibit the HEW Secretary from disclosing, and provide discretionary authority with the state medicaid agencies with regard to disclosing, to the public information relating to the amounts that have been paid to individual doctors of medicine or osteopathy under the medicare or medicaid programs. The American Dental Association feels that the effects of this disclosure policy in the past have been totally negative. Not only does this procedure improperly imply to the public a wrongdoing on the part of those who are named, but in addition the methods by which names have been disclosed have been grossly inaccurate. The implications of this disclosure have caused incalculable damage to the reputations of the individuals involved. Without a showing of wrongdoing there is no valid reason for permitting such disclosure.

We note that the provisions of Section 23 are limited to the disclosure of names of doctors of medicine or osteopathy. It should be noted that the names of other health professionals including dentists have been disclosed under this HEW process. With an amendment to expand the scope of this provision to prohibit disclosing the names of dentists, the American Dental Association heartily endorses this provision.

Termination of HIBAC (Section 18)

It has been our belief that the existence of an advisory council to the Secretary for the medicare program, such as the Health Insurance Benefits Advisory Council, which can bring to the Secretary the advice and recommendations of individuals who are involved with the program, is most commendable. With adequate financial and staff support, we believe that this body could contribute more to the solution of problems faced by medicare and other national health programs. We understand that there have been criticisms of the effectiveness of HIBAC but feel that the major problems of this Council are based on a lack of adequate support within the Department of HEW. We recommend that HIBAC be retained and provided with adequate staff and financial support.

Confidentiality of PSRO data (Section 28)

The Association also supports the provisions to guarantee confidentiality of data compiled by Professional Standards Review Organizations.

In commenting on the PSRO program we would like to once again bring to your attention the necessity for including dentists in this program. We have outlined to the Subcommittee on numerous occasions in the past the extensive involvement of dentists in the medicare and medicaid programs. It is important that the PSRO law be amended to provide formal dental participation in the policymaking and review processes.

The Association has developed legislation to mandate dental membership on the National and State PSR Councils and to require immediate review by dentists of

dental care provided to hospital inpatients. In addition the legislation would require that before PSRO review is expanded to ambulatory care there be full participation of dentists in the review of this dental care. Our suggested amendment to accomplish these objectives is attached and we urge its adoption.

SUGGESTED TECHNICALLY IMPROVED AMENDMENT RELATING TO COVERAGE OF CERTAIN DENTISTS' SERVICES

That clause (2) of the first sentence of section 1861(r) of the Social Security Act is amended to read as follows: "(2) a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function or action and who either is acting within the scope of his license when he performs such function or action or is making the certification required by section 1814(a)(2)(E)."

SUGGESTED AMENDMENT TO COVER NECESSARY HOSPITALIZATION IN CONNECTION WITH A DENTAL PROCEDURE

Section 1814(a)(2)(E) of such Act is amended to read as follows:

"(E) In the case of inpatient hospital services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services; or".

(c) Section 1862(a)(12) of such Act is amended by inserting "or because of the severity of the dental procedure" after "clinical status".

PROPOSED DENTAL PROFESSIONAL STANDARDS REVIEW ORGANIZATION AMENDMENT

SECTION 1. Section 1152 of the Social Security Act is amended—

(a) By renumbering clause (b)(1)(A)(vi) as (b)(1)(A)(vii);

(b) By inserting a new clause (b)(1)(A)(vi) after clause (b)(1)(A)(v) as follows: "(vi) which permits dentists to be dental members with duties and functions limited to those specified in Section 1171,";

(c) By inserting after "restrict" in clause (b)(1)(A)(vii) "(other than as provided for in Section 1171 as in the case of a dental member)".

SEC. 2. Section 1162 of the Social Security Act is amended—

(a) By renumbering paragraph (b)(3) as paragraph (b)(4) and by striking out "and" at the end of paragraph (b)(2);

(b) By adding a new paragraph (b)(3) as follows: "(3) two dentists; and;" and

(c) By inserting in subsection (e) the words "or dentists" after "physicians".

SEC. 3. Section 1163 of the Social Security Act is amended—

(a) By inserting in subsection (a)(1) the words "and two dentists," after "physicians"; and

(b) By inserting in subsection (b) the words "and dentists" after "physicians" the first time it appears and by inserting the words "or dental" after "medical".

SEC. 4. Part B of Title XI of the Social Security Act is amended by adding at the end thereof a new Section 1171 as follows:

Section 1171(a) Notwithstanding any other provision of law the Secretary shall provide by regulation that duties and functions of Professional Standards Review Organizations enumerated in Sections 1155, 1156, and 1157 of this Title as they relate to dental services shall be performed as specified in this Section.

(b) No dental services shall be subject to review under this Title unless such review is participated in or performed by dental members of the Professional Standards Review Organization as specified in subsections (c) and (d) of this Section.

(c) The Secretary shall require that each PSRO include within its membership doctors of dental surgery or of dental medicine, if any, who have staff privileges in hospitals located within the PSRO area for purposes of review of institutional dental services including participation in the review of services which can legally be performed by physicians or dentists.

(d) The approval required under Section 1155(g) for review of other than institutional services shall not be granted with regard to dental services unless the PSRO has entered into an agreement with a majority of dentists in the PSRO area under which such dentists would be dental members of the PSRO and would be responsible for performing all of the duties and functions of Professional Standards Review Organizations as enumerated in Sections 1155, 1156, and 1157 which relate to dental care. Review of institutional dental services shall continue as provided in subsection (c).

(e) For purposes of this Title dental membership on Professional Standards Review Organizations shall be open to all doctors of dental surgery or of dental

medicine in each PSRO area who elect to participate as members in Professional Standards Review Organizations for the purposes enumerated in this Section. The Secretary shall establish a procedure for the participation, on a rotating basis, of dental members in the review process.

(f) Section 1155(c) is amended by inserting after the phrase "doctor of medicine or osteopathy" the first time it is used the following: (except for purposes of review as authorized in Section 1171(c).

(g) Section 1155(b)(1) is amended by striking the phrase (including dentistry).

STATEMENT OF THE WYOMING HOSPITAL ASSOCIATION AND WYOMING HOSPITAL RESEARCH AND EDUCATION FOUNDATION

HOSPITAL COST CONTAINMENT—IT'S IMPACT IN WYOMING

Wage-price controls of 1979-73 demonstrated the impracticality and and ineffectiveness of regulating the economy through arbitrary limitations on the costs of goods and services. The program failed and worse, led to an intensification of the inflation rate following the demise of the program. Further attempts to regulate the health care industry and hospitals in particular, led to serious economic problems in the industry and a major cut-back in services and the development of services in health care institutions. An even greater increase in the inflation rate of health care costs was seen following that programs as the health care industry attempted to recover from the damages that had been inflicted upon it.

The process of regulating the economy as a whole through arbitrary wage-price controls has been discredited. Even the most liberal of politicians shy away from such programs and their inevitable results.

However, in the current crisis of inflation which this country faces, the administration is willing to implement arbitrary controls on the costs of services and income of the health care industry. This measure is taken with the full understanding of the damage that similar programs have done to the health care industry in the past and with the certain knowledge that any success demonstrated by the program must result from a depletion of the assets of the industry, a slowing in the development of facilities and services in the industry and a cut-back in the level and quality of services provided to our citizens.

Wyoming's hospitals and health care industry are especially vulnerable. Due to the small size of our hospitals, our geographic spread and our low population densities the hospital industry in our state has been slow to develop. We have provided primary health care services but are just now in the process of developing some of the more sophisticated diagnostic and therapeutic services taken as a matter of course in more densely populated areas.

This problem of development is intensified by the recent influx of population to the state. Dramatic changes in our population have occurred which are demanding dramatic responses from the health care industry. In the face of this rapidly increasing demand, we can ill-afford to jeopardize the meager resources of our hospitals through imposing artificial controls on top of those already in place.

Wyoming hospitals have a proud record of being amongst the lowest cost health care institutions in the United States. They rank 2nd among all of the states in terms of the costs of the average admission.

It is of compelling interest to us that this advantageous position for our citizens should now be turned to our disadvantage by the federal government. However, it is a fact of the administrations proposed controls that the greatest dollar increases in cost will be allowed to those hospitals whose costs are already the highest and the least dollar increase in costs to those whose costs are now the lowest. Any regard for need has been laid to rest by the proposal. A real blow to Wyoming's hospitals which are hard pressed by impact and development problems. If such a proposal is to be implemented, it should, in equity, give consideration to both the record of individual hospitals in the area of cost containment and to the needs of those hospitals in providing services.

The problems of hospitals in containing their rate of increase, result from many factors. These include the general inflation rate in the economy; the cost of government regulation, intensity of services, demand for services and new technology.

The general inflation rate in the economy reflects the costs of goods and services purchased by hospitals. With the exception of labor costs, it is beyond the control of the hospitals. Labor costs can be controlled only within reasonable limits that relate to the general inflation rate.

The cost of governmental regulations are beyond the control of the hospitals. It is indicated, however, that the cost of new governmental regulation in 1978 (especially

the new System For Hospital Uniform Reporting) will represent a significant part of increased hospital costs.

The three remaining factors; intensity, demand and new technology are more amenable to control. However, they are controllable through the device of providing less service and/or poorer quality service. In view of the increasing demand for hospital services in Wyoming and our need to provide more sophisticated and intensive services, this should be an unacceptable alternative both socially and politically.

While only 6 hospitals in the State of Wyoming would fall under immediate controls under the Administration proposal, it must be noted that those 6 hospitals provide 55 percent of all inpatient hospital services in the State of Wyoming and a far greater percentage of outpatient services. It is those six hospitals which are most pressured to provide the more sophisticated services which are under development in this state. They are subjected to the greatest increases in demand for specialty services and outpatient services. They represent the referral centers for the smaller hospitals in the state.

COMMENTS ON THE PRESIDENT'S HOSPITAL EXPENDITURE GUIDELINES SUBMITTED TO SENATOR MALCOLM WALLOP BY LEWIS W. SPENCER, ADMINISTRATOR, MEMORIAL HOSPITAL OF NATRONA COUNTY

It is with appreciation that the following comments are submitted for your consideration.

1. The voluntary effort is working

The Voluntary Effort has been demonstrated to be an effective approach in reducing the cost of hospital health care. The objective of a reduction in the rate of increase of 2 percent per year for 1978 and 1979 is being met. The reduction in the rate of increase for the year 1978 was 2.9 percent, slowing the inflation rate for health care delivery to 12.9 percent for the year.

This occurred in health care delivery while the general rate of increase in inflation advanced 2.1 percent compared to the prior year. The Voluntary Effort is the only national program that has demonstrated its effectiveness in slowing inflation.

The President estimates the passage of this proposed legislation can save 1.7 billion dollars annually. The Voluntary Effort on a national basis has already achieved savings in the amount of 1.39 billion dollars for 1978. The inflation reduction goals are being achieved as these figures demonstrate and it is unnecessary to establish another governmental bureaucracy with so very little to be gained.

2. Impact of cost on supply items beyond the ability of the hospital to control

In large measure, hospitals are unable to control the cost for items manufactured and supplied by other segments of the economy and utilized in daily hospital operation. Listed below are a few examples comparing the cost increases for Memorial Hospital of Natrona County and the rate of increase that has occurred in the cost of these items.

Item	1977-78 annual expenditure	1978-79 annual expenditure	Percent increase	1979-80 annual expenditure	Percent increase
Natural gas	$70,000	$105,000	50	$140,000	33
Malpractice insurance	0	0	0	40,000	NA
Electricity	56,000	63,000	13	72,000	14
Blood expenses	53,000	53,000	0	72,000	36
Telephone	81,000	95,000	17	109,000	15
Postage	34,000	39,000	15	48,000	23
Equipment replacement	360,000	600,000	67	720,000	20
Social security	375,000	400,000	7	455,000	14

One last example of cost increases over which we have no control, is the Linear Accelerator that Memorial Hospital purchased in September, 1978 for $338,000. Approximately 90 days later, the price on this same unit was increased to $410,000, which is a 21.3 percent increase.

3. Impact of inflation and competition in the local labor market

Hospitals are service organizations and the largest items of expense for any hospital is the salary cost for employees. Memorial Hospital is typical of most

hospitals in that approximately 60 percent of the total expenditure goes for salary expenses. It is absolutely necessary that we maintain a competitive salary schedule for Memorial Hospital employees, if we are to continue to attract competent employees. At this time, our entry level salary scales for non-technical employees is $3.25 per hour. Similar job occupations throughout the community are presently being paid $4.00 per hour. We must increase our entry salary levels to at least $3.90 which is an increase of 20 percent just to remain on a competitive level with the organizations in the community with whom we compete for employees.

We must compete within and without the State in terms of attracting professional employees. Our starting salary for a registered nurse at Memorial Hospital is $5.57 per hour. For a medical technologist, our entry level salary is $5.72 per hour and for an x-ray technologist, $5.20 per hour. These salary levels are approximately 13 percent below some 10 other hospitals in the State and below the Denver and Billings areas from which we recruit many employees. These are salary levels that exist at this time. We anticipate our competition to levy an increase of approximately 10% to 12% in excess of their existing salary levels this summer.

4. The President's approach will damage the effect of the Voluntary Effort

The President's approach to this problem will be to undermine the health care industry's successful Voluntary Effort anti-inflation program. The guidelines are, in fact, federal controls. The threat and fear of the implementation of these controls will cause hospitals all across this country to increase their charges, simply to be in advance of the mandatory controls that would prevent their ability to adjust charges on an as-needed basis. These proposed regulations and the attention that they will receive, will undoubtedly be an inflation contributing factor in health care delivery.

5. The limit on capital expenditures is presently being addressed by existing legislation

The three billion dollar national limit on capital expenditures will undermine the National Health Planning and Resources Development Act. Public Law 641 in conjunction with Wyoming Certificate of Need Legislation has proven to be an adequate mechanism for review and control of capital expenditures.

6. Discrimination in the approach compared to other segments of the economy

For all segments of the economy, except health care, the President's anti-inflation measures are voluntary with no proposed automatic legislation establishing mandatory controls. The Council on Wage and Price Stability has been designated as the responsible agency to promote and develop these voluntary guidelines. The responsible agency for monitoring and evaluating the anti-inflation program for hospitals is being delegated to HEW Secretary Califano, with the automatic threat of mandating price controls on a single segment of the economy if the objective of 9.7 percent ceiling is not achieved. No other segment of the economy has been so singled out in terms of proposed regulations in the President's anti-inflation national goals.

7. Forced reduction in services and reduced technological development

Should price controls be mandated on hospitals, patient care services will, by absolute necessity, have to be reduced. The responsibility of hospital boards of trustees and medical staffs for determining local health care needs will be severely diminished. Technological developments in diagnosis and treatment capabilities will undoubtedly be slowed. The dramatic lifesaving medical advances that this nation has demonstrated for many years will also be severely hampered.

Thank you very much for your consideration of this very important subject. It is respectfully requested that you support the Voluntary Effort of hospital cost reduction and oppose legislation that would mandate price controls on hospitals or any other single segment of the nation's economy.

Statement of the South Dakota Hospital Association

I. THE NATURE OF HOSPITAL EXPENSE AND INCREASES

Although increases in hospital expenditures are often viewed as resulting solely from inflation, they are made up of three basic factors:

Increases in the costs of goods and services that hospitals must purchase;

Increases resulting from both a larger and an older population; and

Increases resulting from improvements in medical technologies and extension of services.

These factors, taken together, account for increases in hospital expenditures and make it misleading and incorrect to compare changes in hospital expenditures to the rate of inflation in the general economy.

Realistic consideration of the impact of each of these factors is basic to an understanding of hospital expenditure increases and to the development of effective and equitable strategies to foster cost containment while maintaining the quality and accessibility of hospital care. Thus, as a part of its efforts to analyze hospital expenditures, the American Hospital Association (AHA) has made estimates of increases in each of these factors for 1979.

Increases in costs of goods and services

In 1979, hospitals will have to pay at least 9.1 percent more for the same goods and services—known as the "hospital market basket"—that they purchased in 1978, even if the President's economy-wide anti-inflation program is successful. About half of this increase will be due to wages and salaries. In the hospital industry, about 20 percent of all wages and salaries are not subject to the wage guidelines of the President's anti-inflation program, inasmuch as they fall under the minimum wage exemption. An additional 20 percent of wages may be exempt under the tandem relationship guideline. Other mandated personnel expenses that do not fall under the wage guidelines, such as Social Security taxes, will increase approximately 12 percent in the coming year.

Approximately 25 percent of hospital nonwage expenditures are made for such items as energy, food, and interest rates that are exempt from the President's wage/price guidelines. Increases in the prices of these items will cause increases in the prices hospitals pay that exceed national price increase averages. Further, hospital operations are now adjusting to the rapid (8.8 to 10.7 percent annualized by calendar quarter) inflation in costs of goods and services in the hospital "market basket" which occurred during 1978. In the aggregate, increases in the wage and nonwage components of hospital costs that are exempt from the wage/price guidelines mean that more than 30 percent of hospital costs will rise faster than the target rate proposed in the President's guidelines.

Increases resulting from both a larger and an older population

Changes in the population will again, as they have in the past, contribute to increased hospital expenditures in 1979. The U.S. population is expected to grow by about 1,800,000 persons, or by more than 0.8 percent. Additionally, there will be an increase of about 500,000 persons in the over-65 group—an increase in the elderly of more than 2.1 percent. Further, the elderly population itself is aging—persons 75 years old and older will, in 1979, become the fastest growing population segment in the country.

Persons 65 and over, who represent about 11 percent of the total population, constitute 26 percent of total hospital admissions and utilize 38 percent of total inpatient days. Elderly persons make greater use of hospitals for a variety of reasons, including a higher incidence of chronic conditions and the existence of multiple medical problems requiring longer and more frequent hospital stays. Per capita expenditures for the aged are about 3.5 times greater than for the younger population. The projected increase in persons 65 and older will add approximately three-tenths of 1 percent to the overall national increase in hospital expenditures during 1979. Thus, predictable changes in the size and age of the population are likely to increase hospital expenses about 1.1 percent.

In South Dakota the effects of population growth in total do not have a marked impact on hospital expenses since the state has been growing only very slowly in the recent past. The effects of a disproportionally elderly population, however, have a dramatic impact in our state. In this decade, the over-65 age group has consistently comprised a greater proportion of South Dakota's population than has been the case nationally (12.2—12.7 percent vs. 9.9—10.7 percent). Of perhaps even greater significance in hospital expense considerations is the proportion of the elderly population which is age 75 and older. In 1970, the most recent year for which we have comparable statistics, 5.1 percent of South Dakotans were over age 75 compared to the national figure of only 3.8 percent.

Increases resulting from technological improvements and extension of services

Hospitals will experience the impact of more complex technology and other service improvements during 1979. Such advances are the products of the continuing national investment in biomedical science and technology. The increasing efficacy and availability of medical care is reflected in increasing utilization of health services—particularly among the elderly. Our capabilities to diagnose and treat illness effectively are expanding. Recently, increases in services due to such en-

hanced capabilities have added about 4 percentage points to the annual increase in hospital expenditures. During 1979, it is expected that advances in technology and increases in utilization will contribute about 3.8 percent to the overall increase in hospital expenditures. Much of this increase will be the result of commitments and activities started years ago that cannot and should not be eliminated in the short run.

Nowhere in the country is this impact of the increase in quality and quantity of hospital services more relevent than in a rural, sparsely populated state such as South Dakota. Consider the impact on hospital expenses of the following:

	Year	
	1960	1977
Number of South Dakota hospitals with:		
Intensive care units	1	30
Radiology therapy and radioactive isotope services	16	30
Blood banks	18	32
Kidney dialysis services	0	7
Physical therapy departments	14	27
Respiratory therapy departments	0	30
Social services programs	0	13

This dramatic change in the quality and number of hospital services has accrued to the benefit of all South Dakotans, but is too often overlooked in discussions about hospital cost increases. By way of summary then, hospitals nationally will face cost increases of about 14 percent in 1979, comprised of the following factors:

A 9.1-percent increase in the costs of necessary goods and services;

A 1.1-percent increase resulting from the growth of population, and a relatively large increase in the number of elderly persons; and

A 3.8-percent increase in services resulting from technological improvements in medical care and expansion, where needed, in availability of services.

These factors may be quite simply and understandably expressed as an equation where:

Increase in Hospital Expenses = Inflation + People + Services

If any one of the factors on the right of the equation changes (as they have changed and continue to change) their hospital expenses will change. Since, in fact, all three of these factors have steadily grown it is apparent and inevitable that hospital expenses will grow in proportion to the combined impact of general inflation, more and older people, more and better hospital services.

In recent testimony before the Subcommittee on Health of the Senate Committee on Labor and Human Resources, the noted economist, Martin Feldstein, President, National Bureau of Economic Research, and Professor of Economics, Harvard University, summarized the basic concepts expressed by this formula with clarity and precision.

"The administration describes the control of hospital costs as a part of its overall anti-inflation strategy. This represents a misunderstanding of the true nature of the rise of hospital costs and the general problem of inflation.

"For the economy as a whole, inflation means the increase in the cost of buying an unchanged bundle of goods and services; this is precisely what the consumer price index tries to measure. In contrast, the relatively rapid rise in the cost of a day of hospital care reflects the rapidly changing hospital product.

"The most obvious thing about hospital care today is that it is very different from what it was 25 years ago or even a decade ago. Today's care is more complex, more sophisticated, and more effective. The cost of hospital care rises more rapidly than the price level in general because patients and their doctors are no longer choosing the same old product but are buying a different and much more expensive product. The rapid rise of hospital costs is therefore not a form of price inflation but represents an increase in the quantity of hospital services that are packed into a day of hospital care."

II. THE "VOLUNTARY EFFORT"

In order to formalize and focus ongoing efforts of the private sector in hospital cost containment, a broadly based national coalition of organizations, the "Voluntary Effort" (VE) was created in late 1977. The overall policy and governing body of

the VE is its National Steering Committee (NSC), made up of representatives of hospitals, physicians, health care suppliers and manufacturers, insurance carriers, local government, business, labor, and consumers. The goals and objectives set by the NSC are implemented through state VE committees established in all 50 states. Technical and educational assistance to hospitals and physicians is provided by the NSC member organizations and the state committees.

Here in our state, the South Dakota Hospital Association and the South Dakota State Medical Association created the South Dakota Voluntary Effort Steering Committee with the express purpose of supporting the national Voluntary Effort and encouraging and assisting South Dakota physicians and hospitals in their voluntary cost containment activities.

The broad goal of the national VE, set in December 1977, is to significantly narrow the gap between the rate of increase in total health care expenditures and the rate of increase in the nation's overall Gross National Product. The most visible and immediate operational component of this goal is the objective of reducing, over a two-year period, the rate of increase in total hospital expenditures by 4 percentage points—from a 15.6 percent rate of increase for calendar year 1977 over the 1976 level to 11.6 percent for calendar year 1979 over the 1978 level. We are pleased to be able to report that the results of the VE's first year have been successful. Nationally, the rate of increase in hospital expenditures in calendar year 1978 was nearly three percentage points lower than proposed an arbitrary "cap" on patient revenue from all sources for all hospitals in the country; literally making it a crime for any hospital to take in more money than allowed by the Secretary of the Department of Health, Education, and Welfare who was to administer the program. The proposal failed to pass the Congress, but President Carter and Secretary of HEW Califano have again in 1979 asked the Congress to pass a similar measure, "The Hospital Cost Containment Act of 1979", (S. 570/H.R. 2626).

The proposed bill calls for the Secretary of HEW to establish so-called "voluntary" limits on hospital expenses. These limits are fundamentally different from the goals of the VE which have been described above. There is absolutely nothing voluntary about this proposal—a hospital is either under a mandatory expenditure increase limit or a mandatory inpatient revenue cap. We hope that no one will be fooled by the misuse of the word "voluntary."

The Administration has consistently opposed standby wage and price controls for the national economy. Its opposition has been based on the concern that standby controls are inflationary, a view with which most economists agree. Standby controls encourage protective actions by those threatened with controls in anticipation of future constraints. Standby controls would be just as harmful in the hospital industry as in other parts of the economy.

Hospitals face a wide variety of different conditions and needs in the local communities they serve throughout the nation and even in South Dakota. There are important differences, for example, in the size and scope of their services, the composition of the populations they serve, the problems of the patients they treat, the characteristics of the medical practice they offer, the levels and patterns of utilization in their localities, and the costs of goods and services in their that for 1977. In 1978, the rate of increase was 12.8 percent, as contrasted to 15.6 percent for 1977. The VE, therefore, has not only achieved its basic goal of a two-percentage-point reduction in 1978, but has also exceeded that goal by almost 50 percent. South Dakota hospitals have performed similarly, reducing the 1976-1977 expense increase of 15.1 percent to 12.7 percent for 1977-1978. While the performance of South Dakota's Gross State Product is less stable than the Gross National Product because of its dependence on the agricultural economy, it is significant to note that in each of the last two years hospital expenses have increased less rapidly than the GSP—in 1977, 15.1 percent compared to a GSP increase of 19.4 percent and in 1978, 12.7 percent compared to an estimated 15.0 percent growth in GSP.

As noted above, VE programs have been established in all 50 states to systematically address and resolve the multifaceted problem of rising hospital and health care costs. Intensified cost containment activities at state and community levels are underway in 1979. In spite of a substantial increase in the rate of inflation in the general economy since the VE began, hospitals were successful in achieving and surpassing the 1978 VE goal and are committed to achieving the 1979 national goal—a maximum of 11.6 percent increase in total hospital expenditures.

III. FEDERAL HOSPITAL REVENUE CONTROL PROPOSALS

In April of 1977 the Carter Administration introduced the Hospital Cost Containment Act of 1977, a measure which proposed a dramatic change in federal policy towards the nation's hospitals. In the several years preceding 1977 a number of

legislative and regulatory changes in the Medicare and Medicaid programs had been adopted which controlled and reduced the amounts hospitals received for care rendered to beneficiaries of those programs. The 1977 initiative, however, communities. There is no formula that can deal adequately with these differences. Attempts to impose a formula must inevitably result in complex and inequitable adjustments and exceptions. The proposed bill presents many such inadequacies, and promises further complexities in the regulations to be issued by the Secretary if he is given the very broad discretionary authorities included in this legislation.

Efforts to implement such a regulatory program would involve a costly and cumbersome bureaucratic machine. A large cadre of administrators and regulators would be necessary to collect, process, and analyze the vast quantity of data that would be required and to consider and make decisions on an infinite variety of special conditions and exceptions. In addition, substantial administrative costs would be imposed on hospitals as they would be required to comply with a new battery of regulatory requirements.

Although the bill as introduced this year exempts hospitals in "non-metropolitan" areas with less than 4,000 annual admissions, its impact would be far reaching even in a state such as South Dakota. Certainly seven and possibly nine hospitals in the state would be directly effected. These hospitals provide some 57 to 63 percent of the hospital care rendered in South Dakota. As the larger hospitals take on additional secondary and tertiary care services in response to area-wide needs their expenses will be directly impacted upon by these changes in the nature and extent of their services. The bill also produces arbitrary inconsistencies in applicability such as covering the Dell Rapids Community Hospital simply because it happens to be in Minnehaha County which under federal regulation is a "Standard Metropolitan Statistical Area." As evidenced by the version of the bill introduced in 1977, it is also the clear intention of the proponents of this concept to eventually cover all hospitals in the country without reference ot size or location. This 34-page bill is extremely complex and some sections are frankly ambiguous and subject to varied interpretations. We will attempt here, however, to summarize and comment upon the most important inequities and dangers in the proposal.

Section 2

Section 2 would direct the Secretary of Health, Education, and Welfare to establish annual limits on increases in hospital expenses. The Secretary would estimate in January of each year the national percentage increases in the costs of goods and services (other than for non-supervisory wages). At the beginning of the following year, the Secretary would make the actual calculation of the so-called "voluntary" limits to apply to increases in hospital expenses in the previous year. Hospitals would not know in advance of their budget year of the voluntary limit set by the Secretary. It would be virtually impossible to effectively manage a hospital under these circumstances—a sort of "Russian roulette" would most nearly describe the situation in which most hospital managers would find themselves.

This section of the bill would provide only a one percent annual allowance for needed improvements in hospital services and medical technology on a continuing basis. This fixed and essentially arbitrary allowance would result in the denial of needed and efficacious medical care to large segments of the American public. We do not believe that the Congress or the public will support a policy that prevents the health delivery system from extending the results of research and technological innovation to the treatment of illness and injury across the country.

This section does not deal adequately with the impact of our growing and aging population on the use of institutional health services. It totally disregards the significant growth in the over-65 age group of our nation. Extensive data on hospital utilization by the elderly, as compared to the population as a whole, demonstrates that this group has a rate of hospitalization more than three times greater. Moreover, the failure of the bill to recognize the impact in local population shifts such as those occurring in South Dakota—especially our proportion of elderly and our rural-urban changes—compounds these problems and dramatizes the unreasonable and inequitable assumptions underlying this proposal.

Another illustration of the unrealistic nature of this section is its promise that wage increases of non-supervisory hospital workers (about 40 percent of hospital payroll expenses) would, in effect, be passed through any voluntary or mandatory limits set by HEW. In fact, the definition of such wages in the bill excludes wage costs for shift differentials and overtime, both of which are very significant for the 24-hour operation of hospitals, as well as fringe benefits that have a direct relationship with real wage increases. Thus, while the bill appears to accommodate fully wage increases for such employees, hospitals would be unable to fulfill this misleading promise. This practical problem is further extended by the inevitable ripple

effect on the hospital's wage structure resulting from upward adjustments of the lower wage levels.

Section 3

In our review of the provisions included in this section, the Secretary of HEW would be authorized to use estimated data for the purpose of determining whether hospitals nationally, by state, or individually met a fixed "voluntary" limit. If hospitals were determined to have failed to meet this limit, a mandatory revenue cap program would be automatically triggered. There is no procedure for evaluating justifiable or trivial variations from the limit. The arbitrary and automatic features of this provision would trigger a broad and complex federal regulatory program. The controls would become effective retroactively; that is, the so-called 1980 program applies to hospital fiscal years beginning after January 1, 1979. Thus, the program, which has been described as standby in nature, if triggered in 1980, would in fact be in force today. These provisions further demonstrate the unreasonableness of this proposal.

Section 6

This section would apply a percentage cap on the per admission revenues of hospitals on a class of purchaser basis for any year in which mandatory controls are triggered. Reliance on a per admission revenue cap applied on a class of purchaser basis would be costly and inequitable, and would undermine hospital solvency. First, the data and administrative burden imposed by such a control structure would be excessive and costly—on hospitals, intermediaries, and the federal government. Second, a per admission control program on a class purchaser basis ignores the existing variations in levels of payments by third party payers, and denies hospitals the opportunity to establish pricing policies that reflect these payment realities. For example, there is no recognition of the cost impact of providing uncompensated care for those persons unable to pay or the need to generate revenues sufficient to cover the often inadequate payments under Medicare and Medicaid. This is particularly significant for South Dakota since a relatively high (45.8 percent in 1976) proportion of the inpatient days in our hospitals are Medicare patient days. Additionally, in their most recent fiscal years, South Dakota hospitals rendered over $570,000 in uncompensated services to the poor and wrote off an additional 2 3/4 million in uncollectibles (bad debts) from all types of patients/insurors. In fact, while the methodology in this section of the administration's proposal provides a cap on revenues from each payer, it does not assure that each purchaser will pay appropriately or provide a means to compensate for inadequate payments. Finally, a per admission control program on a class of purchaser basis artificially segregates sources of revenues without regard to changes in the patient mix or benefit structure.

Section 7

This section provides detailed instructions for calculating the allowable, percentage increase in per admission revenues on a class of purchaser basis for each hospital covered under the mandatory program. In addition to the deficiencies identified earlier with respect to the calculation of the "voluntary" limits, this section includes further inequitable and arbitrary features.

The extremely complex formula for determining the revenue increase limit for hospitals under the mandatory program does not explicity allow for cost increases related to needed improvements and advancements in medical care delivery. While the "voluntary" expenditure limit inadequately recognized the cost impact of improvements in health care, the mandatory per admission cap totally ignores this factor. This policy thus would support a virtual freeze on such advancements, even those determined through the health planning process and South Dakota's Certificate of Need statute (SDCL 34-7A) to be necessary and appropriate.

There are three other broad areas of concern which we have identified in this section of the bill:

The proposed penalty (or bonus) provision is so general and vague as to make it impossible to evaluate its appropriateness or impact. What is clear is that the potential for penalty is substantially greater than possible rewards. Here again there is excessive delegation of authority to the Secretary;

The brief and vague description of possible exceptions or adjustments to be made at the Secretary's discretion is so incomplete as to preclude any evaluation of its adequacy; and

Adjustments to be made by the Secretary in the calculation of the allowable per admission revenue cap with respect to a hospital's performance are entirely puni-

tive. Further, hospital expenditure performance for periods as far back as three years may be used in the calculation of these penalties.

Section 10

This section would permit the Secretary to exclude a hospital from the Medicare, Medicaid, or Maternal and Child Health programs if the hospital changed its admission practices in order to reduce its proportion of low-income patients. This provision assumes that the reasons for changes in admission patterns are solely related to reimbursement considerations, when in fact changes in admission patterns can occur for reasons unrelated to the source or amount of payment. There are no criteria to define an unacceptable change in admission experience, and, finally, there is no provision for due process in the consideration of complaints.

CONCLUSION

While this paper has presented only a limited review of proposed legislation, it is evident to us that this bill is unnecessary, conceptually flawed and would lead to serious disruption in the delivery of hospital care to patients. As we have previously indicated, the proposed bill includes many arbitrary and unreasonable provisions, such as the granting of excessive discretionary authorities to the Secretary. Despite years of effort, HEW has been unable to present promised methods to deal with many key issues, yet the proposed bill addresses critical complexities with a simple solution: let the bureaucrats decide later what to do on their own. Consider also, by way of summary, some additional comments by Professor Feldstein in his testimony:

"Reducing the rise of hospital costs, therefore, means curtailing the quantity of those services and, thereby, the quality of hospital care. . . .

"The proposed limits on increases in hospital costs would freeze the existing geographic disparities in the quality of hospital care. . . .

"The bureaucratic complexity of permanently regulating the costs of 6,000 hospitals is frightening. . . .

"I frankly doubt the government's ability to enforce such an abrupt change in the quality of hospital care, especially in light of the existing disparities of care among communities. Health care, like local schooling, is a highly emotional and personal issue. I think that attempts by the federal government to stop individuals and communities from providing the care that they want would be met by very strong resistance. What precedent do we have for government regulations that require a lower quality of any good or service?

"Moreover, the penalties for violating the so-called mandatory limits are too Draconian to be enforceable. Denying full reimbursement from Medicare, Medicaid, and Blue Cross and levying a punitive 150 percent tax on other "excess" insurance revenues would rapidly exhaust the small reserves of hospitals that did not or could not comply. Many local non-profit hospitals could be forced into bankruptcy within one or two years. The administration's proposal is silent on what would happen as these hospitals reached the verge of bankruptcy. Would the government really force them to close? Would it instead nationalize them or force them onto the budgets of state or local governments? Or would community political pressures result in administrative exceptions that would vitiate the controls?"

Hospitals are sincerely committed to containing health cost increases and are actively participating in the only organized, industry-wide voluntary program to fight inflation. It is our strong conviction that such voluntary actions are the most effective ways of dealing with the containment of health care costs while maintaining the quality of and reasonable accessibility to hospital services. The Voluntary Effort is succeeding and should be allowed to develop without further governmental intervention which would undermine its continued success and cripple our community hospitals in South Dakota and throughout the nation.

NATIONAL CONFERENCE OF STATE LEGISLATURES,
OFFICE OF STATE FEDERAL RELATIONS,
Washington, D.C., March 20, 1979.

Hon. RUSSELL B. LONG,
Chairman, Senate Finance Committee, U.S. Senate, Russell Senate Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: On Thursday, March 22 the Senate Finance Committee will begin its important markup session on Medicare and Medicaid Administrative and Reimbursement Reform (S. 505) and Hospital Cost Containment legislation (S. 570). I would like to inform you of the concerns of the nation's state legislatures with respect to these important public policy areas.

The National Conference of State Legislatures has been a strong supporter of hospital cost containment legislation. As major employers, state governments are greatly concerned about the rapid increase in premiums for hospital care they contribute to on behalf of their employees. And as a purchaser of health care for the needy, States continue to face thirteen to fifteen percent annual increases in their Medicaid budgets—increases which are rapidly drying up scarce resources for other, worthwhile health and social services programs.

Our organization believes that while Senator Talmadge's proposal (S. 505) embodies many excellent features which we support, it simply does not go far enough toward addressing the present crisis in hospital cost inflation. We would hope therefore that the Finance Committee might be able to develop a compromise measure which would combine the best features of Senator Talmadge's bill with the best elements of the Administration's proposal.

We are unable to accept at face value the hospital industry's contention that the voluntary cost containment effort is working and therefore federal legislation is unnecessary and even counterproductive. While it is true that the rate of increase in hospital expenses has decreased over the past two years, the data overlooks the contributions that mandatory state cost containment programs have made to keeping the overall average down. Preliminary estimates indicate that the national average rate of increase in hospital costs in 1978 over 1977 is 13.3 percent, while the estimate for the nine mandatory state programs is 9.9 percent. It seems reasonable to suggest therefore that if it were not for the success of the mandatory state programs, the overall rate of increase under the voluntary effort would be substantially higher.

The general position of the NCSL is one of support for establishing reasonable voluntary guidelines for the hospital sector, to be backed up by a mandatory system in the event a voluntary effort fails. If a mandatory program becomes necessary, there should be exemptions for States that are operating effective mandatory hospital cost containment programs, as well as for States that are able to meet the national guidelines through voluntary action. Finally, we feel that the federal government ought to provide financial assistance, through matching payments, to support start up or developmental costs for States interested in establishing new hospital cost containment programs.

As you know, the NCSL is the only national, non-partisan professional organization representing the nation's 7,500 state lawmakers.

Thank you very much for your consideration.

Sincerely,

Representative JOHN BRAGG,
Chairman, State-Federal Assembly of NCSL,
Chairman, Tennessee House Finance, Ways and Means Committee.

CAROLINA EYE ASSOCIATES, P.A.,
Greenville, S.C., April 6, 1979.

Hon. CARROLL CAMPBELL,
U.S. House of Representatives,
House Office Committee, Washington, D.C.

DEAR CARROLL: There is an amendment, the Talmadge Amendment, which is being tacked onto Senate Bill 505, Section 36 which would permit federal subsidy for non-medical practitioners to treat postoperative cataract patients, i.e. it would allow optometrists to follow and manage patients who have had ocular surgery which of course, is totally out of their realm of ability and would subject these patients to very inadequate care. To allow non-medical personnel to be involved in the care of medical problems is totally unjustified and directly opposed to the best interest of the American public and their medical affairs.

I would urge that you have someone in your staff contact the members of the Medical Affairs Committee in the Senate regarding this bill and urge that it not be allowed. I have enclosed a list of the members of this committee which I was given by one of our Washington contacts and perhaps your office could duplicate this letter and see that a copy goes to each of these men. I am unaware of how to do this on a federal level and felt that your office staff may be of assistance.

Thanking you for your help and consideration.

Sincerely yours,

E.D. JERVEY, M.D.

ALASKA STATE HOSPITAL ASSOCIATION INC.,
Alaska, April 27, 1979.

Mr. MICHAEL STERN,
Staff Director, Senate Committee on Finance,
Dirksen Senate Office Building, Washington, D.C.

DEAR MR. STERN: The Voluntary Effort Cost Containment Committee of the Alaska State Hospital Association has read S. 570 and would like to make the following comments regarding the bill.

We endorse cost containment of hospital costs, as is evident by the 93.75% participation rate of facilities in Alaska in the Voluntary Effort. The control of cost on a voluntary basis has been effective and will continue to be so. The January 1979 14.4 percent increase in expenditures by hospitals is upsetting to those watching the trend, but this is understandable as one looks at the cause for this percentage increase.

Hospitals use numerous commercial products that are not under cost restraints. As those products price increases so does the rate of expenditure by the hospitals. Until there is an across the board restraint in increased expenses one can not expect hospitals to be able to keep their percentage of increase down. Good management can be effective to a certain extent, but there comes a time when it depends on a team effort, with all industries comprising the team members.

We offer two alternative plans of action for your consideration:

1. Allow the hospital industry time to prove itself thru the Voluntary Effort. The percentage increase in 1978 was 12.8 percent down from the 15.6 percent in 1977. When the final reports are in for 1979 the percentage increase will be a further reflection of the conserted effort by hospitals of containing health care costs. Any premature move by the government to implement the S. 570, or any similar legislation would create another bureaucratic layer, which the American taxpayer would be responsible for supporting with their tax dollars. We feel that this is a direct conflict with the intent of the bill, that of containing costs to the consumer.

2. Support the Hospital Cost Containment Bill, S. 570, with the following conditions:

(a) That hospitals must comply with S. 570 within 30 days after all industries are brought into equal compliance of costs.

(b) That all federal facilities must be brought into compliance, with the pilot study S. 570 being carried out in a federal facility. A pilot study is imperative. A program which would effect the entire country should not be undertaken without some preliminary evaluation of a working system, and review of the effectiveness in a working situation.

We trust that you will keep a close watch on this bill. Also that when you vote you will keep our concerns in mind.

If we can be of assistance to you in any way please call upon us.

Sincerely,

MICHAEL HERRING,
Chairman, Voluntary Effort-Alaska.

PLANO, TEX., *April 5, 1979.*

Hon. PAUL LAXALT,
Senate Office Building, Washington, D.C.

Passage of S. 505, Sec. 36 as written will permit federal subsidy for non-medical practitioners to treat post-operative patients with disastrous medical consequences. Urge deletion of Section 36 (aphakia) to eliminate public health hazard.

Sincerely,

ROBERT A. MILLER, M.D.

AMERICAN PSYCHIATRIC ASSOCIATION,
Washington, D.C., May 10, 1979.

Hon. HERMAN E. TALMADGE,
Chairman, Senate Finance Subcommittee on Health,
Dirksen Senate Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: On behalf of the American Psychiatric Association, a medical specialty society representing over 24,000 psychiatrists nationwide, I would like to share with you our concerns about the Administration's hospital cost containment legislation (HR. 2626) now being considered by your Subcommittee.

The APA traditionally concerns itself with issues of patient care and has always been in the forefront of bringing into public focus those issues which would affect

adequate and quality treatment for the mentally ill. However, as you know, we have sought means to chart a responsible course between fiscal restraint and quality care both in our legislative initiatives and in our relations with patients.

We are in sympathy with the Administration's desire to contain the rapid rise in the cost of health care, but we do not believe the Administration's proposal will accomplish the stated objective. Secretary Califano has stated that hospital cost containment is the "most important piece of anti-inflation legislation that the 96th Congress will consider," and for the second year in a row has attempted to bring about mandatory controls on the hospital industry as a whole. However, hospital expenditures, by and large, do not result from inflation alone and we are concerned that such statements are misleading. Hospital expenditure increases are comprised of (a) increases in the costs of goods and services hospitals must buy; (b) increases resulting from medical and hospital services required by a larger and older population; and (c) increases resulting from improvements in medical technology and extension of and improvements in service delivery.

The Administration's proposal takes few, if any, of these factors into account. In brief, the legislation would penalize lower-cost more efficient hospitals, such as the specialty psychiatric hospital; ignore the uncontrollable costs of malpractice insurance, energy, fuel, food and labor; and discriminate against one sector of the health industry by requiring price controls, but yet not controlling wages or supplies.

High on the list of those facilities which would be seriously penalized are those providing psychiatric care. The proposed bill deals with efficiencies and administrative controls which impact on patient care. Unlike large surgical units in general hospitals or many other medical specialties, the psychiatric medical specialty rarely initiates the use of CAT scanners, X-ray, labs, surgical facilities, or other costly intensive care elements which are required to render high quality care for medical treatment. Our medical treatment modalities emphasize people and human relationships and prescribing appropriate psychopharmacologic treatment agents.

Psychiatric facilities require high labor-intensity. Roughly eighty percent of all costs in private psychiatric hospitals go to personnel—professional and nonprofessional—all integrally involved with the daily treatment plans of each and every patient. The Administration's cost containment proposal ignores such facilities and assumes that all hospitals can improve efficiency by ordering fewer tests, using fewer machines or consolidating services. Psychiatric facilities do not routinely use machines or perform tests, and the personnel are the services.

What the Administration's proposal would do—despite its unsubstained denial in the face of historical precedents to the country—would be to generate more volumes and volumes of regulation and paperwork for the health care system. The cost of complying with the regulations and reporting requirements has been roughly placed at $10 million. Such estimate, if historical perspective from the medicare example (now the subject of an overhaul in administrative reform) is reviewed, will likely be, if not inaccurate, dangerously low. Worse, the cost will fall on the shoulders of the health care providers—including the cost-effective providers—further "fattening" the budgets of those hospitals high on costs and driving up those presently with low cost beyond the guidelines. What the Administration's proposal has created, then, is a self-fulfilling prophecy—costs will be high, but for the cost-effective hospital, their budget will be high because as the result of the very regulations imposed to try to curtail costs.

The APA supports the Voluntary Effort and believes it is a cost-effective means of curbing unnecessary hospital costs, in that it would not impose burdensome regulatory compliance requirements—costly in time, labor and dollars—in that it does not impose requirements upon one segment of business—health care—and allow the others to seek the level of market/supply demands. Moreover, the voluntary effort will not launch an attack upon the quality of care—the first principle that regrettably comes under attack when seeking to comply with a too strenuous national package of controls.

We would be pleased to continue to work with your Committee to help develop less discriminatory and more practicable measures through which we can contain health care costs.

Respectfully,

JULES MASSERMAN, M.D.,
President.

APPENDIX

Response to Questions Submitted by Members of the Committee by the Department of Health, Education, and Welfare

Answer to Senator Nelson's question on page 171:

In response to Senator Nelson's question, if you compute the dollar savings which would have resulted if those forty-one states which had a rate of increase of 15.8 percent had been at 12 percent in 1977 you would have a figure of $1.2 billion in savings.

Answer to Senator Talmadge's question on page 171:

WAGE ADJUSTMENTS IN STATES WITH MANDATORY COST CONTAINMENT PROGRAMS

Wage policy differs among the mandatory states. Each state uses a slightly different methodology to calculate wage increases—some use a form of a pass-through; others do not. At present, Maryland offers hospital workers earning below the minimum wage a wage pass-through to the extent that it brings them up to the minimum wage level. New York at one time employed a full wage pass-through but later dropped this provision. Since then, the State has used wage indices relating increases in hospital worker wages to those of comparable workers. For a short period of time, New York allowed no wage increases because of its solvency problems.

Some mandatory states calculate a market basket increase and place no specific cap on hospital wages or other components of the market basket, as long as the hospital is able to maintain its total cost increase within the predetermined allowance. Other states use index procedures and calculate allowable levels of wage increases, by employee classification group, using various national or local labor or CPI data.

Answer to Senator Durenberger's question on page 183:

In response to Senator Durenberger's question, wages represent 50.06 percent of total hospital costs, the figure for non-supervisory personnel wages is 36.8 percent of the total hospital cost.

Answer to Senator Durenberger's question on page 183:

THE 1 PERCENT NET NEW SERVICE INTENSITY ALLOWANCE

The voluntary limits, both at the national and individual hospital levels include three components:

1. a hospital market basket for increases in wages and prices,
2. a population allowance, and
3. a net new service intensity allowance.

The net new service intensity allowance is fixed at 1 percent while the other two components may vary from hospital to hospital and from year to year.

It is possible to measure a hospital's increase in productivity, efficiency or cost savings. The AHA conducts a survey that has found the average productivity increase in the order of 2 percent per year for the past several years.

It is not necessary, however, to make this determination in order to allow more than 1 percent increase in budget for new services if savings are realized. The formula for the voluntary goal determines the total allowable budget for each hospital, but not the distribution of expenditures within the budget. Consequently if a hospital is able to make savings in one part of its budget, through whatever means, this automatically leaves more room in other parts of the budget to increase expenditures for other new services or new inputs.

The hospital industry's own 11.6 percent voluntary goal for 1979 implicitly reduces the historical rate of increase in new services to a net amount of 1.4 percent.

The industry estimated the market basket inflation to equal 9.1 percent and the population allowance to equal 1.1 percent. To meet the 11.6 percent voluntary limit, the net allowance for new services would have to be 1.4 percent, obtained by reducing waste and inefficiency and/or curbing growth.