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United States Senate,

Subcommittee on Health of the Committee on Finance,

Washington, D.C.

The Subcommittee met, pursuant to notice, at 9:10 a.m. in room 2219, Dirksen Senate Office Building, Hon. Herman Talmadge (Chairman of the Subcommittee) presiding.

Present: Senators Talmadge, Gravel, Curtis and Danforth.

Senator Talmadge. Gentlemen, as I explained yesterday, this bill has been in the works for about three years. Our staff has been working with practically every aspect of health care and delivery in the United States. Virtually all of them have had some input in it. We were involved long before HEW and the President recognized that this is a problem that needed attention.

The problem is that we are spending about $51 billion a year, as I recall, in Medicaid and Medicare funds, and that has been escalating at about 15 percent a year.

Up until this year -- and I believe there has been some slight decrease this year, has there not?

Mr. Constantine. What is the total increase?

Mr. Fulberton. I think the increase, as far as Medicare and Medicaid altogether, Mr. Chairman, between '78 and 1980, the figure I remember is a total of a 30 percent increase in Federal outlays on Medicare and Medicaid.

Mr. Constantine. A two-year period.

Senator Talmadge. I thought there had been some slight decrease this year.

Mr. Constantine. There had been some slight decrease in the rate of increase, a slight decline. In part, there has been a change in the number of eligibles at Medicaid as well.

Senator Talmadge. One of the problems, of course, we have in this legislation, not only is it complexity, it is one of the most complex pieces of legislation that I have ever dealt with since I have been in this Senate.

We have divided jurisdiction. We have two committees in the House and two committees in the Senate.

The Senate Human Resources Committee marked up a bill which was substantially the one recommended by the President last year. The Commerce Committee has been dealing with it and, thus far, has not reported a bill.

Ways and Means has not yet reported a bill.

What I was hopeful of being able to do is for our Finance Committee to report a bill and attach it to some House-passed bill, ask for a conference of the two committees and go to Conference and try to work out a bill.

I do believe that time is of the essence. I think that it is most important that this Committee report a bill. We have one that we think is reasonable; we have one that we think is workable; and it does not put the arbitrary flat 9 percent cap on which we think would do inequity to efficient hospitals and reward inefficient hospitals.

Jay, if you will take up that point, I think we can proceed.

Mr. Constantine. Yes, sir.

Mr. Chairman, I thought it would be helpful if I introduced these two gentlemen. Glen Marcus is head of the Health Branch Bureau of the Congressional Research Service, Library of Congress. He has worked for us for ten years. He and his people have had a great deal of input into the bill.

Glen is leaving after about 20 years with the government next month to go with Connecticut General. They are taking away one of our best people, and he has done a superb job, he and his staff, on the work in the bill and have had a great deal of input.

Bill Fullerton is Deputy Administrator of the Health Care Financing Administration. You may recall, in 1969, when Senator John Williams introduced the resolution directing the staff to conduct a complete investigation and submit a report on the operations of Medicare and Medicaid, essentially Bill and I -- Bill was then with the Congressional Research Service --

Bill and I were in a little room in the basement working for six months and so on, and then the Committee held ten days of hearings after that report came out, and a fair amount of legislation came out of that work. And Bill, subsequently, in 1970, went to the Ways and Means Committee where he was Chief of the Health Staff Under Wilbur Mills and worked there for five years.

He then retired. He is now unretired and Deputy Administrator of the Health Care Financing Administration and he is, according to Secretary Califano, the principal department official charged with the responsibility of their work in hospital cost containment.

Secretary Califano has indicated that if anybody has any questions on hospital cost containment or if instant policy is desired, Mr. Fullerton is the man who makes those decisions. He is here this morning. The Commerce Committee is voting, presumably, I believe, this morning on their version of an overall hospital cost containment approach, not Medicare and Medicaid, but everything.

The best estimate is that they will approve a proposal.

Mr. Fullerton. We are quite confident.

Mr. Constantine. They are confident. I do not know how many Veterans' Administration hospitals they have left, but probably they have enough for a favorable vote.

Mr. Chairman, yesterday --

Senator Talmadge. As I recall, yesterday we approved items 6 and 10; nothing else.

Mr. Constantine. Yes. We discussed Sections 11 and 12 but no votes were taken, no decisions were made on those sections. Section 10 was the only section approved by the Committee.

We suggested at that time that the Committee not turn to the hospital reimbursement reform provisions until tomorrow for purposes of mark-up, but we thought we certainly thought we ought to get into that today on Sections 2, 3 and 4 of the bill because those are the most significant sections of the bill and the most complex sections of the bill.

What we will do, as we go along, is indicate any changes and Bob Hoyer and John Kern of our staff will call my attention to any omissions, and Dave is welcome to, also, between what the bill has, what is now suggested, and what was in the bill as originally introduced.

The bill as originally introduced dealt only with adjusted hospital routine costs, initially. Subsequent to that, they were to do work on comparing ancillary costs, x-ray laboratory, pharmacy, operating room, outpatient department costs, all of those costs that are not routine. Routine are essentially room, board and routine nursing costs of the hospital.

The point of the original S. 1470 approach was to develop an orderly process and as the state of the art and the

expertise advanced, to modify the reimbursement to conform to two basic elements of the Talmadge bill -- that is, that an equitable approach to reimbursement under Medicare and Medicaid and getting a handle on it was to classify hospitals so that you are talking about similar types of facilities in similar locations.

Secondly, to compare those hospitals so as to determine which hospitals to compare those cost centers to determine which are relatively efficient, which are relatively inefficient, and which are in the middle, and then reward those which are and then reward those which are more efficient and then penalize those which are inefficient.

That is the basic thrust of the Talmadge approach to reimbursement.

The bill has been generally endorsed by the Federation of Hospitals, specifically endorsed by the Federation of Hospitals, and substantially supported by the American Hospital Association. Both organizations have some suggested modifications.

During the hearings on the bill, the Administration and those advocates of a big approach, a broad approach covering all hospitals and all payers and all services, said that the problem with the Talmadge bill which had been endorsed by the President during his campaign as the longrange answer to an equitable approach, was that it did not cover enough

costs fast enough. That is while the bill provided a means for orderly extention over time to cover all hospital costs, compare them, reward and penalize, it originally only started out with adjusted routine costs.

Adjusted routine costs are, as I said, room, board and routine nursing costs.

Those costs amount to about 40 percent of hospital per diem costs. The estimate is taking out the variable costs, those exceptions that you see up there, brings that down to cover initially about 30 percent of the hospital's costs going in, 40 percent overall. Those variable costs, capital and related education and training, interms and residents and malpractice insurance, are probably about another 10 percent.

Is that right, Bill?

Mr. Fullerton. Yes.

Mr. Constantine. The reason that those costs -- and this was in the original -- those routine costs and those exceptions were in the original. They are highly variable. At this point in time, there is no way of comparing those in anything approximating an equitable fashion.

You can have two 300-bed hospitals, one with six resident interns, another with 60 and you get a complete distortion of the per diem costs. Both cases perfectly justify their staffing.

The malpractice insurance varies all over the lot, obviously.

There is no way of comparing that equitably at this point in time. Similarly, energy costs and the capital and related costs.

A new hospital, the newest hospital can be throwing off the greatest amount of depreciation. It was the highest cost to build, it was depreciating on a new base. That was in the original bill.

The original bill also had grouping of hospitals by bed size, type of hospital. Those were worked out, those first two items here, bed size and type of hospital, using the American Hospital Association's references in consultation with the American Association of Medical Colleges, the Council of Teaching Hospitals, all of the groups.

There are divergencies in the classification, but they concede that it is the best that can be done in terms of the present state of the art and their ability to compare institutions.

As an example of that, the Medical Colleges, when we are trying to define what a medical center was, there is no uniform definition of a medical center. For working purposes, the Talmadge bill says it is a principal hospital and the medical school. That is the way it was introduced two and a half years ago.

The Association of Medical Colleges have been trying desperately to come up with a better definition, because there

are legitimately at least a dozen medical schools that have two, and in a couple of places, three centers, which it is very tough to define.

We have been working closely with them. We believe we can come up with a definition. That is left to another group.

I will discuss the Health Facilities Cost Commission in a moment here. One of the changes we recommend is a further classification change by rural or urban location. There does not seem to be any objection to that further refinement.

The dilemman, again, was the pressure to deal more immediately within Medicare and Medicaid with ancillary costs -- the balance of the costs which are not routine.

Last October when the Committee held about a day and a half hearing, there were some staff suggestions of a maximum allowable rate of increase, and so on, for dealing with the ancillary costs on an interim basis. What we are recommending here is essentially a modified version of the print the Committee had at that time with some other changes.

The key change was the Health Facilities Cost Commission. That, we believe, was the key change, the most significant one.

Recognizing that, this bill has problems. The bill, it is too complex. Apparently Senator Talmadge in his proposal is the only one who recognizes the difficulties of the

complexities in trying to get a handle and moderate the hospital costs equitably. There are a lot of good hospitals out there trying to do a job and doing it responsibly and at reasonable cost. There are others which are inefficient, poorly utilized and at high cost and costing the government a lot of money, and other payers as well.

It is sorting them out. Most of the other proposals make no real attempt to sort out those which are performing from those which are not. The Talmadge bill is an effort to reward those who are performing.

The dilemma was that as the state of the art advances, as the methodology improves, to improve classification and comparison, what mechanism do you use to make those changes?

For example, the example I gave you of medical centers, as a better definition of medical centers comes up, how do you incorporate that into the program, to be as fair as possible to the hospitals and the medical schools?

The answer was to establish an entity which, on a continuing basis, would have responsibility for continually refining the classification and comparison of both the hospital and the cost so as to make them as equitable as possible. The objective is to make rough justice smoother as you proceed.

Senator Curtis. May I ask a question?

Mr. Constantine. Yes.

Senator Curtis. The creation of this Commission, was that

in the Talmadge bill when we held the hearings?

Mr. Constantine. No. That is a new suggested change.

Senator Curtis. Is that a national commission, or a local one?

Mr. Constantine. National.

Senator Curtis. How large?

Mr. Constantine. Fifteen members. I was going to explain it in detail now.

Senator Curtis. All right.

Mr. Constantine. It would be a 15-member group consisting of persons knowledgeable and expert in professional experience in the reimbursement of health care facilities. The point is that this Commission would not only deal with hospitals but it would ultimately extend the comparison and classification to skilled nursing facilities under Medicare and Medicaid, Home Health Agencies, all the entities that we reimburse on a cost basis today on a straight reasonable cost basis, without any effective limitation.

The Commission would be 15 members, a majority of hom would be selected from Federal state and local governmental entities. The reason for that is because they are determining how those governments spend their money under Medicare and Medicaid.

There would be at least three members on the Commission nominated and selected from representatives from hospital

groups to bring their expertise to bear. The balance would be selected from physicians anyone with recognized standing and knowledge in the cost area and the hospitals and other health care facilities operations.

Senator Curtis. Whom are they appointed by?

Mr. Constantine. Senator, the suggestion we have is to have them appointed by the Secretary. In that regard, we would make two points.

One was the staff is well aware of your concern about blank checks to the Secretary of HEW to do this. The dilemma is, what do you do when it is a governmental responsibility and this Commission was an effort to deal, in part, with your concern.

The dilemma was also this: this will not work if incompetent people, and so on, are appointed to that Commission. The thing that we would urge the Committee to stress if it adopts this approach is that absolutely the most competent, expert people be appointed to that Commission because they have a continuing operating responsibility to improve the program.

The choice you had, Senator, if you made them Presidential appointees, which would give them status at a high level, as a practical matter, we all know those names go to the President from the Secretary anyway. If there wre another selection process to assure that kind of representation of competence,

objectivity and expertise, we do believe, in talking with Mr. Fullerton, they do share that same concern. The point is how that translates into people, we do not know.

There are any number of Commissions where the Congress and the statute says it must be of recognized standing and distinction and knowledgeable and expert and objective and it does not mean anything at all when the appointments are made.

Senator Curtis. Of course, it has to be viewed in the light of the direction of the Secretary of HEW. On June 20th, he issued a statement where he is going to move in and regulate the naming of directors of insurance companies, a direct violation of the Ferguson-McCarren Act that left that to the states. I hold his statement right here, where he says because doctors receive fees for their services from these programs that therefore they should not be directors on Blue Cross-Blue Shield or commercial insurance companies.

And we do not know what happens down there.

I will not take time to argue this case right now.

Senator Talmadge. Senator, are you through?

Senator Curtis. I just want to point out to have one agency here that is a super agency to rule on all of these charges and one thing or another, we have a pretty big country and there are only a third of the Senate up for re-election, but the Federal Elections Commission is ruling on those things.

One of my colleagues says that his report the other day on his campaign so far took 30 pages and he has to go there and get permission to buy postage stamps or run an ad in the paper, or something.

That is why I am interested in what sort of an agency we are going to create here, because in the light of the attitude and announced policy of the Secretary of HEW, he is out to control everything.

I do not think he has the slightest bit of authority to say who is eligible to be director of a corporation, but here it is.

Senator Talmadge. Would you like to comment, Mr. Fullerton?

Mr. Fullerton. Mr. Chairman, what the Secretary announced yesterday was a notice of intent to issue regulations in the Medicare and Medicaid programs which expressed a great deal of concern that a number of the carriers operating under Medicare and Medicaid have boards of directors of which more than half of whom are physicians and people who stand to benefit from the decisions made from those organizations.

He is raising essentially a conflict of interest situation. He has no desire to get into naming people on boards of insurance companies or Blue Cross-Blue Shield plans. He is raising some very important questions for the public to comment upon.

These regulations cannot take course after a 60-day period

of comment. Those regulations then become proposed regulations with an additional 60 days of comment, and the whole process will take another six or seven months with very wide and adequate public input into the process.

I think he has raised some very serious and important questions that we need to respond to, as a nation.

Senator Talmadge. Senator Danforth?

Senator Danforth. I do not want to interrupt your flow, but at some point I want to ask you a broad, very general question. Are you sort of in the middle?

Mr. Constantine. I am not sure, Senator. It is just as easy to handle it now.

Senator Danforth. Let me give you a hypothetical. Let us suppose -- I do not know what the simplest surgery is. Let us say it is a tonsilectomy. I do not know what it is; let us say it is a tonsilectomy.

If I live in, say, St. Louis and want to get a tonsilectomy I take it I have some options. I can go -- I do not know, maybe I can go to a doctor's office and get it done there, or I can go --

Senator Talmadge. Incidentally, if you will yield at that point, one of the provisions we are going to recommend is that surgery that can be performed in a doctor's office be performed there, and that will save a tremendous amount of

money.

For instance, I had a biopsy several years ago and it was performed in my surgeon's office with a local anaesthetic. Ten minutes later I walked out, got in my car and drove home. The ordinary procedure would have been to put my in a hospital which would have been an added cost of $200 or $300, Senator Danforth. This is the kind of question I want to ask. Just to spell out the hypothetical, let us assume that a tonsillectomy is a very simple procedure. Then I have an option. I can maybe go to a doctor's office or I can check into a relatively low-cost hospital. Or I can go to Barnes and they have, they will put me up there for a few days and just do the works. The overhead is out of this world, and so forth and so on.

Now, then, suppose, instead of a tonsilectomy, I want a very complicated medical procedure, say -- I do not know, open heart surgery or something. You would not want to do that in a doctor's office, I would not think, or in a very low-cost hospital. You would want to do that in a high-cost hospital.

What I wanted to know, has anythought been given to working that kind of a thing out? It seems to me that maybe we should not be reimbursing a hospital for whatever its cost is. Maybe we should, instead, simply be reimbursing the patient for what his or her medical need happens to be, and

then somehow encourage people to go to the cheapest medical stands available.

Mr. Constantine. There are two things there. The bill does address it in part and allows a potential for addressing it further.

First, essentially, the patient does not choose the hospital; it depends upon the staff privileges of his physician as to where he goes. There are, for example, in New York, anyway, too many hospitals in New York doing open-heart surgery; some under-utilized. There is a correlation between the frequency that a given hospital does the procedure and the mortality rates. They are skilled and better trained and have a greater success.

The planning process, for better or worse, that some of us do not think is working very well, if at all, is designed to deal with the facilities in terms of approving an open-heart unit for Barnes but not for this other hospital which should not be undertaking it, or would be syphoning patients off to deal with it on that basis.

Additionally, the Administration and others, Yale University and some others, have been working on a case mix approach, designed to reimburse institutions based upon the mix and the type of diagnosis to deal with that; in effect, to allow so much for this kind of case, recognizing how much it costs for this type of case with these complications, as

opposed to that.

They are more optimistic about it than we are. We think it is a good concept, but it is a long way off and needs a lot more work. It is being demonstrated now in New Jersey, I believe, and so on. That is another appraoch to dealing with what you have got.

Essentially the key point is the hospital to which the patient goes is dependent upon his personal physician's, his physician's staff privileges and judgment as to where the procedure should be done, rather than the patient's judgment.

Senator Danforth. Something is wrong here. I hope I am not getting back to square one in this whole exercise. It seems to me that something is wrong.

I read an article in "Science" magazine which presented charts showing the increased cost of medical care and the increase in life expectancy. Of course, the increased costs, the curve has just gone straightup and the life expectancy curve has been very, very flat for about 20 years or so.

What this means to me is that we are paying something other than improving people's health, and I wonder why?

I understand it is the doctor's hospital privileges, and so on, that are important, but why should we be delegating the responsibility to determine how much we should pay to a doctor who might say, well, you know, to pierce my daughter's ears we had better check her into Barnes hospital and do a

brain scan on her.

Mr. Constantine. Senator, two things. The mortality rates, you are absolutely right, have been essentially flat, despite the enormous investment. Of course, the mix of costs has changed.

Fewer people are dying from this cause, and more from that. There has been a substantial shift in the causes of death.

The idea -- and I hate to open up another can of worms -- of the PSRO program was to provide the review so that if that patient did not have to have her ears pierced in a hospital setting that they would say we will not pay for it. It is an inappropriate setting, or she is there too long, or these services are too many. That is the concept behind it.

Senator Curtis. Here is the thing that disturbs me. I am not worried abou the doctors, they are well-educated. They can go out and make a living somehow. I am concerned about patients. It is a medical decision where certain services should be performed.

The Chairman is pretty tough. They gave him a biopsy in the office. But there are other people of longstanding diseases or problems, heart conditions, they may be diabetic, many other things. They may be of a nervous disorder, and it is a medical decision where they should be. And I do not think it is a governmental decision at all.

Mr. Constantine. Senator, the staff agrees with you; it is a professional decision on that.

I think that the point is, you do have, the way the programs work, often there is not much choice, or too much choice, of available resources. You have too many units doing the same thing, that kind of thing, or the physician might not have appropriate staff privileges. It is a professional decision, no question about it as to which hospital the patient should go to.

Senator Curtis. Is there anything in writing as to what the health admission policies will cost?

Mr. Constantine. We have a summary of it here, a description of it. At the briefing yesterday Mr. Swoap asked for clarification. We agreed certain additional things he raised were absolutely consistent with the intent and should be spelled out. That is, their authority is limited only to Medicare and Medicaid and the Social Security health program.

Senator Curtis. We have to look down the road and see what authority they will be exercising twenty years from now. As I understand it, it is a new proposal; we have had no hearings on it. It either is going to do nothing or it will have pretty substantial control over the practice of medicine throughout the country.

Mr. Constantine. It has no responsibilities for the practice of medicine. It has to do only with reimbursement

on the health care facilities side.

You are absolutely right. They can do nothing, do a very poor job. The point is, they are visible.

Congress can make the determination that these people are not doing what Congress intended, or not doing it in the manner in which Congress intended, and you can repeal them, and you can repeal them, or change their authority.

When you delegate to the Secretary directly, it is blurred, it is amorphouse. You do not know which GS-11 is making the policy down the line. At least you have visibility, a focal point, and a place for input and there is private representation on this Commission. Anything you do, Senator, any time you do anything, the loss can be subverted. Many of them are well-intentioned, well-structured, but if you do not administer them, it can just go down the tubes on the administrative side of the process.

Senator Curtis. These problems that you are trying to reach, I think that the government and their employees have a very good system. They have options of taking it -- it is an insurance pool, and that sort of thing. In the overall, are the government programs having these same problems to the degree that Medicare and Medicaid are?

Mr. Constantine. Yes, sir. Essentially, if you are saying, are they having the same cost problems, which this deals with and charges, yes, sir.

Senator Curtis. Over-utilization, are they being stuck for things?

Mr. Constantine. Yes, sir. The private health industry, the Association, came to us and recommended an amendment last year to mandate the PSRO's review private patients. They wanted that review because of the problems in over-utilization in conjunction with this bill. They wanted anti-trust exemption because they are having hellish problems with over-utilization and inappropriate utilization, so they could act collectively to do that.

That was in our meetings with them. They wanted that authority. They are handicapped in that regard. It is a general problem.

It is not restricted to the Federal programs.

Senator Gravel. What testimony did we receive with respect to the possibility of just clamping a lid onto the level of normal inflation?

Mr. Constantine. Essentially, the testimony we received was that of the Secretary, Secretary Califano, who wanted to limit the increase to their original proposal, which was to the GNP deflator plus one-third of the difference between the GNP deflator saying, for the sake of argument, 6 or 7 percent, and the actual rise in hospital expenditures. Is that correct?

Mr. Fullerton. It turned out to be 9 percent.

Mr. Constantine. The famous 9 percent.

Mr. Fullerton. The bill in the Commerce Committee right now is one and a half times the GNP deflator. The deflator is at the 6 percent level and there is a 9 percent increase. You give the hospitals inflation, plus half again. That is the proposal that the Administration supports and the Commerce Committee.

Mr. Gravel. Why would you need half again; if you just cover the normal increase of inflation of the rest of society, why would you need half again for medical purposes?

Mr. Fullerton. In constructing the bill, we had quite a bit of discussion on that. The hospital costs at that time were raising well in excess of 15 percent and we wanted to bring the rate of increase down. If we had brought it down from 15 percent to 6 percent, it would have resulted in large distortions.

So the problem we faced was we did not want to bring it down that rapidly. We thought there should be some allowance for the increase of intense services and hospitals. There should be some reasonable amount permitted to the hospital industry to increase the costs associated with increasing the intensity of services, new technology, and so on.

Senator Gravel. Does not all industry have the problem of financing new technology and continue the rate of obsolescence? This is not something indigenous to the health care

field.

Mr. Fullerton. Yes, sir. You make a good point on that.

Senator Gravel. Mr. Chairman, in reviewingthis and the work that my staff has prepared for me, we have taken a lot of interest. I just had a meeting with a situation in Alaska where we have a government hospital and right along side of it a private group, ministry of health, to set up a new hospital, complete duplication, and no apparent control of the situation.

Going back over the legislation and how that can be solved, and meeting with these people and listening to them talk and talking with groups of doctors, I think -- and this is not to be simplistic -- I think that the problem is just that there is no discipline, just no discipline in the whole health care field, no competition, and they are dealing with a consumer who is totally, morally and psychologically, in their hands.

When they are dealing with the consumer, they do not deal with a consumer unless they are sick, so the only time they have got you is when they have you psychologically, so you have no discipline, you have no competition, and now we are going to set up a government program which is going to try to get into the economics of making individual economic decisions through the entire plethora of the health care system.

I am more persuaded the same thing is in the private sector. Two, three years ago I met a doctor in Los Angeles who had opened a business -- his name escapes me now. If we wanted to have a hearing and get his records spread on the public record, I think it might be interesting.

I spent about three hours in his office because I was absolutely fascinated with what he was doing. He was making a million dollars. He was getting very wealthy. His job was he would go to insurance companies or private funds and offer to decrease their costs of what it is to render the health care by merely policing the people who are rendering the service.

He would show me instances like a doctor took six x-rays. He would call up on the phone and say, I want to see the x-rays. The doctor has to send in the x-rays, so he sends in the x-rays. Three of the x-rays are all blank. So he would write back and say, we are only going to pay for three of them; you eat the other three. The next time you take x-rays you can read.

Or one would be filling teeth and he would check the records. Those teeth would not be there to fill, but they were charged for the filling of the teeth.

This is not the majority, but it is certainly a sizable proportion and the PSRO's have not even begun to address it. This doctor has difficulty going into states, because the state's AMA would try to legislate him out of existence so he

could not go in. He spent most of his time, 90 percent of his time, doing nothing more than fighting the political battle from state to state to get in so that there could be a discipoine on the people who are rendering the health care.

Senator Talmadge. If you would yield at that point, that is what we tried to address in our anti-fraud and anti-abuse amendments.

Mr. Constantine. What the bill does do, the Administrations GNP deflator may or may not affect the costs of goods and services in hospitals. What the Talmadge bill tried to do, and tries to do, and we believe reasonably does, is to set up a market basket of the goods and services which hospitals purchase and pay for to the extent possible to parallel that, because their mass of goods and services may not be the same as the general economy's. In other words, to get an index of inflation and what they are actually using, adjusting that for prevailing wage level differences and including the Gravel provision there, taking care of Alaska and Hawaii, the price differentials there, and then adjusting for prevailing wage level differences. There is a keen difference in the wage treatment here, I may as well address it, between what the Talmadge bill has and what the Administration and Labor is trying very hard for.

They want a blank check for wage costs. They want unlimited wages passed through and wage components account for,

inlcuding supervisory personnel, account for a little more than 50 percent of the hospital costs, that all increases to the extent that you exceed a limit are passed through indiscriminately.

Senator Curtis. Who wants that?

Mr. Constantine. The Administration and the AFL-CIO.

Mr. Fullerton. Jay is describing a provision that the Commerce Committee adopted last week.

Senator Curtis. Are you recommending that?

Mr. Constantine. No, we are not. The Talmadge bill's provisions, if you are going to deal with inflation, you have to deal with both components at the same time. The question was, how do you define wages? You cannot argue for substandard wage levels.

What the Talmadge bill has, if the only pass-through would be if a hospital increases and goes beyond a limit to bring hospital wages up to prevailing wages in that area, in that area for comparable work and service, the only pass-through would be, if in the Omaha area hospital wages were substandard at a given hospital, were under the prevailing levels, rather than a blank check for everyone.

Most of the data say that hospital wages generally have caught up with, or are now below, prevailing wage levels and, in some cases, are above prevailing wage levels.

Once they get to the prevailing level, the wage component

that increases under the Talmadge bill, the annual adjustment is a change in the general wage levels in that area, the service industry wage levels, excluding government and farm.

If private wages rise 5 percent, the wage component recognized for Medicare and Medicaid can go up 5 percent. In the hospital, they are free to pay their employees more if they want to, but they do that under productivity, out of productivity and out of incentive payments if they want to, just as the private sector.

The Talmadge bill very specifically is at odds, and the labor people testified very strongly against the bill on that point and are opposed to it because it does not have a blank check for wage costs.

Our suggestion was, if this is the approach adopted, we assume that the President, the Administration and others would be asking for a repeal of the Davis-Bacon Act and the Federal Blue Collar legislation both of which deal with established wage rates on a prevailing wage basis. There is a keen difference in this approach between determining, number one, a market basket of goods and services rather than a reference point that is unrelated to the goods and services which hospitals purchase, and an adjustment in terms of area wage levels rather than no reference to areas and a national difference.

Senator Curtis. You are suggesting it follow the pattern

of the Davis-Bacon Act?

Mr. Constantine. Not quite, just that those acts deal with prevailing wage levels.

Senator Curtis. They permit inflation, the way they are administered.

Mr. Constantine. I am not arguing that, Senator.

Senator Curtis. That outfit will drive 200 miles to find an isolated wage and make the determination that that is the prevailing wage.

Mr. Constantine. Senator, in this, it takes recognition where you have a distortion in an area, where you have a single employer whose wages created a distortion in the wage levels. You use a reasonably comparable area or reference point, so you can come up with a reputable prevailing wage determination.

Glen here, Mr. Marcus, has had a lot of discussions with the Department of Commerce and the Labor Department on this point.

Mr. Marcus. Because of the concerns which you expressed, we met with representatives of the Department of Labor who pointed out to us that data are now gathered with respect to prevailing wages for the kinds of workers that hospitals would typically employ for providing routine services from the Unemployment Insurance Program.

So that the problems that you are articulating of someone going to an unusual place under Davis-Bacon and picking something

wholly unrepresentative of wages in an area can be overcome by a data source we have already gathered.

Mr. Constantine. You may want to amend the Davis-Bacon Act. Labor is coming up with some new approaches.

Senator Gravel. If you take the basic principal that there is neither competition nor discipline in the health care delivery system, what you are saying does not institute competition nor discipline. What you are doing is that you are taking this market basket approach in an area that has run rampant and organizing the running rampant so that they will do it more efficiently and more calculatingly.

There is not an element that you have put forward where there is a discipline on the hospital administrator to call a meeting of the doctors and say, let us knock off a lot of this stuff. No, we cannot expand this open heart surgery unit. People are going to have to go down the street to get it.

Between hospitals, a lot of ego-raising is going on. This is what I have seen in this case in Alaska. Until you have a force on these people -- we have seen from 50 or more years of regulatory experience in the United States that the government regulators have no ability to go in and maintain costs. What they do is they get co-opted by the people they are supposed to be dealing with and then become the advocates of what they are trying to do.

Why would it be so horrendously painful or difficult to just tell the industry that the rest of the society moves at a 6 percent level of increase and you people will march to the same drummer? What is so horrendously terrible about that?

Forgetting all this esoteric --

Senator Curtis. Six percent a year?

Senator Gravel. Not only do this to the public sector, but I would recommend that we take the private plans and limit premium increases similarly to an inflationary increase, and that way you will get the insurance companies -- the insurance companies have no discipline on them now. They are going to pass through the costs. As they expand their volume of dollars, they make more profit.

So if you put a lid on them and say, hey, you cannot charge any more premium than this, you cannot decline service. So what the insurance companies are going to have to do is get off their duff and go down and start hassling the hospitals and hassling the doctors and that is what we need, is a little more hassle here.

Senator Curtis. You just be patient. If we create that Commission, they will be doing everything that you are talking about.

Mr. Constantine. Senator, I do not think you have to wait another twenty years. Under the Talmadge bill, there is

a limitation. There are two things.

The State health officers do this. On the planning, to the extent Alaska had any effective planning mechanism, which did not approve that hospital, under the Talmadge bill there would be no reimbursements under the Federal program for capital costs and direct operating operating costs associated with an unimproved expenditure. That is number one.

Assuming that they were approved originally and then wanted to expand and did not get approval for the expansion because there was already an existing facility, under the Talmadge bill, under another Section, Section 4, there would be no Federal reimbursement. That is number one.

Senator Gravel. What you are saying is, a person from the Federal government, on the Federal tax rolls with his staff and his research capability has to go in, make all of this assessment and come back and hassle them to do something when, if you just have an economic indicator, that discipline is going to permeate itself without any human involvement.

Mr. Constantine. Number one, Senator, that is at the state level. These are the state planning agencies and and the health systems agencies. That determination is made at the state level, not at the Federal level, for better or worse.

Senator Gravel. I do not question that. Why could we not do this? Why could we not have both? Why do we not try a facet of this and then put a lid on the whole thing and let

them squirum around in that kind of a situation?

Mr. Constantine. In effect, the bill does have a target rate and there is a lot of squirming. What it does is that it classifies hospitals nationally by type and size so within a given group, you might have 500 hospitals of between 200 and 300 beds, essentially of the same type, short-term general hospitals.

The bill then adjusts them. We get their average costs per diem, on routine. We adjust that for area wage level differences. To the extent that a given hospital's costs were routine, are below the average for the group, they get an incentive payment equal to 50 percent of the difference between their actual costs and the target rate, the average for the group as an incentive payment to a maximum of 5 percent.

Senator Gravel. Who makes this judgment?

Mr. Constantine. Automatically, in the cost reports.

Senator Gravel. It is the government. It has to get the reports, analyze the reports and returns it?

Mr. Constantine. We get all of those cost reports now, Senator. That is how we use that now. We look at the cost reports. We then say, you are at the average, or below. At the average, you are getting that. If you are below the average for your group of those 500 hospitals you are getting an incentive payment. If you are between the average and 115 percent, 15 percent above the average, the original

Talmadge bill says 20 percent above the average. The suggested change is 15 percent above the average. You receive your costs only.

That is, if you are between the average and 15 percent above the average. If your costs exceed the average --

Senator Gravel. Is that not exactly what happens? If the rate of inflation, let us say, the rate agreed upon deflator is 8 percent in this country. Next year hospitals want to charge 15 percent, they cannot. They have to charge an 8 percent increase. That is it.

So that the ones below it will come up to that and the ones that are above it will come down to it, and you will not have a whole number of reports to arrive at that decision.

Mr. Constantine. Here is the problem with that, Senator. Number one, the thesis underlying the Talmadge bill was the determination of reasonableness of a given hospital cost by comparing it with other hospitals rather than an external thing. If you allowed all hospitals to rise by the same percentage, 6 percent or 7 percent or 9 percent --

Senator Gravel. Do not make my case for me. They will not all rise like that, because some will be lower, and so the new rate is 8 percent, which is what the inflation is, some have been living below that so they may be able to rise to 12 percent, 15 percent, if they are so low.

Mr. Constantine. None of that goes to the base cost.

You can have two hospitals, both doing an equivalent job, serving a similar population, and this is one of the cricisms we had of the Administration's proposal. One is providing care at an average cost of $200 a day, assuming all things being equal, and the other at $300.

Under the Administration's proposal, both hospital would be allowed to go up by 9 percent. The efficient hospital would be limited to an $18 increase in costs and the inefficient one would get $27.

You are further increasing the disparity.

Senator Gravel. Are you not presupposing something that has not existed in the health care system -- efficiency?

Senator Curtis. The bill originally had 120 percent for the routine costs limit and you have changed that to 115 percent.

What is the figure?

Mr. Constantine. The 15 percent was to allow a reasonable, and the 20 percent would allow a reasonable ban above the average, realizing the imprecision in measuring costs and minor variables, and to avoid falling off a cliff. You go from an average where you get an incentive of costs into a penalty situation.

In working on it further, in doing computer runs, in determining the costs, it was felt that 20 percent was probably too high; 15 percent was an adequate limitation.

By going to 15 percent, the amount that CBO estimates would be saved under the bill is increased as well. The savings from the proposal were increased.

The 20 percent was a reasonable band of difference, and the 15 percent was a reasonable band.

Senator Talmadge. What are the estimated savings under this bill?

Mr. Constantine. It is rather interesting. The Administration's cost report siad in fiscal 1980 under the hospital provision only, under the routine $5 million based upon the bill as introduced. CBO, based upon the bill as introduced, had an estimated savings in 1980 of $400 million, and then they estimated that with these changes, the 15 percent, and there is another excluded from the subsequent calculations -- one-half of the excess costs -- those costs you do not allow in calculating the average. The total savings would be $800 million the first year.

Senator Curtis. Who says that?

Mr. Constantine. The Congressional Budget Office.

Senator Curtis. When did they do that?

Mr. Constantine. In June.

They are standing by their estimate, are they not?

Mr. Wilson. That is a very preliminary estimate. The first estimate was for $100 to $400 million. The estimate probably doubled, $200 to $800 million.

Senator Curtis. When did you make that?

Mr. Wilson. When they changed.

Senator Curtis. When did you make your estimate?

Mr. Wilson. Last year some time.

Senator Curtis. That answers my question.

Mr. Constantine. That was the original bill, Senator.

Mr. Wilson. The original bill.

Senator Curtis. I asked you when you made your estimate of $200 million to $800 million?

Mr. Wilson. That is a quick estimate. We did it a couple of weeks ago, which we estimate approximately double the savings.

Senator Curtis. It would be interesting to know what all you included in making your estimate. You could change that 115 percent to 75 percent and on paper, you would save a lot of money. It would not save a nickel in the health care that people have to have and have to pay for some way.

It seems like to me that you have an outline for price control of everything connected with health ultimately, in a few years, and you are assured of control but not assured of any production costs. You have not brought in anything here that would touch this for $5 billion or $6 billion or $7 billion that HEW says that they wasted.

I do not believe there is anything in here that deals with that. But even if it did, it would be only about 20

percent.

Mr. Constantine. That is first year only; it builds from there.

Let me give you an example of the impact on the basis of the original Talmadge, the 1470 hospital bill, as introduced.

There was panic in California. California has an inordinate amount of hospitals, particularly in the Los Angeles and Orange County areas, which are very low-occupancy, under-utilized. These include some of those that are so under-utilized that one has a massage parlor to attract medical staff, another has a gourmet wine cellar. Governor Brown pointed this out; this came from the Government Operations Committee.

Many of those hospitals are at 30 percent occupancy levels, 35 percent occupancy levels. Under the Talmadge bill as originally introduced, the state of California and its consultants sent a letter to us saying that they estimated under the routine per diem limits in the original bill that 58 percent of the hospitals in California -- not by size, not necessarily the large hospitals, but of all hospitals -- would have their allowance for routine costs, their daily routine costs, reduced; that even on a per admission basis, because they have somewhat shorter stays in California, so that you would have fewer days, that 46 percent of the hospitals in California would have their allowances reduced because they would exceed the limits established under theTalmadge

bill.

They said the reason for this was that the Talmadge bill was particularly sensitive to low occupancy and high staffing ratios. The hospitals which are over-staffed -- and, of course, that is what it was designed to be sensitive to.

So, Senator, at least among the state people, they are under no illusions, nor are the hospitals under any illusions that this is not going to affect hospitals.

What it deals with is not cost control except to the extent that reimbursement is involved under Medicare and Medicaid. It deals with a reimbursement reform of how the government pays hospitals. It also, when we get to it, Senator, we would have to discuss the state option which has been expanded. We recommend that it be substantially expanded to allow the state if it can do a better job than the Federal government -- some can, some cannot -- to opt out of this approach.

Senator Curtis. Opt out of what?

Mr. Constantine. Of this system in place of their own system.

There are how many states who have reimbursement systems now?

Mr. Fullerton. About eight. There are various stages of implementation.

Senator Gravel. Does this cover both? Does it cover the

private health care plans?

Mr. Constantine. No, sir.

Senator Gravel. Are the costs runaway -- is it equal in the private sector as well as Medicare and Medicaid?

Mr. Constantine. Our costs are rising at a higher rate, according to the trustees' report.

Mr. Fullerton. As far as rate of increase and possible expenses, it is no higher for Medicare than it is in the private sector. Medicare increases are going up because more people are eligible every year.

Senator Gravel. If we developed a plan, and took the Talmadge bill here for Medicare and Medicaid and then put out an amendment limiting premiums of the private sector and watched it for two, three or four years, we would have a good example as to what would be more effective as a tool for containing costs, would we not?

Mr. Constantine. You might, but we might not want to go that far.

I would like to make two points, Senator. There is no question Senator Curtis is right, that this approach could be expanded, but it would require additional legislation to cover all hospitals, all payers, all revenues.

Senator Gravel. I am not advocating that. I am only suggesting that we take this the way you have it designed and then we put an amendment on. That limits the premium increase

that insurance companies can charge for private plans to the prior year's inflation increase.

Mr. Constantine. There is a problem with that too?

Senator Gravel. What is that?

Mr. Constantine. There is a variation in premium increase requests among companies. You may have a private health insurer that has not had an increase in three years and has had a lag, a substantial lag, considerably beyond last year's inflation, and another which has just had an increase in December, and you are making them eligible for another one. You have all of those variations.

It is a criticism we had of Secretary Califano's point about there was no problem that 20 percent of hospitals had kept their increases in 1976 below 9 percent. But we said how many had done it for two years in a row?

Senator Gravel. Suppose we have a formula going back for two years that some could play catch-up? Certainly that could not be an argument against them that this is an injustice. Hell, look at the amount of injustice that we have going on right now in the whole field. We are paying for a lot of waste, billions and billions of dollars of waste. So why criticize an approach if there is just a slight waste or a slight injustice that you could handle with a formula?

In the last two years, if you have not had any increases, you would be entitled to an increase of the average, but

henceforth, you would have a limit.

I am just talking about the private sector.

Mr. Marcus. One of the problems is, unless you impose those types of limitations, you would have to give the private companies a capability.

Senator Gravel. You are assuming, if this is successful, they will be cleaning their act up on that side, but if they start billing the patients, I think you wuld start to have the patients be more selective as to what is happening to them.

All I am trying to do is institute an element of discipline. You are trying to figure out a way not to have any discipline. We do not want to hassle the patients because he may begin to look at his medical bills. Right now, I belong to a medical plan. I have never looked at the plan. I just have somebody fill it out and sign it. I could care less. It is built into the system and the costs are passed through.

What you want to do is make me look at my medical bill, that is not bad. And you want to make the insurance companies start looking at the doctors and going to the hospitals and finding out if there is a lot of excessive care or duplication.

That is exactly what I want to do. I want to create a lot of conflict and a lot of hassle and a lot of headaches for a lot of people and we will contain the costs that way.

Senator Curtis. You will have a lot of help.

Senator Gravel. Let's go to it. We are both starting out with statistics that are ridiculous, so we will look at it for four years and we will see which is the better and cheaper approach for society, to just go ahead and put a cap on it, let them work that number out, or to get involved in all the intricacies of it and try to push it and make it on paper.

I do not know any discipline that does not exercise some degree of pain. I suffer every time that I cannot go out and buy a Cadillac every year. But for medical stuff, there is no discipline. You get whatever the traffic will bear. Apparently, we are limitless in what we will bear.

Mr. Constantine. I think that this is, it is only going to be four lanes instead of six lanes.

Senator Gravel. I am not knocking that. I am saying let's do that, do that for the government, Medicare and Medicaid. What I am suggesting -- I am not attacking what you have here; let's do this -- I am suggesting we do that and tell the insurance companies that they have to go discipline the people who are letting the costs run away. They are not going to get it passed through anymore.

Mr. Fullerton. The Administration shares that concern with you completely. If we put this kind of system in for Medicare and Medicaid only, the hospital can bulge those expenses out in the private sector. The Administration retains its system of getting ahold of the whole system, not just

government programs.

Senator Gravel. Would not my suggestion do just that? It would do it on one facet without a lot of bureaucracy in the private sector and keep the bureaucracy into the public sector.

Mr. Constantine. We would like to respond to Bill's point because we have another point to make on that. Number one, today, Medicare, Medicaid and Blue Cross reimburse on a cost basis. You have the same problem of the possibility of costs shifting going on today where a hospital says we are not getting enough from Blue Cross or Medicare or Medicaid; we are going to make it up on the other paying patients. That exists today; it is not new.

This bill has a provision saying it shall be illegal to shift those costs. We have, under a prior legislation, we have a requirement beginning next year they are going to start using uniform cost reports, uniform allocation of costs and audit trails so we can track back. Admittedly, that will be incomplete in application and the language is hortatory. The costs can be shifted, no matter what you say there.

However, if you were serious about it, you could put in a requirement -- make it a misdemeanor -- that the principal administrative officer and the individual responsible for the accounting practices in the institution certify, subject to misdemeanor, except as approved by the Medicare intermediary,

that they have not shifted costs.

Senator Gravel. Why do you insist on finding a way that is not as efficient as the one I am suggesting?

Mr. Constantine. It is not as comprehensive.

Senator Gravel. Mine is a thousand times as comprehensive as yours will ever be.

Mr. Constantine. It is.

Senator Gravel. Do we not have to have a comprehensive discipline? You are narrowing it down. You are giving an incentive for the comptroller of a hospital to be smart in shifting his assets and costs around as opposed to giving a discipline and incentive to the insurance company to go down and see that comptroller and make him rationalize to him what the costs are. You are approaching it the wrong way.

Senator Curtis. What you are going to do is, if they cannot provide the coverage for the premium that you are going to have the government regulate, and you have enlarged all of these programs where the government picks up the whole check.

I would like to ask this -- the Administration's plan does call for extending this to all care facilities, not just to Medicare and Medicaid.

Mr. Constantine. Yes, sir. The Administration's is all hospitals, all payers.

Senator Curtis. Of the bills that we are likely to go to conference on, do they have that provision too?

Mr. Constantine. All payers, all hospitals? Yes, sir. What we anticipate is they will use the voluntary effort with a trigger, and if the voluntary effort fails, all hospitals, all payers.

Senator Curtis. I did not make my question clear. These bills that are likely to come over from the House as well as our own other Committee in the Senate here, are they limited to Medicare and Medicaid?

Mr. Constantine. No, sir.

Senator Curtis. There would be four committees at that mass meeting in the conference, or a mob gathering. It is not polite, but I have been to one, and three-fourths of it will be for enlarging these controls.

Mr. Constantine. We can narrow the odds -- two-thirds, because this bill here deals with only Medicare and Medicaid and it is the Social Security bill and it would be only the Finance Committee representing the Senate in Conference on this bill.

Senator Curtis. I thought that one of the reasons you wanted to get this thing through in a hurry was because the Human Resources Committee was about to take jurisdiction.

Mr. Constantine. No, sir. I guess the argument could be made to the Human Resources bill, which was jointly referred to Finance. It has been here for a year.

Senator Talmadge has been arguing against the Administration's

original approach and these other approaches as too broad, undifferentiated.

Senator Curtis. Does the Human Resources Committee of the Senate include -- do they limit their controls to Medicare and Medicaid?

Mr. Constantine. No, sir.

Senator Curtis. Nor the House?

Mr. Constantine. No, sir.

Senator Curtis. The point I am making, Mr. Chairman, if we go to Conference on anything, there will be four committees involved and three of them are committed to the controls not being limited to Medicare and Medicaid.

Mr.Constantine. No, Senator. If you take this bill, just for the sake of argument, if you take this bill and we put it on a tariff bill, this amendment is on a tariff bill and it is a tariff bill that is in Conference on this thing, the other items are not in conference.

Senator Curtis. That is the smartest suggestion you have ever made in connection with a legislative proposal. I agree with you.

Mr. Constantine. One more point, the Committee should understand. The staff is unanimous. If you took this approach or something like this, just for the sake of argument, we absolutely believe that Congress does not have to vote on a mandatory program this year. It does not have to consider a

mandatory program affecting all hospitals and all payers, for this reason. This approach here provides a classification and comparison system, or mechanism, for Medicare and Medicaid and an index for measuring changes in hospital costs. With that in place, the voluntary effort that is anticipated by CBO, the group of private hospitals at the state levels, the American Hospital Association and the American Medical Association, the Federation of Hospitals -- Blue-Cross, I guess, is in there too -- they are expected to meet their target in moderating the rate of increase and also expenditures by 2 percent. That is dropping the rate of increase from 16 percent in '77 over '76 to 14 percent or less in '78 over '77.

CBO -- a nod of the head does not show.

Mr. Wilson. Yes.

Mr. Constantine. CBO expects them to meet them this year. If they meet it this year, it means the earliest that the voluntary effort could fail is 1979. If they fail in '79, it means any mandatory program that Congress decided on would not have to go into effect until 1980.

Is that correct?

Mr. Wilson. Yes.

Mr. Constantine. If the Talmadge bill becomes operative in July of '79, it is not difficult at all to take that methodology if Congress further legislated, decided it wanted

a mandatory program covering all payers and revenues from all sources, to take that classification system and the allowable percentage increase that we use for costs and Medicare and Medicaid under this proposal and say that that is the percentage that we will allow at revenues per admission to increase.

That is not a difficult thing to do. You can make that decision in July of next year, or August of next year, if you wanted to, and then apply it in 1980. You have that option.

What we are saying, in our opinion, based upon CBO's estimates as well, we do not think that the Congress has to make a decision if this were in place on a mandatory program covering everyone. You can wait a year and then decide whether you want to do it at that time, reviewing the amount at that time.

We think that is a key consideration in what you do on the Talmadge bill, unless you are interested -- unless obviously you are advocating a mandatory program now.

Senator Danforth. Shoot down for me the following variation on the Talmadge bill. We go with the Talmadge approach, the average. We pay no attention to classifications of hospitals. We just absolutely drop that feature, could not care less about it.

We pay no attention to the difference between routine costs and ancillary costs, just totally forget about that.

What we average, instead, is the cost of treatment. That is, you gather information on the cost of an appendectomy or a tonsilectomy or whatever else goes on in a hospital. You take the position that you are reimbursing for the treatment of patients rather than for the operation of the hospital and then you apply the averaging on that basis. What is wrong with that?

Mr. Constantine?

Mr. Constantine. That wold be interesting, but it would be disastrous. We have hospitals which maintain other centers, burn centers, complex hospitals that have educational programs where the costs of medical education are added in one case, in the appendectomy situation. In another case, catarracts, they are not.

You would be penalizing all of those variations, many of which are legitimate, between hospitals.

Senator Danforth. The basic, fundamental question is, what are we paying for? What do we want to be paying for? And I say it is fine for medical education to go forward, it is fine for hospitals to do whatever they want to do, you know? If they want restaurants or they want wine cellars or whatever else they want to do, that is their business.

But what we are in the business of doing is reimbursing

for the average cost of a certain kind of treatment.

If somebody goes into the hospital and they have to have the chest surgery or whatever they are going to have done, then there are figures available which give you an average cost in that community for that procedure, and you could even, by computer, you could be very precise about it. You could do it. You could do the average cost by age of the patient or whatever else he wanted to do. But just arrive at a figure.

Then if the hospital were to say, wait a minute, this is a unique cost then fine, they can appeal that smmehow. But it seems to me that that would make sense unless you give me some reason why it would be disastrous.

Mr. Constantine. That is one of the approaches. That is what we describe as a case mix approach being worked on and demonstrated in New Jersey. It may work for certain types of hospitals, be equitable, and come up with a certain result along the lines you suggest. In other cases, it is not. A lot of it is diagnosed as differences, lack of precision in diagnoses, the secondary diagnoses that complicates costs. The standby consideration here is the hospital that has higher costs but is the only game in town.

Mr. Marcus. When you take an appendix out, you could probably take an x-ray and establish that it was gone, but measuring the treatment by diagnosis would be for a person who

who has three or four problems at the same time, particularly the elderly. So the problem arises, among other things, how you label that individual. How are you going to ascertain just the amount you are talking about to pay.

So in some areas it is possible, rather clearly, even around this table, to agree on what we would pay. We might take into account variations, economic, or utilization variations. It gets very comlicated when we start talking about somebody 65 or over.

Senator Talmadge. If I may respond to that very briefly, you have a different mix of hospitals involved and different, complex, things. You have rural hospitals, urban hospitals, teaching hsopitals. You cannot judge all hospitals similarly.

That is the reason why we tried to identify the hospitals, compare the costs with hospitals similarly situated. That is the difference between your approach and ours.

Now, we have about three more minutes before we have to clear the room. We have a briefing here at 11:00 o'clock by the Special Trade Representative, and the Chairman has asked us to adjourn this meeting at 10:30.

Have we made any progress?

Carl, do you look with favor on the approach that we have got?

Senator Curtis. No, I am just finding out about it. The original bill, for instance, did not have that thing that

scares the life out of me, that health facilities cost commission. It is as innocent-looking at OSHA was when I first saw it, but I would like to make one request, and that is that there be a reconciliation of CBO's and the Administration's estimates of how much money we are going to save.

Senator Talmadge. We will see if we can find that out.

Jay keeps referring to this as the Talmadge bill. I want to point out that it is the Talmadge bill, the Long bill, the Ribicoff bill, the Dole bill, the Nunn bill, the Eastland bill, the Matsunaga bill, the Randolph bill, the Hollings bill, the Norway bill, Gravel, Ford, Javits, Pell, Percy, Brooke, Burdick, Stone, Metzenbaum and Hathaway. It runs the gamut from extreme liberals in the Senate to extreme conservatives.

Mr. Constantine. We could drop the health care facilities cost commission if you felt --

Senator Talmadge. That originated with Chairman Rogers over on the House side, as I recall. I can see some problems in legislating on something of this complexity. You are going to have to have some commission with some latitude to adjust for the differences, as I see it.

Mr. Constantine. Senator, what you can do -- the choice was to give the responsibility to the Secretary or a visible group of people who presumably are professional and competent and objective, and on whom Congress can keep an eye, which includes representatives of the private sector, of hospitals,

of the state and local government, with the responsibility for making these refinements as the state of the art advances or give them to the Secretary, where it gets bogged down in the halls of HEW. You will never find out who is doing what to whom, with apologies to the representatives from HEW who came up for the occasion.

Senator Talmadge. It is not 10:30.

Mr. Constantine. Do you want to meet this afternoon? We could continue with anyone who wants to.

Senator Talmadge. Suppose you continue to work with the staff and any Senators who want to meet with you. Unfortunately I have committee meetings and conferences all the afternoon.

We have a briefing with Ambassador Strauss here at 11:00. The Finance Committee has got a luncheon on with the Trade Ministers of Japan, the European Community and Canada at noon.

At 2:00 p.m. we have another conference. At 3:00 p.m. we have a conference on agricultural credit. At 4:00 p.m. a conference on the Customs bill, H. 209 and so on.

I would suggest this, that you try to get the staff together and continue to work as you have. By all means, do not exclude the Minority.

Mr. Constantine. Senator, we have had two three-hour briefings with the staff. I think the staff is briefed -- the staffs of the Senators. I think the staff of the Committee, we would be very glad to answer individual questions.

Senator Talmadge. We have the staffs of the Senators here.

Mr. Constantine. Anybody of the staffs who want to talk further, we are willing to. What I would suggest, Senator, there is no question that Senator Curtis is right -- the hospital part is the most significant and most complex of the various elements of S. 1470, as modified, and as introduced. It is a serious provision and it is an alternative provision and it should be understood and explained.

We agree with Senator Curtis on that, certainly. What we would suggest is that the committee, in its mark-up tomorrow, continue not with the hospital stuff but with those other provisions dealing with administration, reimbursement of physicians, and not deal with the hospital segments of this until Senator Curtis and the other members of the Committee are satisfied, that before they will vote on it, that they understand it, and have their questions raised.

I think you can deal with the other provisions for better or worse, make your decisions up or down. There is relatively little modification in the balance of the bill, but the hospital thing is the most significant, and it should be understood.

Senator Talmadge. I agree. Is that agreeable with you, Carl?

Senator Curtis. That is all right.

Senator Talmadge. We will stand in recess until tomorrow morning at 10:00 o'clock. That is the full Committee meeting.

(Thereupon, at 10:30 a.m. the Subcommittee recessed, to reconvene at the call of the Chair.)

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