HOSPITAL COST CONTAINMENT ACT OF 1977

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE HOUSE OF REPRESENTATIVES

NINETY-FIFTH CONGRESS

FIRST SESSION

ON

H.R. 8121 and H.R. 6575

BILLS TO ESTABLISH A TRANSITIONAL SYSTEM OF HOSPITAL COST CONTAINMENT BY PROVIDING FOR INCENTIVES AND RESTRAINTS TO CONTAIN THE RATE OF INCREASE IN HOSPITAL REVENUES, TO ESTABLISH A SYSTEM OF CAPITAL ALLOCATION DESIGNED TO ENCOURAGE COMMUNITIES TO AVOID THE CREATION OF UNNEEDED AND DUPLICATIVE HOSPITAL FACILITIES AND SERVICES, TO PROVIDE FOR THE PUBLICATION AND DISCLOSURE OF INFORMATION USEFUL TO THE PUBLIC IN MAKING DECISIONS ABOUT HEALTH CARE, TO PROVIDE FOR THE DEVELOPMENT OF PERMANENT REFORMS IN HOSPITAL REIMBURSEMENT DESIGNED TO PROVIDE INCENTIVES FOR THE EFFICIENT AND EFFECTIVE USE OF HOSPITAL RESOURCES, AND FOR OTHER PURPOSES

JULY 18, 1977

Serial No. 95–31

Printed for the use of the
Committee on Interstate and Foreign Commerce

U.S. GOVERNMENT PRINTING OFFICE
95-756 O WASHINGTON : 1977

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

HARLEY O. STAGGERS, West Virginia, *Chairman*

JOHN E. MOSS, California
JOHN D. DINGELL, Michigan
PAUL G. ROGERS, Florida
LIONEL VAN DEERLIN, California
FRED B. ROONEY, Pennsylvania
JOHN M. MURPHY, New York
DAVID E. SATTERFIELD III, Virginia
BOB ECKHARDT, Texas
RICHARDSON PREYER, North Carolina
CHARLES J. CARNEY, Ohio
RALPH H. METCALFE, Illinois
JAMES H. SCHEUER, New York
RICHARD L. OTTINGER, New York
HENRY A. WAXMAN, California
ROBERT (BOB) KRUEGER, Texas
TIMOTHY E. WIRTH, Colorado
PHILIP R. SHARP, Indiana
JAMES J. FLORIO, New Jersey
ANTHONY TOBY MOFFETT, Connecticut
JIM SANTINI, Nevada
ANDREW MAGUIRE, New Jersey
MARTY RUSSO, Illinois
EDWARD J. MARKEY, Massachusetts
THOMAS A. LUKEN, Ohio
DOUG WALGREN, Pennsylvania
BOB GAMMAGE, Texas
ALBERT GORE, JR., Tennessee
BARBARA A. MIKULSKI, Maryland

SAMUEL L. DEVINE, Ohio
JAMES T. BROYHILL, North Carolina
TIM LEE CARTER, Kentucky
CLARENCE J. BROWN, Ohio
JOE SKUBITZ, Kansas
JAMES M. COLLINS, Texas
LOUIS FREY, JR., Florida
NORMAN F. LENT, New York
EDWARD R. MADIGAN, Illinois
CARLOS J. MOORHEAD, California
MATTHEW J. RINALDO, New Jersey
W. HENSON MOORE, Louisiana
DAVE STOCKMAN, Michigan
MARC L. MARKS, Pennsylvania

W. E. WILLIAMSON, *Chief Clerk and Staff Director*
KENNETH J. PAINTER, *First Assistant Clerk*
ELEANOR A. DINKINS, *Assistant Clerk*
FRANK W. MAHON, *Printing Editor*

PROFESSIONAL STAFF

ELIZABETH HARRISON
JEFFREY H. SCHWARTZ
BRIAN R. MOIR
KAREN F. NELSON
ROSS D. AIN
CHRISTOPHER E. DUNNE
WILLIAM M. KITZMILLER
MARK J. RAABE
THOMAS M. RYAN
RICHARD D. LINDSAY

ROBERT HENLEY LAMB, *Associate Minority Counsel*

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

PAUL G. ROGERS, Florida, *Chairman*

DAVID E. SATTERFIELD III, Virginia
RICHARDSON PREYER, North Carolina
JAMES H. SCHEUER, New York
HENRY A. WAXMAN, California
JAMES J. FLORIO, New Jersey
ANDREW MAGUIRE, New Jersey
EDWARD J. MARKEY, Massachusetts
RICHARD L. OTTINGER, New York
DOUG WALGREN, Pennsylvania
HARLEY O. STAGGERS, West Virginia (Ex Officio)

TIM LEE CARTER, Kentucky
JAMES T. BROYHILL, North Carolina
EDWARD R. MADIGAN, Illinois
JOE SKUBITZ, Kansas
SAMUEL L. DEVINE, Ohio (Ex Officio)

STEPHAN E. LAWTON, *Counsel*
ROBERT W. MAHER, *Director of Research and Planning*
JO ANNE GLISSON, *Senior Staff Associate*
DONALD K. DALRYMPLE, *Assistant Counsel*
STEPHEN J. CONNOLLY, *Senior Staff Assistant*
BURKE ZIMMERMAN, *Research Assistant*

CONTENTS

HOSPITAL COST CONTAINMENT ACT OF 1977

MONDAY, JULY 18, 1977

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcomittee met, pursuant to notice, at 9:00 a.m., in Room 2123, Rayburn House Office Building, Hon. Paul G. Rogers (chairman of the subcommittee) presiding.

Mr. ROGERS. The subcommittee will come to order, please.

The hearing this morning is to receive testimony on three new proposals which were introduced by me in H.R. 8121 on June 30. I offered these proposals to stimulate debate and further consideration of two very important issues which I belive must be addressed by any hospital cost containment program.

First, hospitals must be encouraged by a cost containment program to perform efficiently and responsibly. With proper incentives, I can foresee our hospital system providing high quality care to all our citizens with the latest available technology, but I see it free of surplus beds and equipment and free of overlapping and duplicative services.

Second, our health planning system must be enabled to more effectively limit the introduction of new facilities and equipment. Many of these new services are not adding to our ability to care for the ill, but are only duplicating existing services at high cost.

I believe that the three new proposals in H.R. 8121, as well as all others which seek to contain recent increases in hospital costs, must be subjected to the closest scrutiny. The issues involved are many and complex.

I believe Dr. Carter has a statement he would like to present.

Dr. Carter?

Mr. CARTER. Mr. Chairman, proposals to contain the dramatic increases in hospital costs have been a topic of much discussion in the Congress in recent months. As a physician and as ranking minority member of the House Subcommittee on Health and the Environment, I too have become increasingly concerned about this problem. I have listened carefully to the methods proposed to solve it, including the legislation advanced by the administration, H.R. 6575. Although I share the administration's desire for timely action to remedy the problem of escalating hospital costs, I feel that the

administration's proposal is not properly focused, nor can it accomplish the long-term goals towards which we should be working.

The goal of a cost containment system should not simply be defined in terms of how many dollars are spent for hospital care or for any other type of health services. Instead, the goal of a cost containment system should be the provision of effective, efficient, high quality care for all Americans. Accomplishing this goal is a difficult task indeed, but I do not think we can do it with the inflexible, nonspecific approach proposed by the administration.

Hospitals and the problems they face are as varied as the diseases with which we become infected; and an effective cost containment system must have the ability, and the sensitivity, to deal with these variations. Given the wide variations among hospitals in size, location, services, case-mix, and efficiency, I do not believe that it is technically feasible, or desirable, to institute a cost containment program at the Federal level. For this reason, I am announcing today my intention to introduce legislation which will encourage the formation of State cost containment programs as the best approach to a long-term solution.

The President's proposal has focused on the short-term goal of controlling hospital costs without attempting to do much about our long-range goals. I believe that we must begin now to develop a program of rational management of our health care resources. Establishment of State cost containment programs will take time and effort, but the pay-off in terms of a coordinated, balanced approach to the problem will ultimately benefit our health care delivery system. This should not be an issue of Federal versus State power; the important point is the ability of State and local officials to institute selective and cooperative approaches which allow all concerned to participate in maintaining and improving the care we provide our people.

In contrast to the administration's legislation, my bill will focus on the establishment of State Commissions on Hospital Budgets to review prospectively the budgets of hospitals within the State. Key elements in my proposal will be:

Flexibility in the selection of a prospective budget review methodology,

Positive incentives to hospitals to control costs,

Uniform definitions of reimbursable costs,

Federal support for "start-up" costs of State commissions,

Establishment of policy review boards at the State and Federal levels to monitor health financing policies, and

Provisions for Federal oversight of State budget review.

I submit that only a program instituted at the State level as I have proposed can achieve the level of specificity and sophistication necessary to insure the desired efficiency is achieved while maintaining quality of care. Such a program must insure that needed facilities are not forced to close; it must insure that base year budgets are "reasonable," and it must insure that utilization levels represent care which is needed. This is a complex and difficult task and cannot be accomplished by the imposition of a simple formula, as proposed by the administration. More importantly, an effective budget review system must be linked to the planning programs

under Public Law 93-641, and utilization review and quality assurance programs, under Public Law 92-603, which are based at the State and local level. It is difficult to see how these activities could be effectively linked to the cost containment program if it were based in Washington.

My proposal will link these efforts by providing:

Planning (HSA) and utilization review (PSRO) representation on the State Policy Review Board.

Budget Commission support of planning activities through joint financial feasibility studies and support of decertification decisions.

Cooperative quality assurance mechanisms.

In addition, Mr. Chairman, I realize that a transitional program, in some form, may prove appropriate, if we commit ourselves to move aggressively towards development of a long term program, two points must be kept in mind; first, we must insure that the program is indeed transitional, and second, we must insure that the program is as equitable as it can be.

The President has proposed one such transitional program, and much discussion has ensued as a result of that proposal. I submit that the following changes are those which are minimally necessary to insure that a transitional cost containment program will not harm needed components of our health care system. I commend them to you for your consideration:

No hospital's actual revenue increase should be less than the GNP deflator.

Insolvency alone should be a basis for exception.

No hospital in an underserved area should suffer reductions in per admission revenue for volumes higher than the base year.

Needed capital expenditures for National Health Resource Centers—tertiary care institutions serving several States, such as the Mayo Clinic—should not be subject to an individual State's allocation under a capital expenditure program.

Finally, Mr. Chairman, I would like to say that I look forward to working with my colleagues and other concerned citizens in developing this proposal further. I would hope that today's hearing will encourage a thorough exploration of the issues and concepts I have only touched upon. Thank you, Mr. Chairman.

Mr. ROGERS. Thank you, Dr. Carter.

Without objection the text of H.R. 8121 and H.R. 6575, and an agency report on H.R. 6575 from the Office of Management and Budget will be printed at this point in the record.

[Testimony resumes on p. 103.]

[The text of the bills and the agency report referred to follow:]

95TH CONGRESS
1ST SESSION

H. R. 8121

IN THE HOUSE OF REPRESENTATIVES

JUNE 30, 1977

Mr. ROGERS introduced the following bill; which was referred jointly to the Committees on Interstate and Foreign Commerce and Ways and Means

A BILL

To establish a transitional system of hospital cost containment by providing for incentives and restraints to contain the rate of increase in hospital revenues, to establish a system of capital allocation designed to encourage communities to avoid the creation of unneeded and duplicative hospital facilities and services, to provide for the publication and disclosure of information useful to the public in making decisions about health care, to provide for the development of permanent reforms in hospital reimbursement designed to provide incentives for the efficient and effective use of hospital resources, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE

SECTION 1. This Act may be cited as the "Hospital Cost Containment Act of 1977".

REPORT ON PERMANENT REFORM IN THE DELIVERY AND FINANCING OF HEALTH CARE

SEC. 2. The Secretary of Health, Education, and Welfare (hereinafter in this Act referred to as the "Secretary") shall submit to the Congress, no later than March 1, 1978, a report setting forth his recommendations for permanent reforms in the delivery and financing of health care which will increase the efficiency, effectiveness, and quality of health care in the United States and which will replace the transitional provisions of title I of this Act.

TITLE I—TRANSITIONAL HOSPITAL COST CONSTRAINT PROVISIONS

PART A—PURPOSE AND GENERAL DESCRIPTION OF THE PROGRAM

PURPOSE

SEC. 101. It is the purpose of the transitional hospital cost containment program established by this title to constrain the rate of increases in total acute care hospital inpatient costs, beginning October 1, 1977, and continuing until the adoption of the permanent reforms referred to in

section 2, by limiting the amount of revenue which may be received, by the hospitals involved, from Government programs, private insurers, and individuals who pay directly for such care.

GENERAL DESCRIPTION OF PROGRAM

SEC. 102. (a) In order to carry out the purpose of the transitional program as set forth in section 101, the inpatient revenues of short-term acute care and specialty hospitals (excluding new hospitals and certain HMO-related hospitals) are to be limited in the manner outlined in the succeeding provisions of this section (and more particularly described in parts B and C of this title).

(b) The increase in total revenue which a hospital (as defined in section 121) may receive in any accounting year in the form of—

(1) reimbursement paid under the medicare and medicaid programs, and by cost payers, for inpatient services, and

(2) charges imposed upon other persons for inpatient services,

may not, on a per admission basis, exceed the average inpatient reimbursement due or inpatient charges imposed per inpatient admission in the base period (in general, the hos-

pital's accounting year ending in 1976) by more than the percentage which is applicable to the hospital for such accounting year under section 111.

(c) Such percentage, in the case of any hospital for any accounting year, is to be determined by—

(1) establishing for such year, under section 112 (b), an "inpatient hospital revenue increase limit" based on increases in the gross national product deflator and in total hospital expenditures nationwide,

(2) modifying the limit so established by the "admission load formula", as promulgated under section 113, to take account of major changes in patient loads experienced by that particular hospital, in order to arrive at an "adjusted inpatient hospital revenue increase limit" for that hospital in such year, and

(3) applying such adjusted limit for periods after September 30, 1977, with recognition being given under section 111 (a) (1) to cost increases prior to that date.

(d) An exception from the limits otherwise established may be granted in accordance with section 115 (for a particular period) to any hospital which is experiencing substantially higher costs as a result of extraordinary changes in patient loads or major changes in facilities and services, to the extent required to assure that the necessary additional

revenue will be available where necessary to meet actual community needs.

(e) Compliance with these limits is to be enforced, in accordance with section 116, in various ways. Such compliance is required under the medicare program by directly applying the limits for purposes of both interim and final reimbursement. Amounts paid to hospitals under the medicaid program in excess of such limits will be disallowed as a basis for Federal matching payments. Hospitals and nongovernment cost payers exceeding the limits will be subject to a Federal excise tax in an amount equal to 150 per centum of the excess (except in the case of a hospital which is exempt as a result of corrective actions as prescribed under section 116 (d) (2)).

(f) The Secretary is authorized, under section 117, to waive the limits otherwise established for all hospitals located in any State which has had in effect for at least one year a hospital cost containment program which covers at least 90 per centum of all acute care hospitals in the State, applies to all payers except the medicare program, limits inpatient hospital revenue increases to a rate no greater (in the aggregate) than the rate established for the period involved under section 112 (b), and provides for return of excess hospital revenues.

PART B—ESTABLISHMENT OF HOSPITAL COST CONTAINMENT PROGRAM

IMPOSITION OF LIMIT ON HOSPITAL REVENUE INCREASES

SEC. 111. (a) The average reimbursement paid to a hospital for inpatient services under title XVIII of the Social Security Act, under a State plan approved under title V or title XIX of such Act, or by any cost payer, and the average charges imposed by a hospital for inpatient services, in any accounting year any part of which falls within a period subject to this title, may not (except as provided in subsection (b)) exceed the base inpatient hospital revenue per inpatient admission (as established under section 114) by a percentage greater than the sum of—

(1) the percentage by which the costs involved would have increased in the period elapsing after the close of the hospital's base accounting year and prior to October 1, 1977, if such costs had increased (during that period) at the average annual rate actually experienced by the hospital during the two-year period ending with the close of such base accounting year, except that such percentage as applied for purposes of this section shall not be more than 15 per centum nor less than 6 per centum,

(2) the percentage by which such costs would have increased in the period elapsing after September 30, 1977, and prior to the first day of the account-

ing year for which the limit is being imposed if such costs had increased (during such period) at an annual rate consistent with the inpatient hospital revenue increase limit determined and promulgated under section 112(b), and

(3) the percentage by which such costs would have increased in the accounting year for which the limit is being imposed if such costs had increased (during such year) at an annual rate consistent with the adjusted inpatient hospital revenue increase limit applicable to the hospital under section 112(a).

(b) Where less than a full accounting year falls within a twelve-month period subject to this title, the limit set forth in subsection (a) of this section, and the limit established under section 112(a), shall apply with respect to reimbursement due or charges imposed for the part of such accounting year which falls within such period in the same proportion as the number of days in such accounting year that fall within such period bears to the total number of days in such accounting year.

DETERMINATION OF ADJUSTED INPATIENT HOSPITAL REVENUE INCREASE LIMIT

SEC. 112. (a) The "adjusted inpatient hospital revenue increase limit" which is applicable to any hospital for purposes of section 111(a)(3) with respect to any

accounting year shall (subject to section 111(b) and section 124) be equal to the inpatient hospital revenue increase limit determined and promulgated under subsection (b) of this section for the twelve-month period in which such accounting year or any part thereof falls, modified by the application of the "admission load formula" which is promulgated under section 113 and applied to that hospital.

(b) (1) Between July 1 and October 1 of each calendar year beginning with 1977, the Secretary shall promulgate a figure which (subject to paragraph (2)) shall be the "inpatient hospital revenue increase limit" applicable to the twelve-month period beginning October 1 in such year (with each such twelve-month period being referred to in this title as a "period" or a "period subject to this title"). Such figure shall be the sum of—

(A) the implicit price deflator of the gross national product as calculated by the Bureau of Economic Analysis of the Department of Commerce and published in the Survey of Current Business (hereinafter in this title referred to as the "GNP deflator") for the 12-month period ending June 30 of such year, and

(B) one-third of the difference between—

(i) the average annual rate of increase in total

hospital expenditures which is found by the Secretary to have occurred during the twenty-four-month period ending on the day preceding January 1 of such calendar year, and

(ii) the annual rate of increase in the GNP deflator for the twenty-four-month period ending on the day preceding January 1 of such calendar year.

(2) If the Secretary finds during any period subject to this title that the GNP deflator with respect to such period is expected to exceed by more than 1 percentage point the GNP deflator which was used in making the determination under paragraph (1) (or in making a prior adjustment under this paragraph), the Secretary shall increase (or further increase) the GNP deflator so used by the amount of such excess; except that no adjustment made under this paragraph shall be effective with respect to any accounting year ending prior to the calendar quarter preceding the calendar quarter in which such adjustment is made.

PROMULGATION OF ADMISSION LOAD FORMULA

SEC. 113. The admission load formula shall be promulgated by the Secretary by October 1, 1977, and shall be such that—

(1) a hospital will be allowed an increase in total revenue from inpatient services in any accounting year

to the extent (and only to the extent) consistent with the inpatient hospital revenue increase limit promulgated under section 112(b), for the period in which such accounting year or any part thereof falls if admissions in such accounting year have increased by less than 2 per centum or declined by less than 6 per centum as compared to the base accounting year (2 per centum and 10 per centum, respectively, in the case of a hospital with no more than four thousand admissions in the base accounting year);

(2) in the case of a hospital whose admissions in any accounting year are beyond the applicable range set forth in paragraph (1), the amount of total revenue from inpatient services in such year which is otherwise allowed under paragraph (1) shall be further increased for each admission above such range by one-half of the average revenue per admission that would have been allowed under paragraph (1) if the actual percentage change in admissons (as compared to the base accounting year) had been zero, or shall be reduced for each admission below such range by one-half of the average revenue per admission that would have been so allowed, except as provided in paragraph (3); and

(3) in the case of a hospital which had more than four thousand admissions in the base accounting year,

95-756 O - 77 - 2

no additional revenue will be allowed for increased admissions (with respect to any accounting year) beyond 15 per centum above those in the base accounting year, but the revenue otherwise permitted such a hospital under paragraphs (1) and (2) shall be reduced (dollar for dollar) for decreased admissions (in that year) beyond 15 per centum below those in the base accounting year.

BASE INPATIENT HOSPITAL REVENUE

SEC. 114. (a) (1) The revenue base for application of the adjusted inpatient hospital revenue increase limit with respect to any hospital in any accounting year shall (subject to subsection (b)) be the revenue from reimbursement due and inpatient charges imposed for inpatient hospital services provided in the hospital's base accounting year (as defined in paragraph (2)).

(2) For purposes of this title, a hospital's "base accounting year" is its accounting year which ended in 1976, or, in the case of a hospital which did not meet the definition contained in section 121 for at least one full accounting year prior to an accounting year ending in 1976 in which it met such definition, the accounting period immediately prior to the first accounting year in which it satisfied such definition.

(b) The base revenue established for any hospital by

subsection (a) shall (except as provided in subsection (c)) be reduced by an amount equal to any inpatient charges in such base accounting year for elements of inpatient services for which payment is not made to the hospital in an accounting year any part of which falls within a period subject to this title.

ESTABLISHMENT OF EXCEPTIONS

SEC. 115. (a) The Secretary shall have authority to grant exceptions from the limits established under this title to individual hospitals for particular periods, but in any case only to the extent that the hospital requesting the exception provides evidence satisfactory to the Secretary—

(1) of the extent to which costs of providing inpatient hospital services in an accounting year any part of which falls within a period subject to this title exceed such costs in the base accounting year as the result of—

(A) changes in admissions beyond the range specified in section 113 (3), or

(B) changes in capacity or in the character of inpatient services available in the hospital or major renovation or replacement of physical plant, but only if such changes have increased inpatient costs per admission by more than one-third of the difference specified in section 112 (b) (1) (B)

over inpatient care costs per admission in the previous accounting year;

(2) that the revenue otherwise allowable (taking into account all other available resources) is insufficient to assure the solvency of the hospital as indicated by the existence of a current ratio of assets to liabilities (determined in accordance with the last sentence of this subsection) of less than the ratio which the Secretary estimates is being experienced by 25 per centum or less of the hospitals subject to this title; and

(3) that the changes in admissions, capacity, plant, or services available generating the excess costs described in paragraph (1) have been found to be needed under section 1523(a)(5) of the Public Health Service Act or appropriate under section 1523(a)(6) of the Public Health Service Act by the State health planning and development agency, designated under section 1521 of such Act for the State in which the hospital involved is located.

For purposes of paragraph (2), the term "current ratio of assets to liabilities", with respect to any hospital, means the sum of the cash, notes, and accounts receivable (less reserves for bad debts), marketable securities, and inventories held by such hospital divided by the sum of all lia-

bilities of such hospital falling due in an accounting year for which the exception is requested under this section.

(b) The Secretary shall either approve any request for an exception made by a hospital under subsection (a), or deny such request, within a period not to exceed ninety days after the hospital has filed in a manner and form prescribed by the Secretary the evidence required by such subsection. Any such request not denied within such ninety-day period shall be deemed approved.

(c) Any hospital granted an exception under this section must make itself available for an operational review by the Secretary. The findings from any such review shall be made public, and continuance of the exception shall be contingent on implementation of any recommendations which may be made (as a result of such operational review) for improvements to increase efficiency and economy.

(d) (1) If the Secretary grants an exception with respect to any accounting year to a hospital which had 4,000 or more admissions in the base accounting year on the grounds set forth in subsection (a) (1) (A), such hospital shall be allowed increased revenue for purposes of this title as though it were a hospital with fewer than four thousand admissions in such base year under section 113.

(2) If the Secretary grants an exception with respect to any accounting year to a hospital on the grounds set

forth in subsection (a) (1) (B), such hospital shall be allowed increased total revenue for purposes of this title for such accounting year and all subsequent accounting years (and the limit on its allowable rate of increase in inpatient hospital revenues shall be adjusted upward accordingly) in an amount no greater than the amount necessary to maintain the current ratio of its assets to liabilities (determined in accordance with the last sentence of subsection (a)) at the level specified in subsection (a) (2).

(e) (1) Any hospital which is dissatisfied with a determination of the Secretary under this section may obtain a hearing before the Provider Reimbursement Review Board established under section 1878 of the Social Security Act, if the amount in controversy is $25,000 or more and the request for such hearing is filed within one hundred and eighty days after receipt of the Secretary's determination.

(2) For purposes of paragraph (1), the Secretary (notwithstanding section 1878(h) of the Social Security Act) shall appoint five additional members to the Provider Reimbursement Review Board, following the specifications for expertise applicable to the existing five members. Such five additional members shall constitute the Board for purposes of reviewing appeals under this title. All the other provisions of section 1878 of the Social Security Act shall apply except that the Board as so constituted shall be con-

sidered as reviewing decisions of the Secretary rather than of a fiscal intermediary, and subsection (b) of such section shall not apply.

ENFORCEMENT

SEC. 116. (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 limits established under this title.

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

(c) Notwithstanding any other provision of law, receipt by any hospital of payment for inpatient hospital services in excess of the applicable limits established under this title, or payment by any cost payer (as defined in section 122(c)(2)) for inpatient hospital services on a cost basis in excess of such limits, shall subject such hospital or cost payer—

(1) to the Federal excise tax imposed by section 4991 of the Internal Revenue Code of 1954 (as added by section 128 of this Act), and

(2) to exclusion, at the discretion of the Secretary, from participation in any or all of the programs established by titles V, XVIII, and XIX of the Social Security Act.

(d) (1) Where the Secretary determines that average charges per admission billed for inpatient services by a hospital during an accounting year any part of which is included in a period subject to this title exceed the applicable limits established under this title, he shall promulgate (or shall require the hospital to promulgate in such manner as he may prescribe) the percentage by which the average charge per admission billed in that accounting year by the hospital exceeded the applicable limitation on average charges per admission established under this title.

(2) Any hospital described in paragraph (1) shall be exempt from the penalties set forth in subsection (c) if it holds in escrow an amount equal to the percentage promulgated under such paragraph multiplied by the hospital's total inpatient charges less its inpatient charges applicable to cost payers (as defined in section 122 (e)), imposed on the accounting year referred to in such paragraph, until such time as charges below the applicable limits established

under this title, equal in the aggregate to such amount, are experienced; but any such hospital which fails to do so shall be subject to such penalties.

EXEMPTIONS FOR HOSPITALS IN CERTAIN STATES

SEC. 117. (a) At the request of the Governor (or other chief executive) of any State (including the District of Columbia and Puerto Rico) the Secretary may exclude from the application of this title all hospitals physically located in such State if the Secretary finds that—

(1) such State has had in effect for a least one year as of the date of such request a program for containing hospital costs in the State which covers at least 90 per centum of the hospitals in the State which would otherwise be covered under the program established by this title;

(2) the State program applies at least to all inpatient care revenues of such hospitals (except revenues received under title XVIII of the Social Security Act);

(3) the Governor (or chief executive) certifies, and the Secretary determines, that the aggregate rate of increase in inpatient hospital revenues for all hospitals in the State will not exceed the rate promulgated by the Secretary under section 112(b); and

(4) the Governor (or chief executive) has sub-

mitted, and had approved by the Secretary, a plan for recovering any excess of revenue which (notwithstanding paragraph (3)) may occur.

(b) A State which would meet the conditions of this section except that its program does not satisfy subsection (a) (2), but whose program did cover at least 50 per centum of all inpatient care revenues during the twelve-month period preceding the date of its request under subsection (a), will nonetheless be eligible under this section if, by the date of such request, it does have a program which satisfies such subsection.

EXEMPTION FOR HOSPITALS ENGAGED IN CERTAIN EXPERIMENTS OR DEMONSTRATIONS

SEC. 118. A hospital may be excluded from the application of this title if the Secretary determines that (1) such exclusion is necessary to facilitate an experiment or demonstration entered into under section 402 of the Social Security Amendments of 1967 or section 222 of the Social Security Amendments of 1972, and (2) such experiment or demonstration is consistent with the purposes of this title.

PART C—DEFINITIONS AND MISCELLANEOUS PROVISIONS

DEFINITION OF HOSPITAL

SEC. 121. (a) For purposes of this title (subject to subsection (b) of this section), the term "hospital", with respect to any accounting year, means an institution (includ-

ing a distinct part of an institution participating in the program established under title XVIII of the Social Security Act) which—

(1) satisfies paragraphs (1) and (7) of section 1861 (e) of the Social Security Act, and

(2) had an average duration of stay of thirty days or less in the preceding accounting year.

(b) An institution shall not be considered a "hospital" during any part of a period subject to this title if with respect to such period it—

(1) is a Federal hospital;

(2) has met the conditions specified in subsection (a) (under present and previous ownership) for less than two years before such period; or

(3) derived more than 75 per centum of its inpatient care revenues on a capitation basis, disregarding revenues received under title XVIII of the Social Security Act, from one or more health maintenance organizations (as defined in section 1301 (a) of the Public Health Service Act).

OTHER DEFINITIONS

SEC. 122. For purposes of this title—

Accounting Year

(a) The term "accounting year" with respect to any period means—

(1) in the case of a hospital participating in the program established by title XVIII of the Social Security Act, a period of twelve consecutive full calendar months including the same months as the last full reporting period allowed for reimbursement purposes under such title;

(2) in the case of a hospital not participating in the program established by title XVIII of the Social Security Act, a period of twelve consecutive full calendar months including the same months as the last full accounting period used by such other cost payer as the Secretary may designate; and

(3) in the case of a hospital which is not participating in the program established by title XVIII of the Social Security Act and for which the Secretary does not designate an accounting year under paragraph (2), a calendar year.

Inpatient Hospital Services

(b) The term "inpatient hospital services" has the meaning given it by section 1861 (b) of the Social Security Act (including in addition the services otherwise excluded by paragraph (5) thereof).

Inpatient Charges

(c) The term "inpatient charges" means regular rates, applied to all inpatient hospital services, that meet the

requirements of section 405.452(d)(4) of the Federal regulations applicable to title XVIII of the Social Security Act.

Admissions

(d) The term "admission" means the formal acceptance of an inpatient by a hospital, excluding newborn children (unless retained after discharge of the mother) and transfers within inpatient units of the same institution.

Cost Payer

(e) The term "cost payer" means—

(1) a program established by or under title V, XVIII, or XIX of the Social Security Act, and

(2) any organization which (A) meets the definition contained in section 1842(f)(1) of the Social Security Act, and (B) reimburses a hospital subject to this title for inpatient hospital services on the basis of cost as defined for purposes of such reimbursement.

DETERMINATION OF INPATIENT REIMBURSEMENT

SEC. 123. For purposes of section 111, inpatient reimbursement under the programs established by titles V, XVIII, and XIX of the Social Security Act shall be determined without regard to adjustments resulting from the application of section 405.460(g), 405.455(d), 405.415(f), or 405.415(d)(3) of the Federal regulations applicable to such title XVIII.

EXEMPTION OF NONSUPERVISORY PERSONNEL WAGE INCREASE FROM REVENUE LIMIT

SEC. 124. (a) At the request of any hospital which is subject to the provisions of this title and which provides the data necessary for the required calculation, the Secretary shall modify the inpatient hospital revenue increase limit and the adjusted inpatient hospital revenue increase limit otherwise established for such hospital with respect to any accounting year under section 112 to allow such hospital to receive, without restriction, revenue equal to the average amount of any increase in regular wages granted in such year to employees who do not meet the definition of "supervisor" as that term is used for purposes of the National Labor Relations Act and (if not employees of a State or political subdivision thereof) who are covered by such Act.

(b) Such modified limits for any accounting year shall be calculated by adding together—

(1) the average percentage increase in regular wages granted to the employees referred to in subsection (a) since the close of the preceding accounting year multiplied by the percentage of total inpatient cost (as determined for purposes of title XVIII of the Social Security Act) attributable to such wages in such preceding year; and

(2) the inpatient hospital revenue increase limit or, as appropriate, the adjusted inpatient hospital revenue increase limit otherwise applicable to the hospital under this title multiplied by the percentage of revenues (as determined for purposes of title XVIII of the Social Security Act) attributable to all other expenses in the preceding accounting year.

(c) The modified inpatient hospital revenue increase limit and adjusted inpatient hospital revenue increase limit established under subsection (b) for any hospital with respect to any accounting year shall constitute such hospital's inpatient hospital revenue increase limit or, as appropriate, the adjusted inpatient hospital revenue increase limit for such year under section 111 for all of the purposes of this title.

(d) This section shall apply to accounting years beginning after March 31, 1979, only to the extent the Secretary so determines.

DISCLOSURE OF FISCAL INFORMATION

SEC. 125. (a) (1) Every hospital shall (A) submit semiannually to the health systems agency designated under section 1515 of the Public Health Service Act for the health service area in which it is located, by March 1 and September 1 of each year, its average semiprivate room rate and the charges for the 10 other services which the health sys-

tems agency finds represent the services which are most frequently used or most important for purposes of comparing hospitals, and make available all cost reports submitted to cost payers, and (B) submit annually its overall plan and budget described in section 1864(z) of the Social Security Act.

(2) Failure by any hospital to comply with the requirement of paragraph (1) shall subject it to exclusion, at the discretion of the Secretary, from participation in any or all of the programs established by titles V, XVIII, and XIX of the Social Security Act.

(b) Each health systems agency designated under section 1515 of the Public Health Service Act shall publish every April 1 and October 1, in readily understandable language for public use, the information it receives under this section, in a manner designed to facilitate comparisons among the hospitals in its area.

IMPROPER CHANGES IN ADMISSION PRACTICES

SEC. 126. Upon written complaint by any institution meeting the conditions set forth in paragraphs (1) and (7) of section 1861(e) of the Social Security Act that one or more hospitals subject to this title in a health service area for which a health systems agency has been designated under

section 1515 of the Public Health Service Act has changed its admission practices in a manner that would tend to reduce the proportion of inpatients of such hospital or hospitals for whom reimbursement at less than the inpatient charges (as defined in section 122(c) of this Act) applicable to such inpatients is anticipated, such health systems agency shall investigate the complaint and, upon a finding by such agency that the complaint is justified, the Secretary may impose the sanction set forth in section 116(c)(2) of this Act.

REVIEW OF CERTAIN DETERMINATIONS

SEC. 127. Any determinations made on behalf of the Secretary under this title with respect to the application of its provisions to individual hospitals (other than determinations made under section 115 or 126) shall be subject to the provisions of section 1878 of the Social Security Act in the same manner as determinations with respect to the amount of reimbursement due a provider of services under title XVIII of such Act.

EXCISE TAX ON EXCESSIVE PAYMENTS FOR INPATIENT HOSPITAL SERVICES

SEC. 128. (a) Subtitle D of the Internal Revenue Code of 1954 (relating to miscellaneous excise taxes) is amended by adding at the end thereof the following new chapter:

95-756 O - 77 - 3

"CHAPTER 45—TAX ON CERTAIN EXCESSIVE PAYMENTS FOR INPATIENT HOSPITAL SERVICES

"SEC. 4991. IMPOSITION OF TAX.

"(a) IN GENERAL.—There is hereby imposed, with respect to the receipt by any hospital of payment for inpatient hospital services in excess of the applicable limits established by title I of the Hospital Cost Containment Act of 1977, and with respect to any payment made by any cost payer as defined in section 122(e)(2) of such Act for inpatient hospital services on a cost basis in excess of such limits, a tax equal to 150 percent of the amount of such excess. The tax imposed by this subsection shall be paid by the hospital or cost payer.

"(b) EXCEPTION.—The tax imposed by subsection (a) shall not apply with respect to any hospital so long as it is determined by the Secretary of Health, Education, and Welfare to be taking the corrective action described in section 116(d)(2) of the Hospital Cost Containment Act of 1977.

"(c) DEFINITIONS.—Terms used in subsections (a) and (b) have the meanings given them by title I of the Hospital Cost Containment Act of 1977.

"(d) ADMINISTRATION.—Under and to the extent provided by regulations of the Secretary, the appropriate provisions of subtitle F (relating to procedure and administration) shall be made applicable with respect to the tax imposed by subsection (a) of this section.".

(b) The table of chapters for subtitle D of such Code is amended by adding at the end thereof the following new item:

"CHAPTER 45. Tax on certain excessive payments for inpatient hospital services.".

PART D—INCENTIVES FOR GOOD PERFORMANCE BY HOSPITALS IN CONTAINING COST INCREASES

ELIGIBILITY FOR INCENTIVE PAYMENT

SEC. 131. (a) If a hospital's cost per inpatient admission, incurred with respect to inpatient hospital services provided in any accounting year falling wholly or partly within a period subject to this title, exceeds the hospital's corresponding cost per inpatient admission in the preceding accounting year by a percentage which is less than the inpatient hospital revenue increase limit promulgated for such period under section 112(b) (as modified with respect to such hospital under section 124), the hospital shall upon application be entitled to a lump-sum incentive payment for such year in an amount determined under section 132.

(b) The incentive payment to which any hospital is en-

titled under subsection (a) for any accounting year shall be made by the Secretary at or after the close of such year on the basis of the best information and data which is then available to him, with appropriate adjustments to reflect any amounts by which previous incentive payments under such subsection were greater or less than they should have been.

(c) Any application made by a hospital for an incentive payment under subsection (a) shall include or be accompanied by such documentation as the Secretary may require with respect to inpatient costs for purposes of determining the amount of the excess referred to in subsection (a) of this section and with respect to outpatient costs for purposes of determining the hospital's outpatient deficit (if any) under subsections (a) (2) and (b) of section 132.

AMOUNT OF INCENTIVE PAYMENT

SEC. 132. (a) The amount of the incentive payment to which a hospital may be entitled under section 131 for any accounting year shall be—

(1) one-third of the difference between—

(A) the product of (i) the cost per inpatient admission which was incurred by the hospital in such accounting year, and (ii) the total number of such admissions, and

(B) the product of (i) the cost per inpatient

admission which would have been incurred by the hospital in such year if such cost had exceeded the corresponding cost incurred in the preceding accounting year by a percentage equal to the inpatient hospital revenue increase limit promulgated for the period involved under section 112(b) (as modified under section 124), and (ii) the total number of such admissions, or

(2) the amount of the hospital's outpatient deficit for such accounting year as determined under subsection (b),

whichever is less.

(b) For purposes of subsection (a)(2), a hospital's outpatient deficit for any accounting year is the amount by which its allowable costs attributable to the provision of outpatient hospital services in such year (not including emergency room services) exceed its revenues attributable to such services, as determined in accordance with standards and procedures prescribed by the Secretary.

AUTHORIZATION OF APPROPRIATIONS

SEC. 133. There are authorized to be appropriated, for each fiscal year beginning on or after October 1, 1977, such sums as may be necessary to enable the Secretary to make the incentive payments provided for in this part.

TITLE II—LIMITATION ON CAPITAL EXPENDITURES

SEC. 201. (a) Part A of title XV of the Public Health Service Act is amended by adding at the end thereof the following new section:

"LIMITATION ON HOSPITAL CAPITAL EXPENDITURES, CEILING FOR THE SUPPLY OF HOSPITAL BEDS, AND STANDARD FOR OCCUPANCY OF HOSPITAL BEDS

"SEC. 1504. (a) (1) Before the beginning of the fiscal year beginning October 1, 1977, and at least 60 days before the beginning of each succeeding fiscal year, the Secretary shall promulgate a sum as a hospital capital expenditure limit applicable to such fiscal year. The sum promulgated as a limit under the preceding sentence for any period shall be an amount which may not exceed $2,500,000,000.

"(2) The Secretary shall apportion the sum promulgated under paragraph (1) for any fiscal year among the various States on the basis of the population of the various States; except that for any fiscal year beginning more than 18 months after the date of enactment of this section the Secretary shall apportion the sum promulgated under paragraph (1) for such fiscal year among the various States, taking into account the population of the various States; and

also taking into account, to the extent feasible, variations among the States in the costs of construction, population patterns and growth, the need for hospital facilities and equipment and for modernization of existing hospital facilities and equipment, and other factors important to the equitable apportionment of such sum.

"(b) (1) At the time the Secretary promulgates under subsection (a) a hospital capital expenditure limit the Secretary shall also promulgate for the fiscal year to which such limit is applicable—

"(A) a national ceiling for the supply of hospital beds within health service areas established under section 1511 (hereinafter in this title referred to as the 'supply ceiling'), and

"(B) a national standard for the rate of occupancy of hospital beds within such areas (hereinafter in this title referred to as the 'occupancy standard').

"(2) The supply ceiling promulgated for any fiscal year under paragraph (1) (A) may not exceed the ratio of four hospital beds per one thousand of population; but the Secretary may promulgate under such paragraph a different supply ceiling for health service areas which have special characteristics or which meet special requirements established by the Secretary.

"(3) The occupancy standard promulgated under paragraph (1) (B) for any fiscal year may not be less than 80 percent; but the Secretary may establish a different occupancy standard for health service areas which have special characteristics or which meet special requirements established by the Secretary.".

(b) (1) Part C of title XV of the Public Health Service Act is amended by adding at the end thereof the following new section:

"CERTIFICATE OF NEED PROGRAM

"SEC. 1527. (a) The certificate of need program required by section 1523 (a) (4) (B) shall provide for the following:

"(1) Review and determination of need under such program of major medical equipment, institutional health services, health care facilities, and health maintenance organizations shall be made before the time such equipment is acquired or such services, facilities, and organizations are offered or developed or substantial expenditures are undertaken in preparation for such offering or development.

"(2) The program shall be administered in such a manner that only equipment, services, facilities, and organizations found to be needed shall be acquired,

offered, or developed in the State in which the program applies.

"(3) In issuing a certificate of need for any such equipment, service, facility, or organization, the State shall specify in the certificate the maximum amount of capital expenditures which may be made for such equipment, service, facility, or organization under such certificate.

"(4) The aggregate of the maximum amounts of capital expenditures authorized in a fiscal year in accordance with paragraph (3) for hospitals may not exceed the portion of the sum promulgated under section 1504(a)(1) and apportioned to the State under section 1504(a)(2) for such fiscal year, as adjusted in accordance with this paragraph. For any fiscal year the sum apportioned to a State under section 1504(a)(2) shall (A) if the aggregate of the maximum amounts of capital expenditures authorized by the State in the preceding fiscal year in accordance with paragraph (3) for hospitals was less than the portion of such sum so apportioned to the State for such fiscal year, the difference between such authorized maximum amounts and the sum so apportioned shall be added to the sum so apportioned to the State for the fiscal year following such fiscal year, and (B) if in the fiscal year there was a closure of a

hospital (or part thereof) through which institutional health services found under section 1523 (a) (6) to be inappropriate were provided, then the amount by which the historical cost (as defined for purposes of title XVIII of the Social Security Act) of such hospital or part exceeds the total amount of depreciation of such hospital or part claimed for purposes of establishing the reasonable costs of services provided by the hospital for purposes of receiving reimbursement under title XVIII of the Social Security Act shall be added to the portion of such sum so apportioned to the State for such fiscal year.

"(b) (1) Under such a certificate of need program a certificate of need may not, except as provided in paragraph (2), be granted for an institutional health service or health care facility within a health service area established under section 1511 if the development of such service or facility under such certificate would result in a number of hospital beds within such area which is in excess of the applicable supply ceiling promulgated under section 1504 (b) (1) (A).

"(2) If in a health service area the number of hospital beds is in excess of the supply ceiling applicable to a fiscal year, then a certificate of need may be granted for such a service or facility the development of which would result in a number of new hospital beds which is not more than one-half of the number of hospital beds removed permanently

from service in such area in such fiscal year. The amount by which the number of new hospital beds with respect to which certificates of need may be issued in a fiscal year under the preceding sentence is less than the number of new hospital beds with respect to which certificates of need were issued in such fiscal year may be added to the number of new hospital beds with respect to which certificates of need may be issued in the succeeding fiscal year.

"(c) (1) Under such a certificate of need program a certificate of need may not, except as provided in paragraph (2), be granted for an institutional health service or health care facility within a health service area if the development of such service or facility could reasonably be expected to produce a number of hospital beds which would result in a hospital bed occupancy rate within such area which is less than the applicable occupancy standard promulgated under section 1504(b) (1) (B).

"(2) If in any fiscal year the hospital bed occupancy rate within a health service area is less than the occupancy standard applicable for such fiscal year, then a certificate of need may be granted for a service or facility the development of which would result in a number of new hospital beds which is not more than one-half of the number of hospital beds removed permanently from service in such area in such fiscal year. The amount by which the number of

new hospital beds with respect to which certificates of need may be issued in a fiscal year under the preceding sentence is less than the number of new hospital beds with respect to which certificates of need were issued in such fiscal year may be added to the number of new hospital beds with respect to which certificates of need may be issued in the succeeding fiscal year.

"(d) In granting certificates of need under such a program a State shall take into account priorities recommended by health systems agencies within the State under section 1513(h).".

(2) Section 1523(a)(4)(B) of the Public Health Service Act is amended by inserting after "within the State" the following: "and to capital expenditures for major medical equipment to be used in the State".

(3) The second sentence of section 1523(a) of such Act is repealed.

(c) Section 1531 of the Public Health Service Act is amended (1) by striking out "For purposes of this title" and inserting in lieu thereof "Except as otherwise provided for purposes of this title", and (2) by adding after paragraph (5) the following new paragraphs:

"(6) For purposes of sections 1504 and 1527, the term 'hospital', with respect to any accounting year, means an institution (including a distinct part of an institution

participating in the program established under title XVIII of the Social Security Act) which—

"(A) satisfies paragraphs (1) and (7) of section 1861(e) of the Social Security Act, and

"(B) has an average duration of stay of 30 days or less in the preceding accounting year,

except that for any fiscal year such term does not include a Federal hospital or an institution which during such fiscal year derived more than 75 per centum of its inpatient care revenues on a capitation basis, disregarding revenues received under title XVIII of the Social Security Act, from one or more health maintenance organizations (as defined in section 1301(a)).

"(7) For the purposes of sections 1504 and 1527, the term 'capital expenditure' means an expenditure (A) which is made for major medical equipment for the provision of medical and other health services and which exceeds $150,000, or (B) which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance and which (i) exceeds $150,000, (ii) changes the bed capacity of the facility with respect to which such expenditure is made, or (iii) substantially changes the services of the facility with respect to which such expenditure is made, except that such term includes expenditures for obtaining a facility or part thereof,

or equipment for a facility or part, under a lease or comparable arrangement but does not include the acquisition of an existing hospital facility if such acquisition does not make a change in the services or bed capacity of such hospital facility. For purposes of clause (B) (i) of the preceding sentence, the cost of the studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of the plant and equipment with respect to which such expenditure is made shall be included in determining whether such expenditure exceeds $150,000. If a person makes an acquisition of major medical equipment for a hospital and donates it to the hospital, the expenditure for such acquisition shall be considered a hospital capital expenditure for purposes of sections 1504 and 1527.

"(8) For purposes of sections 1523 and 1527, the term 'major medical equipment' means medical equipment for the provision of medical and other health services and which costs in excess of $150,000.".

(d) Section 1532 (b) (2) of the Public Health Service Act is amended (1) by striking out "ninety days" and inserting in lieu thereof "one year", and (2) by adding before the period "or longer than such shorter period from such date as the Secretary may prescribe".

SEC. 202. (a) Section 1122 of the Social Security Act is amended to read as follows:

"LIMITATION ON FEDERAL PARTICIPATION FOR CAPITAL EXPENDITURES

"SEC. 1122. (a) (1) For the purposes of assuring that Federal funds appropriated under titles V, XVIII, and XIX are not used to support unnecessary capital expenditures for health care facilities and major medical equipment, the Secretary shall enter into agreements with the Governors of the States under which State health planning and development agencies designated under section 1521 of the Public Health Service Act shall review proposed capital expenditures for facilities and equipment within their jurisdiction to determine if they are needed and if such expenditures are consistent with criteria adopted by such agency. In making such reviews such agencies shall—

"(A) provide health systems agencies designated under section 1515 of such Act with opportunity to submit recommendations,

"(B) follow procedures prescribed by section 1532 (b) of such Act, and

"(C) base such reviews on the criteria developed pursuant to section 1532 (c) of such Act.

"(2) The Secretary shall pay a State from the Federal Hospital Insurance Trust Fund, in advance or by way of

reimbursement as may be provided in the agreement entered into under paragraphs (1) (and may make adjustments in such payments on account of overpayments or underpayments previously made), for the reasonable costs of its State health planning and development agency in carrying out reviews under such agreement.

"(3) If the Governor of a State has not entered into an agreement with the Secretary under paragraph (1) before the expiration of the one-year period beginning on the date of the enactment of the Hospital Cost Containment Act of 1977, no payments may be made to such State under title XIX for any calendar quarter in which such an agreement has not been entered into.

"(b) If a capital expenditure is made for major medical equipment or a health care facility—

"(1) the Secretary shall not include in Federal payments under titles V, XVIII, and XIX any amount for services provided by such equipment, and

"(2) in determining Federal payments under such titles for services furnished in such health care facility, the Secretary shall not include any amount (A) attributable to depreciation, interest on borrowed funds, a return on equity capital (in the case of proprietary facilities), or any other expense related to such capital expenditure, or (B) for direct operating costs for the

provision of such services to the extent such costs can be directly associated with such capital expenditure,

unless the State health planning and development agency with jurisdiction over such equipment or facility has determined, in accordance with an agreement entered into under subsection (a) (1), that such equipment or facility is needed and meets criteria adopted by such agency.

"(c) Where a person obtains under a lease or comparable arrangement any facility or part thereof, or equipment for a facility, which would have been subject to an exclusion under subsection (b) or (d) if the person had acquired it by purchase, the Secretary shall (1) in computing such person's rental expense in determining the Federal payments to be made under titles V, XVIII, and XIX with respect to services furnished in such facility, deduct the amount which in his judgment is a reasonable equivalent of the amount that would have been excluded if the person had acquired such facility or such equipment by purchase, and (2) in computing such person's return on equity capital deduct any amount deposited under the terms of the lease or comparable arrangement.

"(d) Except as provided in paragraph (2), in determining the Federal payments to be made under titles V, XVIII, and XIX with respect to services furnished in a State, the Governor of which has not entered into an agree-

ment with the Secretary under subsection (a) (1) or which does not have a certificate of need program approved under title XV of the Public Health Service Act, the Secretary shall not include—

"(1) any amount (A) which is attributable to depreciation, interest on borrowed funds, return on equity capital (in the case of proprietary facilities), or any other expense related to capital expenditures for any health care facility in such State through which such services were furnished, or (B) for direct operating costs for the provision of such services to the extent such costs can be directly associated with such expenditures, and

"(2) charges for services provided in such State by major medical equipment for which capital expenditures were made,

unless the Secretary has approved, in accordance with procedures and criteria established by the Secretary, such expenditures after taking into account any recommendation made by a State agency designated under section 1521 of the Public Health Service Act. With respect to any organization which is reimbursed on a per capita or a 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 which in his judgment is a

reasonable equivalent to the amount which would otherwise be excluded under this subsection if payment were to be made on other than a per capita or a fixed fee or negotiated rate basis.

"(e) For the purposes of this section, a 'capital expenditure' is an expenditure (1) which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance and which (A) exceeds $150,000, (B) changes the bed capacity of the facility with respect to which such expenditure is made, or (C) substantially changes the services of the facility with respect to which such expenditure is made, or (2) which is made for major medical equipment for the provision of medical and other health services and which exceeds $150,000. For purposes of clause (1) (A) of the preceding sentence, the cost of the studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of the plant and equipment with respect to which such expenditure is made shall be included in determining whether such expenditure exceeds $150,000.

"(f) The provisions of this section shall not apply to Christian Science sanatoriums operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.".

(b) The amendments made by subsection (a) shall apply with respect to capital expenditures (as defined in section 1122(e) of the Social Security Act) made after September 30, 1977.

SEC. 203. (a) Section 103 of the Internal Revenue Code of 1954 (relating to exclusion from gross income of interest on certain governmental obligations) is amended by redesignating subsection (f) as subsection (g), and by inserting after subsection (e) the following new subsection:

"(f) OBLIGATIONS SUPPORTING INCREASES IN ACUTE CARE HOSPITAL BEDS.—Any obligation issued by a State or territory for an institutional health service, health care facility, or health maintenance organization—

"(1) the development of which would result in a number of hospital beds within a health service area which number is in excess of the applicable supply ceiling for such area promulgated under section 1504(b)(1)(A) of the Public Health Service Act, or

"(2) for which a certificate of need has not been issued under a certificate of need program approved under title XV of the Public Health Service Act,

shall be treated as an obligation not described in subsection (a)(1).".

(b) The amendments made by subsection (a) shall

apply with respect to taxable years beginning after the date of the enactment of this Act.

SEC. 204. (a) No person engaged in the business of selling medical equipment in interstate commerce may, after September 30, 1977, sell any medical equipment for more than $150,000 unless the State health planning and development agency designated under section 1521 of the Public Health Service Act has determined under section 1122 of the Social Security Act or under an approved certificate of need program under title XV of the Public Health Service Act that there is a need for the use of such equipment by its purchaser.

(b) (1) Any person who makes a sale of medical equipment in violation of subsection (a) shall be liable to the United States for a civil penalty in an amount not to exceed five times the sale price of such equipment.

(2) A civil penalty for a volation of subsection (a) shall be assessed by the Secretary by an order made on the record after opportunity (provided in accordance with this subsection) for a hearing in accordance with section 554 of title 5, United States Code. Before issuing such an order, the Secretary shall give written notice to the person to be assessed a civil penalty under such order of the Secretary's proposal to issue such order and provide such person an opportunity to request, within fifteen days of the date the

notice is received by such person, such a hearing on the order.

(3) Any person who requested in accordance with paragraph (2) a hearing respecting the assessment of a civil penalty and who is aggrieved by an order assessing a civil penalty may file a petition for judicial review of such order with the United States Court of Appeals for the District of Columbia Circuit or for any other circuit in which such person resides or transacts business. Such a petition may only be filed within the thirty-day period beginning on the date the order making such assessment was issued.

(4) If any person fails to pay an assessment of a civil penalty—

(A) after the order making the assessment has become a final order and if such person does not file a petition for judicial review of the order in accordance with paragraph (3), or

(B) after a court in an action brought under paragraph (3) has entered a final judgment in favor of the Secretary,

the Attorney General shall recover the amount assessed (plus interest at currently prevailing rates from the date of the expiration of the thirty-day period referred to in paragraph (3) or the date of such final judgment, as the case may be) in an action brought in any appropriate district

court of the United States. In such an action, the validity, amount, and appropriateness of such penalty shall not be subject to review.

TITLE III—PROGRAM TO ASSIST AND ENCOURAGE THE DISCONTINUANCE OF UNNEEDED HOSPITAL SERVICES

SEC. 301. The Secretary of Health, Education, and Welfare (hereinafter in this title referred to as the "Secretary") shall, within six months of the date of enactment of this title, establish a program under which financial assistance and encouragement shall be provided, in accordance with this title and during the fifty-four-month period beginning on the date of the enactment of this Act, for the discontinuance of unneeded hospital services.

SEC. 302. (a) Within the one-year period beginning on the date of the enactment of this title the Secretary shall promulgate such regulations as may be necessary to include in the guidelines required by section 1501 (a) of the Public Health Service Act guidelines, consistent with applicable supply ceilings and occupancy standards promulgated under section 1504 (b) of such Act, for each health service area, established under section 1511 of such Act, respecting—

(1) the maximum appropriate supply within each such area of hospital services measured by the number and types of hospital beds, hospital services measured by

the supply of major medical equipment within hospitals, and hospital services measured by the type of specialized services offered by a hospital, and

(2) the minimum appropriate rate of use within each such area of hospital services described in paragraph (1).

Guidelines under this section may vary with respect to a health service area to take into account special characteristics of such area.

(b) (1) Section 1513 (b) (2) of the Public Health Service Act is amended by inserting after the first sentence the following: "An HSP shall identify the actions required to comply with applicable guidelines under section 1501 (a) promulgated pursuant to section 302 (a) of the Hospital Cost Containment Act of 1977.".

(2) Section 1523 (a) (2) of such Act is amended by inserting after the first sentence the following: "In the preparation of the preliminary State health plan, the State agency shall take into account the extent to which such HSP's identify actions required to comply with applicable guidelines under section 1501 (a) promulgated pursuant to section 302 (a) of the Hospital Cost Containment Act of 1977.".

SEC. 303. (a) Under the program established under section 301, any hospital which has been in operation for at least two years and—

(1) which intends to discontinue providing inpatient health services may apply for a debt payment and an incentive payment under section 304 for such discontinuance,

(2) which intends to discontinue an identifiable unit of the hospital which provides inpatient health services may apply for an incentive payment under section 304 for such discontinuance, or

(3) which intends to convert an identifiable part of the hospital into a long-term care facility or an ambulatory care facility may apply for a conversion payment under section 304.

(b) An application of a hospital for a payment under section 304 shall include—

(1) a description of the service (or services) to be discontinued or the part of the hospital to be converted;

(2) an evaluation of the impact of such discontinuance or conversion on the health systems in the health service area in which such hospital is located;

(3) if the services of a unit of a hospital are to be discontinued, an estimate of the change in the applicant's revenues which will result from such discontinuance;

(4) (A) if all the services of a hospital are to be discontinued, the revenue of the hospital for its last full

reporting period for reimbursement purposes under title XVIII of the Social Security Act which revenue under section 111 of this Act is subject to the base inpatient hospital revenue per admission (as established under section 114 of this Act), and (B) if the services of a unit of a hospital are to be discontinued, the amount of charges for such services recorded by the applicant during such reporting period;

(5) with respect to the incentive payment for the discontinuance of all the services of a hospital—

(A) if the applicant intends to engage in the planning, development (including construction and equipment), and delivery of ambulatory care services, home health care services, or long-term care services for the community served by the applicant, which services the State health planning and development agency, after consideration of the recommendations of the health systems agency with jurisdiction over such community, has determined is needed, a description of the means with which (including a description of any Federal financial assistance the applicant intends to apply for) and the manner in which such activities will be carried out;

(B) the amount that the applicant intends to expend for—

(i) the activities described in subparagraph (A),

(ii) if the applicant has merged with another hospital, the operations of that hospital,

(iii) reasonable (as determined under guidelines prescribed by the Secretary) termination pay for personnel of the applicant who will lose employment because of the discontinuance, or

(iv) the activities described in clauses (i) and (ii) and the pay described in clause (iii); and

(C) if the expenditures for the activities described in clause (i) or (ii) of subparagraph (A) will be made but the applicant will not be responsible for making such expenditures, identification of the person (or persons) who will be responsible for making such expenditures; and

(6) such other information as the Secretary may require.

A hospital which has an application under this subsection approved is entitled to receive the payments applied for.

(c) The health systems agency designated under section 1515 of the Public Health Service Act for the health service area in which is located an applicant under this sec-

tion shall determine the need for the service (or services) proposed to be discontinued by such applicant or for the part of the hospital to be converted, as the case may be, and shall make a recommendation to the State health planning and development agency for the State in which the applicant is located respecting approval by the Secretary of such applicant's application. A determination of a health systems agency under this subsection shall be based upon any applicable guidelines promulgated under section 302 and criteria under section 1532(c) of the Public Health Services Act.

(d) A State health planning and development agency which has received a recommendation from a health systems agency under subsection (c) shall, after consideration of such recommendation, make a recommendation to the Secretary respecting the approval by the Secretary of the application with respect to which the health systems agency's recommendation was made. A State health planning and development agency's recommendation under this subsection with respect to the approval of an application shall be accompanied by the health systems agency's recommendation made with respect to the approval of such application.

(e) In considering applications submitted under this section, the Secretary shall give priority to applications (1) which will assist health service areas to meet applicable guidelines promulgated under section 302, or (2) which

will result in the greatest reduction in hospital revenues within a health service area.

SEC. 304. (a) The amount of a debt payment which shall be made to a hospital, with an approved application under section 303, for the discontinuance of all of its services is—

(1) the lesser of—

(A) the total outstanding financial obligation of the applicant attributable (as determined under regulations promulgated by the Secretary) to the equipment and facilities of the hospital, or

(B) the amount of unexpensed depreciation attributable (as determined under regulations promulgated by the Secretary) to the equipment and facilities of the hospital, less

(2) the fair market value of the equipment and facilities of the hospital.

(b) The amount of an incentive payment which shall be made to a hospital, with an approved application under section 303, for the discontinuance of all of its services or the services of an identifiable unit of the hospital is—

(1) in the case of the discontinuance of all of the services of a hospital, the lesser of—

(A) 5 per centum of the revenues reported by the hospital under section 303 (b) (4) (A), or

(B) the amount reported by the hospital under section 303 (b) (5),

but in no event more than $500,000, and

(2) in the case of the discontinuance of the services of an identifiable unit of the hospital, 30 per centum of the charges reported by the hospital for such unit under section 303 (b) (4) (B) but in no event more than $200,000.

(c) The amount of a conversion payment which shall be made to a hospital, with an approved application under section 303, for the conversion of an identifiable part of the hospital into a long-term care facility or ambulatory care facility is 50 per centum of the reasonable (as determined by criteria determined by the Secretary) cost of such conversion.

(d) The debt payment, incentive payment, and conversion payment to which a hospital is entitled shall be paid in a single payment.

(e) (1) If an incentive payment is to be made for the discontinuance of all the services of a hospital, the health systems agency designated for the health service area in which such hospital is located shall receive a payment equal to 10 per centum of such incentive payment. Such health systems agency may use a payment under this paragraph to make grants and contracts in accordance with section 1513 (c) (3) of the Public Health Service Act for projects and

programs within the community served by such hospital or if such community does not need any such project or program, within another community.

(2) If an incentive payment is to be made for the discontinuance of the services of an identifiable unit of a hospital, the health systems agency designated for the health service area in which such hospital is located shall receive a payment equal to 10 per centum of such incentive payment. Such health systems agency may use a payment under this paragraph to make grants and contracts in accordance with section 1513(c)(3) of the Public Health Service Act for projects and programs within the community served by such hospital or if such community does not need any such project or program, within another community.

(f) If a debt payment and an incentive payment is made for the discontinuance of a service and such service is resumed in the area in which it was originally offered or if any part of a service discontinued in connection with a conversion for which a conversion payment was made is resumed in the area in which it was originally offered, no reimbursement for such service may be made under title XVIII of the Social Security Act or under a State plan approved under title V or XIX of such Act unless capital expenditures (if any) made for such service (1) have been approved under section 1122 of the Social Security Act or

under a certificate of need program approved by the Secretary under title XV of the Public Health Service Act or if the Governor of the State in which such service is provided has not entered into an agreement for reviews under such section 1122 or the Secretary has not approved a certificate of need program for such State, have been approved by the Secretary.

(g) To make the payments required by this title, there are authorized to be appropriated for the fiscal year ending September 30, 1979, and for each of the next three fiscal years, such sums as may be necessary.

SEC. 305. (a) If, upon the expiration of the program established under section 301, a health service area is not in compliance with any applicable guideline promulgated under section 302(a), the amount of the reimbursement provided under titleXVIII of the Social Security Act and under a State plan approved under titles V and XIX of such Act for each hospital in the health service area be reduced by 5 per centum until such noncomplying area is in compliance with such guidelines.

(b) A health systems agency may apply to the Secretary for an extension of the time required for its health service area to come into compliance with applicable guidelines promulgated under section 302(a) without incurring the reimbursement reduction required by subsection (a).

The Secretary may grant a health service area such an extension—

(1) after taking into account the effort made by such area to come into compliance with such guidelines, the capabilities of such area to come into compliance, and the effect of the reduction in reimbursements paid to hospitals in such area on the quality of health care provided in such area, or

(2) if such area is not in compliance with such guidelines because of the necessity to correct a maldistribution in such area of hospital beds and a certificate of need has been granted under section 1527 (b) or 1527 (c) of the Public Health Service Act to assist in making such correction.

If the Secretary grants an extension of time, he shall specify the time within which the noncomplying area shall be in compliance with such guidelines.

SEC. 306. (a) In the administration of certificate of need programs under title XV of the Public Health Service Act and the program under section 1122 of the Social Security Act relating to capital expenditures, special consideration shall be given to proposals of hospitals which have discontinued services which have been determined to be not needed.

(b) In making grants under section 330 of the Public

Health Service Act or in providing other assistance for the development and delivery of ambulatory health services, the Secretary shall give priority to applications which will provide such services for communities in which all hospital services have been discontinued as a result of the program established under section 301.

(c) In the administration of titles XVIII and XIX of the Social Security Act, the Secretary shall permit losses incurred in connection with the sale or other disposition of facilities and equipment used in the provision of inpatient health services provided by an identifiable unit of a hospital and for the discontinuance of which an incentive payment was made under section 304 (c) to be included in determining costs for which reimbursement may be made under such title XVIII and payments may be made under State plans approved under such title XIX.

SEC. 307. The Secretary shall make a study of the first twenty-five applications approved under section 303 to determine their effect on the elimination of unneeded hospital services. The Secretary shall report the results of such study to Congress together with his recommendations for any revisions in the program which he determines to be appropriate.

95TH CONGRESS
1ST SESSION

H. R. 6575

IN THE HOUSE OF REPRESENTATIVES

APRIL 25, 1977

Mr. ROGERS (for himself and Mr. ROSTENKOWSKI) introduced the following bill; which was referred jointly to the Committees on Ways and Means and Interstate and Foreign Commerce

A BILL

To establish a transitional system of hospital cost containment by providing for incentives and restraints to contain the rate of increase in hospital revenues, to establish a system of capital allocation designed to encourage communities to avoid the creation of unneeded and duplicative hospital facilities and services, to provide for the publication and disclosure of information useful to the public in making decisions about health care, to provide for the development of permanent reforms in hospital reimbursement designed to provide incentives for the efficient and effective use of hospital resources, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE

SECTION 1. This Act may be cited as the "Hospital Cost Containment Act of 1977".

REPORT ON PERMANENT REFORM IN THE DELIVERY AND FINANCING OF HEALTH CARE

SEC. 2. The Secretary of Health, Education, and Welfare (hereinafter in this Act referred to as the "Secretary") shall submit to the Congress, no later than March 1, 1978, a report setting forth his recommendations for permanent reforms in the delivery and financing of health care which will increase the efficiency, effectiveness, and quality of health care in the United States and which will replace the transitional provisions of title I of this Act.

TITLE I—TRANSITIONAL HOSPITAL COST CONSTRAINT PROVISIONS

PART A—PURPOSE AND GENERAL DESCRIPTION OF THE PROGRAM

PURPOSE

SEC. 101. It is the purpose of the transitional hospital cost containment program established by this title to constrain the rate of increases in total acute care hospital inpatient costs, beginning October 1, 1977, and continuing until the adoption of the permanent reforms referred to in section 2, by limiting the amount of revenue which may be received, by the hospitals involved, from Government

programs, private insurers, and individuals who pay directly for such care.

GENERAL DESCRIPTION OF PROGRAM

SEC. 102. (a) In order to carry out the purpose of the transitional program as set forth in section 101, the inpatient revenues of short-term acute care and specialty hospitals (excluding new hospitals and certain HMO-related hospitals) are to be limited in the manner outlined in the succeeding provisions of this section (and more particularly described in parts B and C of this title).

(b) The increase in total revenue which a hospital (as defined in section 121) may receive in any accounting year in the form of—

(1) reimbursement paid under the medicare and medicaid programs, and by cost payers, for inpatient services, and

(2) charges imposed upon other persons for inpatient services,

may not, on a peradmission basis, exceed the average inpatient reimbursement due or inpatient charges imposed per inpatient admission in the base period (in general, the hospital's accounting year ending in 1976) by more than the percentage which is applicable to the hospital for such accounting year under section 111.

pliance is required under the medicare program by directly applying the limits for purposes of both interim and final reimbursement. Amounts paid to hospitals under the medicaid program in excess of such limits will be disallowed as a basis for Federal matching payments. Hospitals and nongovernment cost payers exceeding the limits will be subject to a Federal excise tax in an amount equal to 150 per centum of the excess (except in the case of a hospital which is exempt as a result of corrective actions as prescribed under section 116(d)(2)).

(f) The Secretary is authorized, under section 117, to waive the limits otherwise established for all hospitals located in any State which has had in effect for at least one year a hospital cost containment program which covers at least 90 per centum of all acute care hospitals in the State, applies to all payers except the medicare program, limits inpatient hospital revenue increases to a rate no greater (in the aggregate) than the rate established for the period involved under section 112(b), and provides for return of excess hospital revenues.

PART B—ESTABLISHMENT OF HOSPITAL COST CONTAINMENT PROGRAM

IMPOSITION OF LIMIT ON HOSPITAL REVENUE INCREASES

SEC. 111. (a) The average reimbursement paid to a hospital for inpatient services under title XVIII of the Social

(c) Such percentage, in the case of any hospital for any accounting year, is to be determined by—

(1) establishing for such year, under section 112 (b), an "inpatient hospital revenue increase limit" based on increases in the gross national product deflator and in total hospital expenditures nationwide,

(2) modifying the limit so established by the "admission load formula", as promulgated under section 113, to take account of major changes in patient loads experienced by that particular hospital, in order to arrive at an "adjusted inpatient hospital revenue increase limit" for that hospital in such year, and

(3) applying such adjusted limit for periods after September 30, 1977, with recognition being given under section 111 (a) (1) to cost increases prior to that date.

(d) An exception from the limits otherwise established may be granted in accordance with section 115 (for a particular period) to any hospital which is experiencing substantially higher costs as a result of extraordinary changes in patient loads or major changes in facilities and services, to the extent required to assure that the necessary additional revenue will be available where necessary to meet actual community needs.

(e) Compliance with these limits is to be enforced, in accordance with section 116, in various ways. Such com-

Security Act, under a State plan approved under title V or title XIX of such Act, or by any cost payer, and the average charges imposed by a hospital for inpatient services, in any accounting year any part of which falls within a period subject to this title, may not (except as provided in subsection (b)) exceed the base inpatient hospital revenue per inpatient admission (as established under section 114) by a percentage greater than the sum of—

(1) the percentage by which the costs involved would have increased in the period elapsing after the close of the hospital's base accounting year and prior to October 1, 1977, if such costs had increased (during that period) at the average annual rate actually experienced by the hospital during the two-year period ending with the close of such base accounting year, except that such percentage as applied for purposes of this section shall not be more than 15 per centum nor less than 6 per centum,

(2) the percentage by which such costs would have increased in the period elapsing after September 30, 1977, and prior to the first day of the accounting year for which the limit is being imposed if such costs had increased (during such period) at an annual rate consistent with the inpatient hospital revenue in-

crease limit determined and promulgated under section 112 (b), and

(3) the percentage by which such costs would have increased in the accounting year for which the limit is being imposed if such costs had increased (during such year) at an annual rate consistent with the adjusted inpatient hospital revenue increase limit applicable to the hospital under section 112 (a).

(b) Where less than a full accounting year falls within a twelve-month period subject to this title, the limit set forth in subsection (a) of this section, and the limit established under section 112 (a), shall apply with respect to reimbursement due or charges imposed for the part of such accounting year which falls within such period in the same proportion as the number of days in such accounting year that fall within such period bears to the total number of days in such accounting year.

DETERMINATION OF ADJUSTED INPATIENT HOSPITAL REVENUE INCREASE LIMIT

SEC. 112. (a) The "adjusted inpatient hospital revenue increase limit" which is applicable to any hospital for purposes of section 111 (a) (3) with respect to any accounting year shall (subject to section 111 (b) and section 124) be equal to the inpatient hospital revenue in-

crease limit determined and promulgated under subsection (b) of this section for the twelve-month period in which such accounting year or any part thereof falls, modified by the application of the "admission load formula" which is promulgated under section 113 and applied to that hospital.

(b) (1) Between July 1 and October 1 of each calendar year beginning with 1977, the Secretary shall promulgate a figure which (subject to paragraph (2)) shall be the "inpatient hospital revenue increase limit" applicable to the twelve-month period beginning October 1 in such year (with each such twelve-month period being referred to in this title as a "period" or a "period subject to this title"). Such figure shall be the sum of—

(A) the implicit price deflator of the gross national product as calculated by the Bureau of Economic Analysis of the Department of Commerce and published in the Survey of Current Business (hereinafter in this title referred to as the "GNP deflator") for the 12-month period ending June 30 of such year, and

(B) one-third of the difference between—

(i) the average annual rate of increase in total hospital expenditures which is found by the Secretary to have occurred during the twenty-four-month

period ending on the day preceding January 1 of such calendar year, and

(ii) the annual rate of increase in the GNP deflator for the twenty-four-month period ending on the day preceding January 1 of such calendar year.

(2) If the Secretary finds during any period subject to this title that the GNP deflator with respect to such period is expected to exceed by more than 1 percentage point the GNP deflator which was used in making the determination under paragraph (1) (or in making a prior adjustment under this paragraph), the Secretary shall increase (or further increase) the GNP deflator so used by the amount of such excess; except that no adjustment made under this paragraph shall be effective with respect to any accounting year ending prior to the calendar quarter preceding the calendar quarter in which such adjustment is made.

PROMULGATION OF ADMISSION LOAD FORMULA

SEC. 113. The admission load formula shall be promulgated by the Secretary by October 1, 1977, and shall be such that—

(1) a hospital will be allowed an increase in total revenue from inpatient services in any accounting year to the extent (and only to the extent) consistent with the inpatient hospital revenue increase limit promul-

gated under section 112(b), for the period in which such accounting year or any part thereof falls if admissions in such accounting year have increased by less than 2 per centum or declined by less than 6 per centum as compared to the base accounting year (2 per centum and 10 per centum, respectively, in the case of a hospital with no more than four thousand admissions in the base accounting year);

(2) in the case of a hospital whose admissions in any accounting year are beyond the applicable range set forth in paragraph (1), the amount of total revenue from inpatient services in such year which is otherwise allowed under paragraph (1) shall be further increased for each admission above such range by one-half of the average revenue per admission that would have been allowed under paragraph (1) if the actual percentage change in admissions (as compared to the base accounting year) had been zero, or shall be reduced for each admission below such range by one-half of the average revenue per admission that would have been so allowed, except as provided in paragraph (3); and

(3) in the case of a hospital which had more than four thousand admissions in the base accounting year, no additional revenue will be allowed for increased admissions (with respect to any accounting year) beyond

15 per centum above those in the base accounting year, but the revenue otherwise permitted such a hospital under paragraphs (1) and (2) shall be reduced (dollar for dollar) for decreased admissions (in that year) beyond 15 per centum below those in the base accounting year.

BASE INPATIENT HOSPITAL REVENUE

SEC. 114. (a) (1) The revenue base for application of the adjusted inpatient hospital revenue increase limit with respect to any hospital in any accounting year shall (subject to subsection (b)) be the revenue from reimbursement due and inpatient charges imposed for inpatient hospital services provided in the hospital's base accounting year (as defined in paragraph (2)).

(2) For purposes of this title, a hospital's "base accounting year" is its accounting year which ended in 1976, or, in the case of a hospital which did not meet the definition contained in section 121 for at least one full accounting year prior to an accounting year ending in 1976 in which it met such definition, the accounting period immediately prior to the first accounting year in which it satisfied such definition.

(b) The base revenue established for any hospital by subsection (a) shall (except as provided in subsection (c)) be reduced by an amount equal to any inpatient charges in

such base accounting year for elements of inpatient services for which payment is not made to the hospital in an accounting year any part of which falls within a period subject to this title.

(c) Subsection (b) shall not apply with respect to revenue for inpatient services which have been found inappropriate under section 1523 (a) (6) of the Public Health Service Act by the State health planning and development agency designated under section 1521 of such Act for the State in which the hospital involved is located.

ESTABLISHMENT OF EXCEPTIONS

SEC. 115. (a) The Secretary shall have authority to grant exceptions from the limits established under this title to individual hospitals for particular periods, but in any case only to the extent that the hospital requesting the exception provides evidence satisfactory to the Secretary—

(1) of the extent to which costs of providing inpatient hospital services in an accounting year any part of which falls within a period subject to this title exceed such costs in the base accounting year as the result of—

(A) changes in admissions beyond the range specified in section 113 (3), or

(B) changes in capacity or in the character of inpatient services available in the hospital or

major renovation or replacement of physical plant, but only if such changes have increased inpatient costs per admission by more than one-third of the difference specified in section 112(b)(1)(B) over inpatient care costs per admission in the previous accounting year;

(2) that the revenue otherwise allowable (taking into account all other available resources) is insufficient to assure the solvency of the hospital as indicated by the existence of a current ratio of assets to liabilities (determined in accordance with the last sentence of this subsection) of less than the ratio which the Secretary estimates is being experienced by 25 per centum or less of the hospitals subject to this title; and

(3) that the changes in admissions, capacity, plant, or services available generating the excess costs described in paragraph (1) have been found to be needed under section 1523(a)(5) of the Public Health Service Act or appropriate under section 1523(a)(6) of the Public Health Service Act by the State health planning and development agency, designated under section 1521 of such Act for the State in which the hospital involved is located.

For purposes of paragraph (2), the term "current ratio of assets to liabilities", with respect to any hospital, means

the sum of the cash, notes and accounts receivable (less reserves for bad debts), marketable securities, and inventories held by such hospital divided by the sum of all liabilities of such hospital falling due in an accounting year for which the exception is requested under this section.

(b) The Secretary shall either approve any request for an exception made by a hospital under subsection (a), or deny such request, within a period not to exceed ninety days after the hospital has filed in a manner and form prescribed by the Secretary the evidence required by such subsection. Any such request not denied within such ninety-day period shall be deemed approved.

(c) Any hospital granted an exception under this section must make itself available for an operational review by the Secretary. The findings from any such review shall be made public, and continuance of the exception shall be contingent on implementation of any recommendations which may be made (as a result of such operational review) for improvements to increase efficiency and economy.

(d) (1) If the Secretary grants an exception with respect to any accounting year to a hospital which had 4,000 or more admissions in the base accounting year on the grounds set forth in subsection (a) (1) (A), such hospital shall be allowed increased revenue for purposes of this title

as though it were a hospital with fewer than four thousand admissions in such base year under section 113.

(2) If the Secretary grants an exception with respect to any accounting year to a hospital on the grounds set forth in subsection (a) (1) (B), such hospital shall be allowed increased total revenue for purposes of this title for such accounting year and all subsequent accounting years (and the limit on its allowable rate of increase in inpatient hospital revenues shall be adjusted upward accordingly) in an amount no greater than the amount necessary to maintain the current ratio of its assets to liabilities (determined in accordance with the last sentence of subsection (a)) at the level specified in subsection (a) (2).

(e) (1) Any hospital which is dissatisfied with a determination of the Secretary under this section may obtain a hearing before the Provider Reimbursement Review Board established under section 1878 of the Social Security Act, if the amount in controversy is $25,000 or more and the request for such hearing is filed within one hundred and eighty days after receipt of the Secretary's determination.

(2) For purposes of paragraph (1), the Secretary (notwithstanding section 1878(h) of the Social Security Act) shall appoint five additional members to the Provider Reimbursement Review Board, following the specifications

95-756 O - 77 - 6

for expertise applicable to the existing five members. Such five additional members shall constitute the Board for purposes of reviewing appeals under this title. All the other provisions of section 1878 of the Social Security Act shall apply except that the Board as so constituted shall be considered as reviewing decisions of the Secretary rather than of a fiscal intermediary, and subsection (b) of such section shall not apply.

ENFORCEMENT

SEC. 116. (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 limits established under this title.

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

(c) Notwithstanding any other provision of law, receipt by any hospital of payment for inpatient hospital serv-

ices in excess of the applicable limits established under this title, or payment by any cost payer (as defined in section 122(e)(2)) for inpatient hospital services on a cost basis in excess of such limits, shall subject such hospital or cost payer—

(1) to the Federal excise tax imposed by section 4991 of the Internal Revenue Code of 1954 (as added by section 128 of this Act), and

(2) to exclusion, at the discretion of the Secretary, from participation in any or all of the programs established by titles V, XVIII, and XIX of the Social Security Act.

(d)(1) Where the Secretary determines that average charges per admission billed for inpatient services by a hospital during an accounting year any part of which is included in a period subject to this title exceed the applicable limits established under this title, he shall promulgate (or shall require the hospital to promulgate in such manner as he may prescribe) the percentage by which the average charge per admission billed in that accounting year by the hospital exceeded the applicable limitation on average charges per admission established under this title.

(2) Any hospital described in paragraph (1) shall be exempt from the penalties set forth in subsection (c) if it holds in escrow an amount equal to the percentage promul-

gated under such paragraph multiplied by the hospital's total inpatient charges less its inpatient charges applicable to cost payers (as defined in section 122(e)), imposed on the accounting year referred to in such paragraph, until such time as charges below the applicable limits established under this title, equal in the aggregate to such amount, are experienced; but any such hospital which fails to do so shall be subject to such penalties.

EXEMPTION FOR HOSPITALS IN CERTAIN STATES

SEC. 117. (a) At the request of the Governor (or other chief executive) of any State (including the District of Columbia and Puerto Rico) the Secretary may exclude from the application of this title all hospitals physically located in such State if the Secretary finds that—

(1) such State has had in effect for at least one year as of the date of such request a program for containing hospital costs in the State which covers at least 90 per centum of the hospitals in the State which would otherwise be covered under the program established by this title;

(2) the State program applies at least to all inpatient care revenues of such hospitals (except revenues received under title XVIII of the Social Security Act);

(3) the Governor (or chief executive) certifies,

and the Secretary determines, that the aggregate rate of increase in inpatient hospital revenues for all hospitals in the State will not exceed the rate promulgated by the Secretary under section 112 (b) ; and

(4) the Governor (or chief executive) has submitted, and had approved by the Secretary, a plan for recovering any excess of revenue which (notwithstanding paragraph (3)) may occur.

(b) A State which would meet the conditions of this section except that its program does not satisfy subsection (a) (2), but whose program did cover at least 50 per centum of all inpatient care revenues during the twelve-month period preceding the date of its request under subsection (a), will nonetheless be eligible under this section if, by the date of such request, it does have a program which satisfies such subsection.

EXEMPTION FOR HOSPITALS ENGAGED IN CERTAIN EXPERIMENTS OR DEMONSTRATIONS

SEC. 118. A hospital may be excluded from the application of this title if the Secretary determines that (1) such exclusion is necessary to facilitate an experiment or demonstration entered into under section 402 of the Social Security Amendments of 1967 or section 222 of the Social Security Amendments of 1972, and (2) such experiment or demonstration is consistent with the purposes of this title.

PART C—DEFINITIONS AND MISCELLANEOUS PROVISIONS

DEFINITION OF HOSPITAL

SEC. 121. (a) For purposes of this title (subject to subsection (b) of this section), the term "hospital", with respect to any accounting year, means an institution (including a distinct part of an institution participating in the program established under title XVIII of the Social Security Act) which—

(1) satisfies paragraphs (1) and (7) of section 1861 (e) of the Social Security Act, and

(2) had an average duration of stay of thirty days or less in the preceding accounting year.

(b) An institution shall not be considered a "hospital" during any part of a period subject to this title if with respect to such period it—

(1) is a Federal hospital;

(2) has met the conditions specified in subsection (a) (under present and previous ownership) for less-than two years before such period; or

(3) derived more than 75 per centum of its inpatient care revenues on a capitation basis, disregarding revenues received under title XVIII of the Social Security Act, from one or more health maintenance organizations (as defined in section 1301 (a) of the Public Health Service Act).

OTHER DEFINITIONS

SEC. 122. For purposes of this title—

Accounting Year

(a) The term "accounting year" with respect to any period means—

(1) in the case of a hospital participating in the program established by title XVIII of the Social Security Act, a period of twelve consecutive full calendar months including the same months as the last full reporting period allowed for reimbursement purposes under such title;

(2) in the case of a hospital not participating in the program established by title XVIII of the Social Security Act, a period of twelve consecutive full calendar months including the same months as the last full accounting period used by such other cost payer as the Secretary may designate; and

(3) in the case of a hospital which is not participating in the program established by title XVIII of the Social Security Act and for which the Secretary does not designate an accounting year under paragraph (2), a calendar year.

Inpatient Hospital Services

(b) The term "inpatient hospital services" has the meaning given it by section 1861(b) of the Social Secu-

rity Act (including in addition the services otherwise excluded by paragraph (5) thereof).

Inpatient Charges

(c) The term "inpatient charges" means regular rates, applied to all inpatient hospital services, that meet the requirements of section 405.452 (d) (4) of the Federal regulations applicable to title XVIII of the Social Security Act.

Admissions

(d) The term "admission" means the formal acceptance of an inpatient by a hospital, excluding newborn children (unless retained after discharge of the mother) and transfers within inpatient units of the same institution.

Cost Payer

(e) The term "cost payer" means—

(1) a program established by or under title V, XVIII, or XIX of the Social Security Act, and

(2) any organization which (A) meets the definition contained in section 1842 (f) (1) of the Social Security Act, and (B) reimburses a hospital subject to this title for inpatient hospital services on the basis of cost as defined for purposes of such reimbursement.

DETERMINATION OF INPATIENT REIMBURSEMENT

SEC. 123. For purposes of section 111, inpatient reimbursement under the programs established by titles V,

XVIII, and XIX of the Social Security Act shall be determined without regard to adjustments resulting from the application of section 405.460(g), 405.455(d), 405.415(f), or 405.415(d)(3) of the Federal regulations applicable to such title XVIII.

EXEMPTION OF NONSUPERVISORY PERSONNEL WAGE INCREASES FROM REVENUE LIMIT

SEC. 124. (a) At the request of any hospital which is subject to the provisions of this title and which provides the data necessary for the required calculation, the Secretary shall modify the inpatient hospital revenue increase limit and the adjusted inpatient hospital revenue increase limit otherwise established for such hospital with respect to any accounting year under section 112 to allow such hospital to receive, without restriction, revenue equal to the average amount of any increase in regular wages granted in such year to employees who do not meet the definition of "supervisor" as that term is used for purposes of the National Labor Relations Act and (if not employees of a State or political subdivision thereof) who are covered by such Act.

(b) Such modified limits for any accounting year shall be calculated by adding together—

(1) the average percentage increase in regular wages granted to the employees referred to in sub-

section (a) since the close of the preceding accounting year multiplied by the percentage of total inpatient cost (as determined for purposes of title XVIII of the Social Security Act) attributable to such wages in such preceding year; and

(2) the inpatient hospital revenue increase limit or, as appropriate, the adjusted inpatient hospital revenue increase limit otherwise applicable to the hospital under this title multiplied by the percentage of revenues (as determined for purposes of title XVIII of the Social Security Act) attributable to all other expenses in the preceding accounting year.

(c) The modified inpatient hospital revenue increase limit and adjusted inpatient hospital revenue increase limit established under subsection (b) for any hospital with respect to any accounting year shall constitute such hospital's inpatient hospital revenue increase limit or, as appropriate, the adjusted inpatient hospital revenue increase limit for such year under section 111 for all of the purposes of this title.

(d) This section shall apply to accounting years beginning after March 31, 1979, only to the extent the Secretary so determines.

DISCLOSURE OF FISCAL INFORMATION

SEC. 125. (a) (1) Every hospital shall (A) submit semiannually to the health systems agency designated under

section 1515 of the Public Health Service Act for the health service area in which it is located, by March 1 and September 1 of each year, its average semiprivate room rate and the charges for the 10 other services which the health systems agency finds represent the services which are most frequently used or most important for purposes of comparing hospitals, and make available all cost reports submitted to cost payers, and (B) submit annually its overall plan and budget described in section 1864(z) of the Social Security Act.

(2) Failure by any hospital to comply with the requirement of paragraph (1) shall subject it to exclusion, at the discretion of the Secretary, from participation in any or all of the programs established by titles V, XVIII, and XIX of the Social Security Act.

(b) Each health systems agency designated under section 1515 of the Public Health Service Act shall publish every April 1 and October 1, in readily understandable language for public use, the information it receives under this section, in a manner designed to facilitate comparisons among the hospitals in its area.

IMPROPER CHANGES IN ADMISSION PRACTICES

SEC. 126. Upon written complaint by any institution meeting the conditions set forth in paragraphs (1) and (7) of section 1861(e) of the Social Security Act that one or

more hospitals subject to this title in a health service area for which a health systems agency has been designated under section 1515 of the Public Health Service Act has changed its admission practices in a manner that would tend to reduce the proportion of inpatients of such hospital or hospitals for whom reimbursement at less than the inpatient charges (as defined in section 122(c) of this Act) applicable to such inpatients is anticipated, such health systems agency shall investigate the complaint and, upon a finding by such agency that the complaint is justified, the Secretary may impose the sanction set forth in section 116(c)(2) of this Act.

REVIEW OF CERTAIN DETERMINATIONS

SEC. 127. Any determinations made on behalf of the Secretary under this title with respect to the application of its provisions to individual hospitals (other than determinations made under section 115 or 126) shall be subject to the provisions of section 1878 of the Social Security Act in the same manner as determinations with respect to the amount of reimbursement due a provider of services under title XVIII of such Act.

EXCISE TAX ON EXCESSIVE PAYMENTS FOR INPATIENT HOSPITAL SERVICES

SEC. 128. (a) Subtitle D of the Internal Revenue Code of 1954 (relating to miscellaneous excise taxes) is amended by adding at the end thereof the following new chapter:

"CHAPTER 45—TAX ON CERTAIN EXCESSIVE PAYMENTS FOR INPATIENT HOSPITAL SERVICES

"SEC. 4991. IMPOSITION OF TAX.

"(a) IN GENERAL.—There is hereby imposed, with respect to the receipt by any hospital of payment for inpatient hospital services in excess of the applicable limits established by title I of the Hospital Cost Containment Act of 1977, and with respect to any payment made by any cost payer as defined in section 122(e)(2) of such Act for inpatient hospital services on a cost basis in excess of such limits, a tax equal to 150 percent of the amount of such excess. The tax imposed by this subsection shall be paid by the hospital or cost payer.

"(b) EXCEPTION.—The tax imposed by subsection (a) shall not apply with respect to any hospital so long as it is determined by the Secretary of Health, Education, and Welfare to be taking the corrective action described in section 116(d)(2) of the Hospital Cost Containment Act of 1977.

"(c) DEFINITIONS.—Terms used in subsections (a) and (b) have the meanings given them by title I of the Hospital Cost Containment Act of 1977.

"(d) ADMINISTRATION.—Under and to the extent

provided by regulations of the Secretary, the appropriate provisions of subtitle F (relating to procedure and administration) shall be made applicable with respect to the tax imposed by subsection (a) of this section.".

(b) The table of chapters for subtitle D of such Code is amended by adding at the end thereof the following new item:

"CHAPTER 45. Tax on certain excessive payments for inpatient hospital services.".

TITLE II—LIMITATION ON HOSPITAL CAPITAL EXPENDITURES

SEC. 201. (a) Part A of title XV of the Public Health Service Act is amended by adding at the end thereof the following new section:

"LIMITATION ON HOSPITAL CAPITAL EXPENDITURES, CEILING FOR THE SUPPLY OF HOSPITAL BEDS, AND STANDARD FOR OCCUPANCY OF HOSPITAL BEDS

"SEC. 1504. (a) (1) Before the beginning of the fiscal year beginning October 1, 1977, and at least 60 days before the beginning of each succeeding fiscal year, the Secretary shall promulgate a sum as a hospital capital expenditure limit applicable to such fiscal year. The sum promulgated as a limit under the preceding sentence for any period shall be an amount which may not exceed $2,500,000,000.

"(2) The Secretary shall apportion the sum promulgated under paragraph (1) for any fiscal year among the various States on the basis of the population of the various States; except that for any fiscal year beginning more than 18 months after the date of enactment of this section the Secretary shall apportion the sum promulgated under paragraph (1) for such fiscal year among the various States, taking into account the population of the various States; and also taking into account, to the extent feasible, variations among the States in the costs of construction, population patterns and growth, the need for hospital facilities and equipment and for modernization of existing hospital facilities and equipment, and other factors important to the equitable apportionment of such sum.

"(b) (1) At the time the Secretary promulgates under subsection (a) a hospital capital expenditure limit the Secretary shall also promulgate for the fiscal year to which such limit is applicable—

"(A) a national ceiling for the supply of hospital beds within health service areas established under section 1511 (hereinafter in this title referred to as the 'supply ceiling'), and

"(B) a national standard for the rate of occupancy of hospital beds within such areas (hereinafter in this title referred to as the 'occupancy standard').

"(2) The supply ceiling promulgated for any fiscal year under paragraph (1) (A) may not exceed the ratio of four hospital beds per one thousand of population; but the Secretary may promulgate under such paragraph a different supply ceiling for health service areas which have special characteristics or which meet special requirements established by the Secretary.

"(3) The occupancy standard promulgated under paragraph (1) (B) for any fiscal year may not be less than 80 percent; but the Secretary may establish a different occupancy standard for health service areas which have special characteristics or which meet special requirements established by the Secretary.".

(b) (1) Part C of title XV of the Public Health Service Act is amended by adding at the end thereof the following new section:

"CERTIFICATE OF NEED PROGRAM

"SEC. 1527. (a) The certificate of need program required by section 1523 (a) (4) (B) shall provide for the following:

"(1) Review and determination of need under such program of institutional health services, health care facilities, and health maintenance organizations shall be made before the time such services, facilities, and organizations are offered or developed or substantial expendi-

tures are undertaken in preparation for such offering or development.

"(2) The program shall be administered in such a manner that only those services, facilities, and organizations found to be needed shall be offered or developed in the State in which the program applies.

"(3) In issuing a certificate of need for any such service, facility, or organization, the State shall specify in the certificate the maximum amount of capital expenditures which may be made for such service, facility, or organization under such certificate.

"(4) The aggregate of the maximum amounts of capital expenditures authorized in a fiscal year in accordance with paragraph (3) for hospitals may not exceed the portion of the sum promulgated under section 1504(a)(1) and apportioned to the State under section 1504(a)(2) for such fiscal year, as adjusted in accordance with this paragraph. For any fiscal year the sum apportioned to a State under section 1504(a)(2) shall (A) if the aggregate of the maximum amounts of capital expenditures authorized by the State in the preceding fiscal year in accordance with paragraph (3) for hospitals was less than the portion of such sum so apportioned to the State for such fiscal year, the difference between such authorized maximum amounts and the sum

so apportioned shall be added to the sum so apportioned to the State for the fiscal year following such fiscal year, and (B) if in the fiscal year there was a closure of a hospital (or part thereof) through which institutional health services found under section 1523 (a) (6) to be inappropriate were provided, then the amount by which the historical cost (as defined for purposes of title XVIII of the Social Security Act) of such hospital or part exceeds the total amount of depreciation of such hospital or part claimed for purposes of establishing the reasonable costs of services provided by the hospital for purposes of receiving reimbursement under title XVIII of the Social Security Act shall be added to the portion of such sum so apportioned to the State for such fiscal year.

"(b) (1) Under such a certificate of need program a certificate of need may not, except as provided in paragraph (2), be granted for an institutional health service or health care facility within a health service area established under section 1511 if the development of such service or facility under such certificate would result in a number of hospital beds within such area which is in excess of the applicable supply ceiling promulgated under section 1504 (b) (1) (A).

"(2) If in a health service area the number of hospital beds is in excess of the supply ceiling applicable to a fiscal year, then a certificate of need may be granted for such a

service or facility the development of which would result in a number of new hospital beds which is not more than one-half of the number of hospital beds removed permanently from service in such area in such fiscal year. The amount by which the number of new hospital beds with respect to which certificates of need may be issued in a fiscal year under the preceding sentence is less than the number of new hospital beds with respect to which certificates of need were issued in such fiscal year may be added to the number of new hospital beds with respect to which certificates of need may be issued in the succeeding fiscal year.

"(c) (1) Under such a certificate of need program a certificate of need may not, except as provided in paragraph (2), be granted for an institutional health service or health care facility within a health service area if the development of such service or facility could reasonably be expected to produce a number of hospital beds which would result in a hospital bed occupancy rate within such area which is less than the applicable occupancy standard promulgated under section 1504(b) (1) (B).

"(2) If in any fiscal year the hospital bed occupancy rate within a health service area is less than the occupancy standard applicable for such fiscal year, then a certificate of need may be granted for a service or facility the development of which would result in a number of new hospital

beds which is not more than one-half of the number of hospital beds removed permanently from service in such area in such fiscal year. The amount by which the number of new hospital beds with respect to which certificates of need may be issued in a fiscal year under the preceding sentence is less than the number of new hospital beds with respect to which certificates of need were issued in such fiscal year may be added to the number of new hospital beds with respect to which certificates of need may be issued in the succeeding fiscal year.

"(d) In granting certificates of need under such a program a State shall take into account priorities recommended by health systems agencies within the State under section 1513(h).".

(2) The second sentence of section 1523(a)(4) of the Public Health Service Act is repealed.

(c) Section 1531 of the Public Health Service Act is amended (1) by striking out "For purposes of this title" and inserting in lieu thereof "Except as otherwise provided for purposes of this title", and (2) by adding after paragraph (5) the following new paragraphs:

"(6) For purposes of sections 1504 and 1527, the term 'hospital', with respect to any accounting year, means an institution (including a distinct part of an institution

participating in the program established under title XVIII of the Social Security Act) which—

"(A) satisfies paragraphs (1) and (7) of section 1861 (e) of the Social Security Act, and

"(B) has an average duration of stay of 30 days or less in the preceding accounting year,

except that for any fiscal year such term does not include a Federal hospital or an institution which during such fiscal year derived more than 75 per centum of its inpatient care revenues on a capitation basis, disregarding revenues received under title XVIII of the Social Security Act, from one or more health maintenance organizations (as defined in section 1301 (a)).

"(7) For the purposes of sections 1504 and 1527, the term 'capital expenditure' means an expenditure which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance and which (A) exceeds $100,000, (B) changes the bed capacity of the facility with respect to which such expenditure is made, or (C) substantially changes the services of the facility with respect to which such expenditure is made, except that such term includes expenditures for obtaining a facility or part thereof, or equipment for a facility or part, under a lease or comparable arrangement but does not in-

clude the acquisition of an existing hospital facility if such acquisition does not make a change in the services or bed capacity of such hospital facility. For purposes of clause (A) of the preceding sentence, the cost of the studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of the plant and equipment with respect to which such expenditure is made shall be included in determining whether such expenditure exceeds $100,000. If a person makes an acquisition of equipment for a hospital and donates it to the hospital, the expenditure for such acquisition shall be considered a hospital capital expenditure for purposes of sections 1504 and 1527.".

(d) Section 1532(b)(2) of the Public Health Service Act is amended (1) by striking out "ninety days" and inserting in lieu thereof "one year", and (2) by adding before the period "or longer than such shorter period from such date as the Secretary may prescribe".

SEC. 202. (a) (1) Section 1122 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(j) (1) Except as provided in paragraph (2), in determining the Federal payments to be made under titles V, XVIII, and XIX with respect to services furnished in a health care facility located in a State—

"(A) which has not entered into an agreement with the Secretary under this section, or

"(B) which does not have a certificate of need program approved under title XV of the Public Health Service Act,

the Secretary shall not include an amount equal to ten times any amount which is attributable to depreciation, interest on borrowed funds, and return on equity capital (in the case of proprietary facilities) or other expenses related to capital expenditures after September 30, 1977, for such health care facility unless the Secretary has approved, in accordance with procedures and criteria established by the Secretary, such expenditures after taking into account any recommendation made by a State agency designated under section 1521 of the Public Health Service Act. With respect to any organization which is reimbursed on a per capita or a 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 which in his judgment is a reasonable equivalent to the amount which would otherwise be excluded under this subsection if payment were to be made on other than a per capita or a fixed fee or negotiated rate basis.

"(2) Paragraph (1) shall not apply with respect to determination of Federal payments to be made under title V,

XVIII, or XIX with respect to services furnished in a health care facility located in a State which has a certificate of need program, approved by the Secretary for purposes of this section, which applies to capital expenditures for hospitals and with respect to which such capital expenditures meet the requirements of section 1527 of the Public Health Service Act.".

(2) Subsection (e) of such section 1122 is amended by striking out "subsection (d)" and inserting in lieu thereof "subsection (d) or (j)".

(3) Subsection (b) of such section 1122 is amended by inserting before the period at the end thereof the following: "or does not meet any applicable requirement of subsection (a) (4), (b), or (c) of section 1527 of the Public Health Service Act".

(4) Subsection (d) (1) of such section 1122 is amended by striking out "any amount" in the matter following subparagraph (B) of the first sentence of such section and inserting in lieu thereof "an amount equal to ten times any amount".

(b) The amendments made by subsection (a) shall apply with respect to capital expenditures made after September 30, 1977.

SEC. 203. (a) Section 103 of the Internal Revenue Code of 1954 (relating to exclusion from gross income of

interest on certain governmental obligations) is amended by redesignating subsection (f) as subsection (g), and by inserting after subsection (e) the following new subsection:

"(f) OBLIGATIONS SUPPORTING INCREASES IN ACUTE CARE HOSPITAL BEDS.—Any obligation issued by a State or territory for an institutional health service, health care facility, or health maintenance organization—

"(1) the development of which would result in a number of hospital beds within a health service area which number is in excess of the applicable supply ceiling for such area promulgated under section 1504(b)(1)(A) of the Public Health Service Act, or

"(2) for which a certificate of need has not been issued under a certificate of need program approved under title XV of the Public Health Service Act,

shall be treated as an obligation not described in subsection (a)(1).".

(b) The amendments made by subsection (a) shall apply with respect to taxable years beginning after the date of the enactment of this Act.

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

JUN 2 1977

Honorable Harley O. Staggers
Chairman, Committee on Interstate
and Foreign Commerce
House of Representatives
Washington, D. C. 20515

Dear Mr. Chairman:

This is in response to your request of May 6, 1977 for the views of this Office on H.R. 6575, a bill entitled the "Hospital Cost Containment Act of 1977."

H.R. 6575 is identical to legislation submitted by the President to the Congress on April 25, 1977. The bill is a major Administration initiative to hold down the growth of the most significant component of health cost increases--rising hospital expenditures. It is designed to limit increases in the reimbursements which hospitals receive from all sources: Medicare, Medicaid, Blue Cross, commercial insurers, and individuals. Based on current trends, the limit for fiscal year 1978 will be approximately nine percent.

In his message to Congress on April 25, 1977, the President urged enactment of the proposed Hospital Cost Containment Act of 1977 as an important step in bringing soaring medical costs under control. For the reasons stated by the President, we recommend that the Committee give favorable consideration to the bill. Enactment of H.R. 6575 would be in accord with the program of the President.

Sincerely,

(Signed) James M. Frey

James M. Frey
Assistant Director for
Legislative Reference

Mr. ROGERS. Today the subcommittee will receive testimony from several organizations which have timely and knowledgeable perspectives. Because we have severely limited time for the hearings, the number of witnesses invited has been restricted. I hope that other persons and organizations will submit written testimony so that the subcommittee may benefit from their knowledge and expertise.

Our first witnesses this morning are Dr. Karen Davis, who is Deputy Assistant Secretary for Health Planning and Evaluation, and Mr. Grant Spaeth, Deputy Assistant Secretary for Legislation (Health), Department of Health, Education, and Welfare. I believe Dr. Ronald M. Klar and Mr. Robert P. O'Connor are here also.

We welcome you to the committee and are pleased to have your testimony.

STATEMENT OF KAREN DAVIS, PH.D., DEPUTY ASSISTANT SECRETARY FOR HEALTH PLANNING & EVALUATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY GRANT SPAETH, DEPUTY ASSISTANT SECRETARY FOR LEGISLATION (HEALTH); ROBERT P. O'CONNOR, ACTING ASSISTANT ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION; AND RONALD M. KLAR, M.D., ACTING DIRECTOR, OFFICE OF POLICY DEVELOPMENT AND PLANNING, OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

Dr. DAVIS. I would like to have my statement entered into the record.

Mr. ROGERS. Without objection, it will be made a part of the record [see p. 107].

Dr. DAVIS. We particularly appreciate the leadership role you have played in the development and continued refinement of H.R. 6575 the Hospital Cost Containment Act of 1977. Your staff has been particularly helpful to us in going over H.R. 8121 very carefully and pointing out areas where there was need for substantial changes and improvement. We feel the result will be a stronger, more effective cost containment bill.

It is a pleasure to appear before you today to offer the Department's comments on H.R. 8121, which includes several additions to the Hospital Cost Containment Act of 1977.

We all share your deep concern that a workable, equitable way of dealing with rapidly inflating hospital costs depends on modifications of the reimbursement system to encourage hospitals to operate more efficiently, to halt the duplication of costly technology and facilities, and to substitute less costly ambulatory care for inpatient care. Further, we all recognize the important role of health planning in reducing the pressures for ever-increasing numbers of facilities and services while existing facilities and services remain underutilized.

Mr. Chairman, what we are discussing here today are additions to an emergency cost containment program which must be established to buy time while more permanent solutions are developed and implemented.

As we developed H.R. 6575 we examined a large number of proposals that ultimately were not included. Many of these represented good ideas, but could not be implemented quickly or without a major administrative burden. They would require more time to refine, and would destroy the simplicity that is an absolute necessity in such an emergency program. However, in a cooperative spirit, I would like to comment on the specific new provisions of H.R. 8121.

H.R. 8121 provides that a hospital may apply for an incentive payment if during an accounting year covered by the program its increase in cost per inpatient admission is less than the inpatient hospital revenue increase limit. These incentive payments are intended to be used to reduce deficits in the hospital's outpatient department. However, I am not convinced that this provision will achieve your objective. While I agree that it might be a good idea to allow cost reimbursers to offer an incentive payment to hospitals that do not spend their full allowance—since normally only actual costs are reimbursed—H.R. 8121 also extends that provision to charge payers. In effect, if a hospital keeps its cost increases below its charge increases, it gets a double profit. First, it is allowed to keep all the surplus charges it has generated. Second, H.R. 8121 provides an additional profit of up to one-third of the first surplus. Thus, if this were to be done, it would be preferable to restrict the incentive to cost payers.

There are also a number of administrative issues which would have to be addressed. For example, the term "cost" per admission as applied to charge payers would have to be defined carefully enough so that a new reporting system is not required for this incentive program. Further, a new mechanism would be required to assure that hospitals continue to attempt to collect outpatient receivables, rather than calling them all bad debts. A definition would be required to determine when accounts receivable in the outpatient departments become operating deficits or bad debts. There would also be administrative complications created by the requirement that hospitals that have received funds under the Hill-Burton program must provide some free care. This free care would have to be deducted from the outpatient deficits to which the incentive payments could apply.

Mr. Chairman, I believe that the provisions of H.R. 6575 are already adequate to deal with the need for positive incentives, even in this transitional program. First, by limiting increases in total revenues, hospitals are encouraged to reduce patient loads in order to maximize the increase in revenues available for the remaining patients. Second, by limiting the constraints only to revenues from inpatient services we encourage hospitals to shift patients to outpatient settings. Third, hospitals that eliminate unneeded services may keep the allowable revenues in the base—any savings may be redirected into improvements in other patients services. Finally, a hospital is allowed to carry forward any unused portions of its allowance—the first major departure from the spend more, get more atmosphere fostered by retrospective cost reimbursement.

The purchase of major medical equipment by physicians and other non-hospital providers not now subject to Certificate of Need

(CON) is an increasing problem. The establishment of a limit on the value of new CON's awarded to hospitals will likely exacerbate the situation. This problem will clearly need to be addressed in the near future.

Unfortunately, we do not believe this legislation is the best vehicle for such consideration since a number of complex issues are involved. We would prefer to postpone such analysis until amendments to the planning act are taken up in the coming months. These issues include: definition of medical equipment, the value of equipment to be reviewed, and sanctions.

The final point is especially difficult. A State CON program can deal effectively with the problem of unapproved equipment through its licensure authority. The time necessary for every State to enact and implement such a law would likely, however, be extensive. On the other hand, applying reimbursement penalties to ambulatory services under the section 1122 program would leave Medicare beneficiaries unprotected since physicians can bill them directly regardless of program reimbursement. Therefore, your proposal to apply sanctions to manufacturers who sell equipment to providers who do not have a CON is interesting and worthy of consideration.

It is clear that there are many excess hospital beds in the Nation today. The overall national ratio of 4.5 beds per thousand population is much too high. Correspondingly, the 75 percent average occupancy rate is too low. As H.R. 6575 suggests, 4.0 beds per thousand and an 80 percent occupancy level would be a reasonable goal for the system to attain in the near future. Even fewer beds and higher occupancy rates can be achieved later on.

In addition to too many beds, it is clear that too many hospitals offer and maintain certain specialty services. Obstetrics, pediatrics, open-heart surgery, and coronary care units are examples of services which are in excess supply. In many communities consolidation of the services into fewer, larger units would not only result in more efficient provision of services but would improve quality as well.

While H.R. 6575 would stop new investment in excess beds or duplicative equipment, in the future it may be necessary to take other measures to close or consolidate units. The carrot-and-stick approach proposed in your bill—grants for hospitals, national guidelines followed by sanctions, and reduced reimbursement for hospitals in areas of excess supply—is one possible avenue for achieving this change. Other approaches also merit exploration.

We particularly support your position that national guidelines are necessary to help States and HSA's identify excess hospital capacity. In H.R. 6575, States are prohibited from approving projects which add to the bed supply in areas with more than 4.0 beds per thousand population or less than 80 percent occupancy rate. The Department is also planning to issue further guidelines under section 1501 of the Public Health Service Act in September. We expect that these guidelines will assist States and HSA's to identify services which are in excess supply.

At this time, however, we would point out that the actual operation of a program of this sort would be very complex. In order to be fair to the various hospitals and communities involved and to

prevent fraud, a variety of specific legislative provisions and administrative activities would need to be enacted and instituted.

We do not believe that such detailed provisions can be put into place in the context of the transitional legislation which is being considered by the committee at this time. We believe that it would be more appropriate for these sorts of programs to be developed and included as part of future legislation, such as the amendments to the planning act or national health insurance, which will be considered by the committee in the coming months.

We estimate our bill would save $607 million. We urgently need these savings in order to expand initiatives in the ambulatory and preventive care area.

Thank you very much, Mr. Chairman.

[Testimony resumes on p. 116.]

[Dr. Davis' prepared statement follows:]

STATEMENT OF KAREN DAVIS, Ph.D., DEPUTY ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Thank you Mr. Chairman. It is a pleasure to appear before you today to offer the Department's comments on H.R. 8121, which includes several additions to the Hospital Cost Containment Act of 1977. I recall that in introducing H.R. 6575 you stated your hope that the proposal would focus and intensify the dialogue on the problems of increasing health costs, particularly in the area of hospital care. We all share your deep concern that a workable, equitable way of dealing with rapidly inflating hospital costs depends on modifications of the reimbursement system to encourage hospitals to operate more efficiently, to halt the duplication of costly technology and facilities, and to substitute less-costly ambulatory care for inpatient care. Further, we all recognize the important role of health planning to reduce the pressures for ever-increasing numbers of facilities and services that remain underutilized.

H.R. 6575 includes a number of provisions designed as a first, transitional step toward these many needed modifications of the reimbursement system. We have stated our intention, and have already begun, to discuss with a large number of individuals and groups their ideas for longer term, more permanent reforms. I should also point out, Mr. Chairman, that in the Secretary's testimony before your subcommittee in May he encouraged careful analysis of our proposal by all interested parties to see if any further short-term steps could be included without sacrificing

the basic goals of our program. Therefore, I want to applaud your continued leadership role in proposing the additions to our bill embodied in H.R. 8121.

Mr. Chairman, what we are discussing here today are additions to an emergency cost containment program which must be established to buy time while more permanent solutions are developed and implemented. As we developed H.R. 6575 we examined a large number of proposals that ultimately were not included. Many of these represented good ideas, but which could not be implemented quickly or without a major administrative burden. They would require more time to refine, and would destroy the simplicity that is an absolute necessity in such an emergency program. However, in a cooperative spirit, I would like to comment on the specific new provisions of H.R. 8121.

Incentives for Good Performance by Hospitals in Containing Cost Increases

H.R. 8121 provides that a hospital may apply for an incentive payment if, during an accounting year covered by the program its increase in cost per inpatient admission is less than the inpatient hospital revenue increase limit. These incentive payments are intended to be used to reduce deficits in the hospital's outpatient department. I support your desire to find positive incentives to encourage good performance by hospitals.

However, I am not convinced that this provision will achieve your objective. While I agree that it might be a good idea to allow cost reimbursers to offer an incentive payment to hospitals that do not spend their full allowance (since normally only actual costs are reimbursed), H.R. 8121 also extends that provision to charge payers as well. In effect, if a hospital keeps it cost increases below its charge increases it gets a double profit. First, it is allowed to keep all the surplus charges it has generated. Second, H.R. 8121 provides an additional profit of up to one-third of the first surplus. Thus if this were to be done, it would be preferable to restrict the "incentive" to cost payers only.

There are also a number of administrative issues which would have to be addressed. For example, the term "cost" per admission as applied to charge payers would have to be defined carefully enough so that a new reporting system is not required for this incentive program. Further, a new mechanism would be required to assure that hospitals continue to attempt to collect outpatient receivables, rather than calling them all bad debts. A definition would be required to determine when accounts receivable in the outpatient departments become operating deficits or bad debts. There would also be administrative complications created by the requirement that hospitals that have received funds under the Hill-Burton program must provide

some free care. This free care would have to deducted from the outpatient deficits to which the incentive payments could apply.

Mr. Chairman, I believe that provisions of H.R. 6575 are already adequate to deal with the need for positive incentives, even in this transitional program. First, by limiting increases in total revenues, hospitals are encouraged to reduce patient loads in order to maximize the increase in revenues available for remaining patients. Second, by limiting constraints to revenues from inpatient services we encourage hospitals to shift patients to outpatient settings. Third, hospitals that eliminate unneeded services may keep the allowable revenues in the base -- any savings may be redirected into improvements in other patients services. Finally, a hospital is allowed to carry forward any unused portions of its allowance--the first major departure from the spend more, get more atmosphere fostered by retrospective cost reimbursement.

Extension of capital expenditure review to ambulatory settings. The purchase of major medical equipment by physicians and other non-hospital providers not now subject to Certificate of Need (CON) is an increasing problem. The establishment of a limit on the value of new CONs awarded to hospitals will likely exacerbate the situation. This problem will clearly need to be addressed

in the near future.

Unfortunately, we do not believe this legislation is the best vehicle for such consideration since a number of complex issues are involved. We would prefer to postpone such analysis until amendments to the planning act are taken up in the coming months. These issues include:

- o Definition of medical equipment
- o The value of equipment to be reviewed
- o Sanctions

The final point is especially difficult. A state CON program can deal effectively with the problem of unapproved equipment through its licensure authority. The time necessary for every state to enact and implement such a law would likely, however, be extensive. On the other hand, applying reimbursement penalties to ambulatory services under the Section 1122 program would leave Medicare beneficiaries unprotected since physicians can bill them directly regardless of program reimbursement. Therefore, your proposal to apply sanctions to manufacturers who sell equipment to providers who do not have a CON is interesting and worthy of consideration.

Program to Encourage the Closure of Unneeded Hospital Beds and Services

It is clear that there are many excess hospital beds in the nation today. The overall national ratio of 4.5 beds per thousand population is much too high. Correspondingly, the 75% average occupancy rate is too low. As H.R. 6575 suggests, 4.0 beds per thousand and an 80% occupancy level would be a reasonable goal for the system to attain in the near future. Even fewer beds and higher occupancy rates can be achieved later on.

In addition to too many beds, it is clear that too many hospitals offer and maintain certain specialty services. Obstetrics, pediatrics, open-heart surgery, and coronary care units are examples of services which are in excess supply. In many communities consolidation of the services into fewer, larger units would not only result in more efficient provision of services but would improve quality as well.

While H.R. 6575 would stop new investment in excess beds or duplicative equipment it may be necessary to take other measures in the future to close or consolidate units. The carrot-and-stick approach proposed in your bill -- grants for hospitals, national guidelines followed by sanctions, and reduced reimbursement for hospitals in areas of excess supply -- is one possible

avenue for achieving this change. Other approaches also merit exploration.

We particularly support your position that national guidelines are necessary to help states and HSAs identify excess hospital capacity. In H.R. 6575, states are prohibited from approving projects which add to the bed supply in areas with more than 4.0 beds per thousand population or less than 80% occupancy rate. The Department is also planning to issue further guidelines under Section 1501 of the Public Health Service Act in September. We expect that these guidelines will assist states and HSAs to identify services which are in excess supply.

Financial payments to close individual hospitals also could further desired objectives. Hospitals which are closed completely could benefit from assistance in paying off residue liabilities, to provide severance pay, retraining or placement services for their employees. Hospitals might also be induced to close unnecessary units with some supplemental support to convert useful space to other purposes.

At this time, however, we would point out that the actual operation of a program of this sort would be very complex. In order to be fair to the various hospitals and communities involved and to prevent fraud, a variety of specific legislative provisions and administrative activities would need to be enacted and instituted.

We do not believe that such detailed provisions can be put into place in the context of the transitional legislation which is being considered by the Committee at this time. We believe that it would be more appropriate for these sorts of programs to be developed and included as part of legislation, such as the amendments to the planning act or national health insurance, which will be considered by the Committee in the coming months.

Community Reimbursement Penalty

H.R. 8121 provided that if the hospitals in any HSA area are not in compliance with the Federal guidelines on capacity by the end of the four year program established by the Act, each hospital in the area would be subject to a five percent reduction in reimbursements from programs under Titles XVIII, XIX and V of the Social Security Act. I believe that States and local communities must feel a sense of urgency to meet Federal guidelines, but I am not sure that this provision would be the best way to achieve the desired end. I agree that some real sanctions ought to be developed, but I am not sure reduction of reimbursements to all hospitals in an area under Federal programs would be completely fair. Further, the criteria under which the Secretary may grant an extension of the time allowed for compliance as they are now written are so loose as to make it almost impossible for the Secretary to deny any such requests.

I believe we should examine this program further in the coming months in the context of the amendments of P.L. 93-641.

In summary, let me reiterate that I believe that the Hospital Cost Containment Act of 1977, H.R. 6575, is the best alternative, under present circumstances, to the continued escalation of unnecessary hospital costs. Your proposals, Mr. Chairman, as presented in H.R. 8121 represent positive steps that have much long-run potential. However, as I have illustrated throughout my testimony, such proposals often raise more questions than they resolve. In some circumstances, and I believe this is one, we simply do not have the time to refine proposals to ensure that they have the desired effect and preserve administrative simplicity.

The Department is committed to working with you and your staff in any way possible to refine your proposals and clarify all the administrative issues that have been raised and to improve the workability of the Hospital Cost Containment Act. We support the efforts you have made thus far and hope that we may be of assistance to you as the legislative process continues. However, hospital costs continue to increase at a rate of $20 million each day. Therefore, I must urge that the Congress quickly pass H.R. 6575, the Hospital Cost Containment Act of 1977 as originally proposed, as the first and desperately needed step in devising a permanent solution to the critical national problem of controlling rising health costs.

Mr. ROGERS. Thank you very much, Miss Davis.

Dr. Carter.

Mr. CARTER. Thank you, sir.

Do you really think that your present legislation is adequate and will be effective in cost containment without damage to hospitals in rural areas?

Dr. DAVIS. Dr. Carter, I know you are very familiar with rural areas. In visitng your State and other States in the South, I found the most pressing need is for better ambulatory care. We feel that this program is an effective program, will limit the rate of hospital cost inflation and will divert some very much needed resources so we can afford primary care initiatives in rural areas.

Mr. CARTER. As a physician, suppose you had a very ill patient; would you want him in the hospital or would you want to treat him as an ambulatory patient and risk the liability of sudden death and suit for malpractice?

Dr. DAVIS. Dr. Carter, there is no question that a very ill patient should be admitted to a hospital. What we have identified through various studies, up to 10 to 15 percent of all patients who are currently treated in hospitals could well be treated outside of the hospital setting if adequate ambulatory care facilities were available.

Mr. CARTER. If adequate ambulatory care facilities were available?

Dr. DAVIS. Ambulatory care.

Mr. CARTER. Lack of ambulatory care is a problem. Providing more of it is devoutly to be wished. How extensive is the problem of outpatient department deficits?

Dr. DAVIS. I would like to call on Bob O'Connor with the Health Care Financing Administration to address that problem.

Mr. O'CONNOR. I think the outpatient deficit problem is very serious.

Mr. CARTER. Sir?

Mr. O'CONNOR. The outpatient deficits are a serious problem.

Mr. CARTER. You do not know how extensive they are; you just know they are a serious problem?

Mr. O'CONNOR. We could provide that information for the record.

Mr. CARTER. I think that would be helpful.

[The following information was received for the record:]

OUTPATIENT BAD DEBT FACTOR

STUDY BY CONSTANCE HIRSCHMAN AND MICHAEL FITZMAURICE, MARCH 1977

Issue: What is the potential cost of assuming community hospital outpatient bad debts?

General Findings:

Outpatient cost data are very difficult to obtain and of unreliable quality; there is no bad debt line item in AHA data.

In 1975, inpatient and outpatient "total Bad Debts, Charity, Contractual Arrangements and so forth" amounted to $2.3 billion for all community hospitals.

In 1975, outpatent "Bad debts, charity, contractual arrangements and so forth" amounted to $1.8 billion or 78 percent of total inpatient and outpatient bad debts, etc.

Of this $1.8 billion, approximately $500 million is attributable solely to outpatient bad debts.

Source of Data: AHA Guide Issue and AHA Office of Research; K. Davis, *Community Hospitals 1962-1966.*

Policy Implications: It would cost approximately $500 million to assume community hospitals' outpatient bad debts. However, if Government were to assume these debts, community hospitals would undoubtedly improve their reporting sophistication to document higher bad debt levels.

LANGUAGE TO RESTRICT OUTPATIENT DEFICIT TO AMOUNTS ACTUALLY UNCOLLECTABLE

(c) In order to qualify for the incentive payment provided under this section the hospital must establish to the satisfaction of the Secretary—

(1) that it made reasonable efforts to collect all revenues due for the provision of outpatient services and

(2) that any uncollected amounts are in fact uncollectable and that there is no substantial likelihood of future collection.

Mr. CARTER. How many hospitals would you estimate would actually be eligible for an incentive payment as proposed by this legislation?

Dr. DAVIS. We can provide that information for the record. We do have a distribution of the number of hospitals who are keeping their costs increases below 9 percent. About 22 percent of all hospitals keep their cost increases below 9 percent and we could give you detailed information on that.

[The following information was received for the record:]

NUMBER OF HOSPITALS ELIGIBLE FOR AN INCENTIVE PAYMENT

The number of community hospitals potentially eligible for an incentive payment in accordance with sections 141 and 142 of H.R. 6575, as amended, could be as high as 1,423. This was the number of such hospitals experiencing increases in total operating expenses of less than nine percent for 1974-75. This figure is derived from American Hospital Association data for 1974 and 1975. The figure for 1975-1976 will be provided as soon as possible after the necessary data becomes available.

Mr. CARTER. Do you not think it is conceivable needed hospital facilities might be closed if we provide deficit payments or incentive payments to hospitals which close facilities or discontinue services before the planning process has matured and complete health systems plans have been developed?

Dr. DAVIS. Dr. Carter, we would not support closure of any facility unless it had the approval of local and State health planning departments. Perhaps Dr. Klar, of the Office of the Assistant Secretary for Health, would like to comment.

Dr. KLAR. Just one comment may be helpful. As you recall, in writing the bill we clearly recognized that there is an interrelationship between facilities in any given area. The Department would be concerned if any one facility because of financial or other reasons, would make a decision that would adversely affect other facilities and the overall ability to provide the care in the area. It is in that context that we hope, with the development of the health systems agencies and the guidelines to the departments, to be able to look at the closure of facilities in the context of what closure would do to the health care delivery in the entire area.

Mr. CARTER. How often has major medical equipment costing over $150,000 actually been installed in physician's offices? Do you have statistics on this?

Dr. DAVIS. The major type of equipment which would be affected by this provision we feel is the new computerized axial tomography, the so-called CAT scanner.

Mr. CARTER. Computerized axial tomography?

Dr. DAVIS. This is fairly new equipment, as I am sure you know.

Mr. CARTER. It is a beautiful piece of equipment but I don't think many doctors can afford it or would attempt to have it. Do you know if any doctor in the United States has it in his office?

Dr. DAVIS. If we do have figures on that, we will provide that information for the record.

Mr. CARTER. You know that private physicians do have this in their offices?

Dr. DAVIS. Yes. Typically these are radiology groups.

Mr. CARTER. But not single physicians as a usual thing?

Dr. DAVIS. As a rule, that is correct.

Mr. CARTER. Of course, in your legislation you have a 2 percent leeway for volume increases by, above that 2 percent, up to a 15-percent increase in patients, those patients would be paid for at only half the rate of the other patients. Is that correct?

Dr. DAVIS. That is correct. Studies have shown as a hospital expands its patient load there are certain fixed costs that do not increase, various overhead items, and even to a certain extent staffing do not increase significantly. Adding one more patient really does not increase the hospital's costs.

Mr. CARTER. How much do you think each vacant bed costs a hospital per year?

Dr. DAVIS. Our estimates are that the additional costs of treating an additional patient runs about 50 percent of the full costs. With regard to the excess beds, our estimates are it runs to $10,000 to $20,000 a year per bed.

Mr. CARTER. It would cost about 50 percent of what a filled bed would cost; is that correct?

Dr. DAVIS. That is right.

Mr. CARTER. I have another question. Using your own words, the Breckenridge Hospital is in the district I represent, in Wendover, Kentucky. Last year the increase in patient load was 26 percent, while this year they have projected it to be at least 20 percent. According to your legislation, 13 percent of those patients will be above the 2 percent leeway for volume increases; and therefore 13 percent will be paid for at only half the rate of other patients; is that not correct?

Dr. DAVIS. I did have the privilege of visiting the Breckenridge Hospital. It is a new hospital and I think one of the reasons it is continuing to experience an expansion is that it is a brand new facility. We do have separate provisions in our bill for new facilities because we understand as you open up a new facility——

Mr. CARTER. It has been open for 2 or 3 years now. I do not see those special provisions. It seems to me you have to get from HEW an exemption at that time. Let's look at the situation when a hospital is above the 15 percent we are talking about. If they increase admissions 20 percent, they receive nothing for the 5 percent above the 15-percent limit; is that not correct?

Dr. DAVIS. A smaller hospital, such as the Breckenridge Hospital gets the 50 percent forever.

Mr. CARTER. I have not read that in your legislation. It may be there. In what section of the bill is that particular part?

Dr. DAVIS. Section 113.

Mr. CARTER. It seems there is a little bit of an anomaly in that you state that a vacant bed costs one-half as much as a filled bed. Yet if the admission that fills the bed increases volume above the 2-percent leeway, up to 15 percent, the hospital receives only half the cost of each patient. The extra cost would be difficult to absorb. For the 5 percent above the 15-percent level you would get nothing for those patients. That would be very, very difficult for many of the hospitals to comply with. I think you would be really impressing them.

Of course, you would have a non-supervisional wage pass-through but we know that it will only be a floor as there will be a ripple effect in every one of the groups who work in a hospital. Increasing wages for the other people employed in the hospital is not accounted for in the proposed legislation. You make no effort to take care of the payment of these people, do you?

Dr. DAVIS. Let me make a couple of comments. First of all, the wage pass-through would apply not only to those workers at the minimum wage but to all non-supervisory employees, so that would cover about 87 percent of the workforce.

Second, about the 15-percent increase in admissions we have two ways of dealing with that. If it is a small hospital, fewer than 4,000 admissions per year, which works out to be about 100 beds, they get the 50 percent forever.

Mr. CARTER. That is still a penalty, though, is it not?

Dr. DAVIS. Our studies show that 50 percent approximates the percentage of total operating expenses represented by variable costs.

Mr. CARTER. Again, it does not cost any more to treat an additional patient, but yet your vacant bed costs you $10,000 to $20,000 a year. You know those things do not go together.

Thank you, Mr. Chairman.

Mr. ROGERS. Mr. Walgren.

Mr. WALGREN. I have no questions at this time.

Mr. ROGERS. I have a few questions here. First of all, have guidelines been issued pusuant to the Health Planning Act yet?

Dr. DAVIS. Mr. Chairman, those have not been issued yet. The Department has indicated it is planning to issue those guidelines in September and is working very hard to get those ready.

Mr. ROGERS. I realize you are new, but they should have been a year ago and perhaps that has given rise to some of the problems which we are now trying to solve with this legislation.

Dr. DAVIS. Yes, Mr. Chairman. We are very concerned about that.

Mr. ROGERS. I think getting those guidelines out may be as important to holding down costs and planning for the future as this bill itself, because our health planning agencies simply have no guidelines from us at all, although they were supposed to be issued a year ago.

Mr. CARTER. I want to say this. I am for cost containment. Do not get me wrong. We will have legislation to obtain that purpose. But I certainly feel that we must integrate, as you said, different hospitals and have them use shared facilities as much as possible. I think that will be extremely helpful. With that portion of your bill I certainly agree.

As far as I am concerned, I support the concept.

Dr. DAVIS. I think Dr. Klar can give us more information on the guidelines.

Dr. KLAR. I was going to add that the drafts of the guidelines have been circulating for many months, as you are aware. The Department has not stopped considering the comments that have continued to come in while revising the guidelines that are now under consideration. One of the issues being discussed right now is what role the National Council would be playing prior to the issuance of those guidelines.

Second, you are aware that regulations related to certificate of need have been issued and there is guidance in that related to the Department's intent.

Finally, the Bureau of Health Planning has continued to provide both technical assistance and meet with the health systems agencies and the State agencies, in order to make sure that the program is still moving forward, while waiting for the final issuance of those guidelines.

Mr. ROGERS. The point I am making is we should have issued those a year ago, which would have helped in planning, which would help in solving these problems, certainly.

Dr. KLAR. The Secretary and Under Secretary recognize the significance of those guidelines and have asked for a total reassessment, and the reassessed guidelines are about ready to be issued.

Mr. ROGERS. Would you let us know when they will be issued and what they will contain? The committee will be very interested in knowing.

Dr. KLAR. Certainly.

[The following statement was received for the record:]

In 1976 a preliminary draft of the National Guidelines for Health Planning was prepared by the Health Resources Administration and distributed for review and comment. The Department has now revised the Guidelines and expects to publish them as a Notice of Proposed Rulemaking in the *Federal Register* in September. The revised Guidelines provide specific standards which are designed to impact on both cost containment and quality of care. Later iterations of the Guidelines will outline general health goals as well as standards for resource development.

A 60 day period will be provided for comment by the public. The Guidelines will be presented to the National Council on Health Planning at their first meeting on September 23 for its review and comment. It is anticipated that various medical experts and health planners will be invited to participate in the review of the specific medical standards contained in the revised Guidelines during the 60 day comment period.

Mr. ROGERS. What about slow reimbursement from the Federal Government? Some of them say the reason they are concerned about this problem is they do not get reimbursement from the Federal Government in time. What could we do? Should we try to put some time limits in the law? Should we try to have a study on this? How should we begin to address that problem? It is a serious problem, is it not?

Mr. O'CONNOR. I do not think there is really a basis for that. In most situations the Medicare intermediary is reimbursing hospitals on an interim basis, very often weekly, as costs are incurred throughout the year.

Mr. ROGERS. You do not think there is a lag?

Mr. O'CONNOR. Where there have been substantial problems of lag, I believe they are more usually related to the particular hospital's billing practices rather than the intermediary's reimbursement practice.

Mr. ROGERS. That is not the information I have. I have, for instance, information that Blue Cross in Florida owed a hospital $117,000 for some months and they were having to carry it.

Mr. O'CONNOR. I do not know of the situation to which you are referring to. It may be a situation involving a controversy over some amount. Very often the intermediary and the hospital are in disagreement.

Mr. ROGERS. I do not think there was any disagreement on that. I understand there can be disagreements. Also there can be excuses for non-payment to bring up a disagreement, but I keep getting inquiries on why hospitals do not get more prompt payment, and I think maybe we should have a study on that. We might put that in the bill.

Mr. O'CONNOR. We would be very happy to look into the situation that has been called to your attention and give you a report on it, sir.

Mr. ROGERS. I think that would be helpful.

Is there any way of getting any paperless billing system, in other words, to use a credit system of some type to provide prompt payment and then balance it off?

Mr. O'CONNOR. This is how it operates now. We have had a system of periodic interim payment, for example, that provides an option to the hospital whereby the interim payment is not directly related to the billing but rather paid at regular intervals throughout the year. Each year more and more hospitals have shifted to that method because they find it gives them a steady, more predictable flow of income.

Mr. ROGERS. What are we doing to encourage hospitals to share in the areas of computer buying and equipment?

Dr. DAVIS. Mr. Chairman, I think our proposal would give hospitals an incentive to share with regard to equipment, computers and other types of specialized facilities. Perhaps Dr. Klar would like to add some information on that.

Mr. ROGERS. All right.

Dr. KLAR. With regard to the proposal, there is the incentive for an individual hospital administrator, where he perceives an underutilized service, to discontinue that service and possibly rely on the services of other facilities in the community. At the same time, the current proposal does allow for that facility to keep the revenues that would have been generated by that service in its base to be used for the operation of other new or existing services.

I think, however, the Department probably would conclude that issues such as that are a part of the planning program. It is important for us to realize the Assistant Secretary for Health, who does have the responsibility for implementing the Planning Act, has only recently been confirmed. He and his Deputy, Dr. Lashof, have identified the planning program and the implementation of that act as one of their highest priorities that is being given very consider-

able attention. Over the next several months I think you will see quite a few issuances from the Department and the Public Health Service related to the issue of planning guidelines, sharing, and development of health resources.

Mr. ROGERS. You say the incentive is you give them all of the savings?

Dr. DAVIS. That is correct. If a hospital discontinues a service and has another hospital pick it up for them and that is approved by the local health systems agency, they get to retain that entire amount in their base under our program.

Mr. ROGERS. How does that really effect a savings?

Dr. DAVIS. The hospital would be permitted not only that amount but 9 percent on that amount in its overall allowable inpatient revenue limit.

Mr. ROGERS. I understand that, but how does that effect a savings if you are letting them have the same service but you are moving that service to another hospital or consolidating it? You are still going to pay the full amount in the base, then they get the 9 percent on top of that.

Dr. KLAR. That would allow the hospital administrator some room to develop additional services that he may not have been able to accomplish within his revenue limits.

Mr. ROGERS. Suppose he does not need any additional services?

Dr. KLAR. Then he need not spend the money this year and can carry it forward.

Mr. ROGERS. He will. Do you think he would not? I wonder if we should not try to work out a program where if they effect savings maybe they get one-half of those savings after a period of years, 2 or 3 or 4 years, particularly where they consolidate services or they share computer services. In other words, I am not sure we should give everybody the same amount for doing away with the service that they were going to eliminate anyhow.

Dr. DAVIS. I think the chairman has a very good point. We notice that you did delete that provision in H.R. 8121. I think we would be willing to look at that and perhaps reduce the amount.

Mr. ROGERS. I think they need some incentive but I am not sure a 100 percent effects any savings.

Dr. DAVIS. We would be willing to look at that.

Mr. ROGERS. We had that problem in the bill I had introduced too, in providing all of the savings as the incentive. Then you do not effect much of a saving.

Should we separate hospitals into categories? Should we say that those with 4,000 admissions should be exempt, or 2,000, or what? Or should there be any difference in categories?

Dr. DAVIS. Mr. Chairman, we found in looking at the data that hospitals of all types have been able to meet the 9 percent limit. In fact, a slightly higher fraction of the smaller hospitals have succeeded in doing that voluntarily, so we do not see a need to exempt certain categories of hospitals.

Mr. ROGERS. So you do not favor that?

Dr. DAVIS. That is correct.

Mr. ROGERS. You think they all should be treated alike?

Dr. DAVIS. It is our experience that the percentage increase in hospital costs did not differ by type of hospital. If you are looking at levels, that is a different matter but if you are talking about a percentage increase, that does not vary between large and small or teaching or non-teaching.

Mr. ROGERS. What should we do about all of the paperwork that a hospital goes through in all of the inspections? Why can we not consolidate those inspections? Is there any reason why we cannot? Can we not have Medicare, Medicaid, OSHA inspections all at once without continual duplication?

Mr. O'CONNOR. The recent administrative consolidation of Medicare and Medicaid under the new Health Care Financing Administration will give us an opportunity to move in that direction.

Mr. ROGERS. Move in that direction. Why should we not require it? Do you see any reason not to?

Mr. O'CONNOR. I think clearly the Department intends it.

Mr. ROGERS. Would you give us language that would help us set that forth? In fact, I think it would be helpful also to have some quick communication with States—they have an organization here, State Governors—to see what can be done by the States in consolidating inspections. It is just a needless cost as long as we have proper inspection to duplicate that inspection. The paperwork they say is unbelievable.

Dr. DAVIS. Mr. Chairman, we very much share your concern and the Health Care Financing Administration is taking steps administratively to try to achieve some of these simplifications. I think we can do much of this administratively if we can identify areas where additional legislation would be helpful.

Mr. ROGERS. If you can let us have something on that, that would be helpful, very much so.

[The following statement was received for the record:]

Consideration could be given to amending Title XI of the Social Security Act to include a section providing for coordinated audits—that is, if an entity provides services on a cost-related basis under titles V and XIX as well as under title XVIII, common audit procedures could be required.

Mr. ROGERS. As to whether we should extend the capital expenditure cap outside the hospital, it is my understanding you feel we probably should not extend the certificate of need on technology or equipment outside of a hospital?

Dr. DAVIS. Mr. Chairman, we can see the merit of extending certificate of need outside the hospital setting. I think as we put capital limits, dollar limits on the amount of new investment within the hospital there will be a tendency which—although Dr. Carter pointed out that it hasn't occurred extensively so far—would be a real danger in the future. Much of this duplicative equipment might be moved out of the hospital sector. We share your concern that this will happen and think action in this area is probably going to be needed. I think we would prefer, however, to look at that issue in the context of the health planning legislation that is coming up for renewal and address it more thoroughly at that time than we can do currently.

Mr. CARTER. Mr. Chairman, would the gentleman yield?

Mr. ROGERS. Yes.

Mr. CARTER. It was my pleasure not too long ago to visit a hospital in London and also its satellite clinics there. I was amazed to find that even in a 12-man clinic there was not even one microscope, nor was there an X-ray. They have to send their patients out for those services. My goodness, this might contain costs but it certainly would not in my opinion be good medicine.

Mr. ROGERS. I do not think anyone would not support having the equipment that is necessary. I would agree with the gentleman wholeheartedly. I think we do not want inefficiency.

Dr. DAVIS. Furthermore, we would favor, as you indicated in your bill, exempting equipment below $150,000 so that microscopes and other routine equipment that every physician's office should have would be automatically included.

Mr. CARTER. That is quite true. Very few physicians would want one item of equipment costing more than $150,000. As you say, usually only groups can afford a CAT scanner or other exotic equipment.

Mr. ROGERS. What I have heard is there have been some instances where a hospital is not given a certificate of need for a scanner so they lease a room out to a physician who then buys a scanner and puts it in the hospital under his right to purchase. Has that happened?

Dr. KLAR. There is some evidence of that. More commonly physicians, particularly radiologists who have privileges within a hospital, may open or have an office across the street or nearby the hospital and they place the scanner in that facility.

Mr. CARTER. I commend to you the relationship between St. Anthony's and Baptist Hospital in Louisville.

Mr. ROGERS. I think you are right. I do not know whether it is true or not but someone has told me that in one area psychiatrists are having all of their patients subjected to the CAT scanner and it is running up bills rather significantly.

Mr. CARTER. That may be true. I have not heard that, but just yesterday I did hear news of a case from a neurologist in Panama City your great State of Florida. One of his patients had had headaches for 12 years and the neurologist referred this patient to a facility which had a CAT scanner. They found a benign tumor which the patient had had for that entire length of time. I certainly do not think that they should be used indiscriminately, but it is certainly a wonderful item.

Mr. ROGERS. It is a great advance, I think, and we want to have adequate numbers of them and properly used but just not over-used.

Mr. CARTER. Yes.

Mr. ROGERS. Should there be any consideration of the Government taking over the responsibility of malpractice costs for hospitals?

Dr. DAVIS. Mr. Chairman, I know your committee has been very interested in this issue for some time. The Department is currently looking at this issue, trying to see whether there are needs in this area and would be happy to report back to you at a later date.

Mr. ROGERS. I think it would be helpful for us to know that.

What about public disclosure if a hospital is charging more for an allowed procedure or charging more than other hospitals of a like nature?

Dr. DAVIS. Mr. Chairman, we feel more information on charges would be of benefit to patients. As part of H.R. 6575 we have required that hospitals submit their cost reports and their charges on common services to the local health systems agencies. We would then require these agencies to publish semiannually comparisons of common charges and costs of all hospitals within their area. We feel this type of comparative information would be of great value to citizens.

Mr. ROGERS. What is the cost of labor in a hospital generally?

Dr. DAVIS. Payroll expenses, exclusive of fringe benefits, have been declining as a portion of hospital costs and currently run about 53 percent of all hospital expenses.

Mr. ROGERS. What is the rate of increase?

Dr. DAVIS. Payroll expenses have been going up much less rapidly than all expenses. I could get you the exact figures on that.

Mr. ROGERS. What about non-payroll expenses; have they been going up?

Dr. DAVIS. We would be happy to supply that, too.

[The following table was received for the record:]

Payroll, Non-Payroll, and Total Expense per Inpatient Day for Community Hospitals in 1975, and Percentage Increase over 1974

	Payroll Expense Per IPD*	Percent Change	Non-Payroll Expense Per IPD*	Percent Change	Total Expense Per IPD*	Percent Change
All Community Hospitals	70.93	14.7	62.88	21.6	133.81	17.8
By Type of Ownership						
Non-profit	71.34	14.9	62.02	20.7	133.36	17.5
Proprietary	57.76	14.1	75.04	28.9	132.80	22.0
Governmental	73.62	14.2	62.01	22.2	135.64	17.7
By Region						
New England	89.07	14.2	71.72	19.2	160.79	16.4
Mid-Atlantic	81.30	14.5	64.20	21.8	145.50	17.6
South Atlantic	62.83	13.9	60.24	24.7	123.07	18.9
East North Central	71.26	15.2	60.24	20.2	131.49	17.4
East South Central	51.11	12.4	50.40	20.3	101.52	16.2
West North Central	57.48	15.1	50.56	19.7	108.04	17.2
West South Central	58.52	17.1	57.57	22.8	116.08	19.9
Mountain	67.17	15.8	63.01	18.6	130.18	17.1
Pacific	88.65	14.7	88.21	23.9	176.87	19.1

*Inpatient Day

Source: Office of the Deputy Assistant Secretary for Planning & Evaluation/Health, Department of Health, Education, and Welfare.
All figures are derived from the 1975 and 1976 editions of Hospital Statistics, American Hospital Association.

Mr. ROGERS. No one here has any of those figures.

Mr. CARTER. Mr. Chairman, the Phase IV Economic Stabilization Program put a cap on hospital expenditures, as you know. When the program ended there was an immediate rise of about 15.2 percent for that year. I believe that is correct. But that was because it had been held down over a period of years.

Dr. DAVIS. Dr. Carter, between 1974 and 1975 payroll expenses went up 14 percent in all U.S. hospitals. Non-payroll expenses went up 23 percent. Overall, expenses went up 18 percent. That is total expenditures, not on a per-day basis.

Mr. CARTER. That was when the cap was lifted, is that correct?

Dr. DAVIS. That is correct.

Mr. ROGERS. Suppose that were included in the cap? I know you do not in your proposal. Suppose it were worked out on a regional basis so that for nonsupervisory labor you could in a region, State or area agree to a pass-through but not have it openended; would that be helpful?

Dr. DAVIS. I think we need some clarification of the proposal. We have done studies looking at the rate of increase of payroll and wage cost across regions, and again in this area we have found no significant difference in the rate of increase by regions of the country, whether it's urban or rural or Northwest or South Atlantic area. At this time we really don't see the need to complicate the provision further by allowing for regional variations in wage increases.

Mr. ROGERS. Here are the figures I have per patient day by region and hospital type.

In New England per patient day, $53.23. The adjusted figure is $49.79. That is for investor owned.

The not-for-profit rate is $90.27 or adjusted $78.33.

In the Middle Atlantic region, for the investor owned, $57 per patient day. $82.62 for the non-profit adjusted, $53 for the investor, $71 for the non-profit. This seems to be the pattern throughout almost without exception.

I would like to have you look at these figures and give us your comments.

Dr. DAVIS. Mr. Chairman, I believe what you are looking at are the levels of payroll expenses per patient day, not the rate of increase.

Mr. ROGERS. No, this is exactly what they are now. I presume it has been affected by the increase.

Dr. DAVIS. You would think that, but if you look at the percentage increases—and we will supply those for the record—you will find those didn't really differ by type of ownership.

What you are looking at there are the levels. However, we found that if you break them down by bed size you would find that the difference in levels by ownership disappears.

The investor owned hospitals tend to be smaller hospitals. If you compare investor owned hospitals with small non-profit hospitals, you won't find those distinction by even the absolute levels of cost. Nearly all of that difference is explained by the difference in the average size of the hospital by type of ownership.

Mr. ROGERS. Then should we make a difference in category, if there is a difference between the small and large?

Dr. DAVIS. Mr. Chairman, there is no question if you were dealing with levels of hospital costs you would have to go to a classification scheme. If we are talking about a limit on rates of increase, a percentage increase, then that does not differ significantly by type of hospital or by bed size. So if you are talking about a percentage increase you don't have to go to a classification system.

Mr. ROGERS. You take a hospital that is spending $49 per patient day vis-a-vis $78 and you put an increase of a certain amount, I would think the impact would be greater on the hospital which is charging less per patient than on the hospital that is charging more, wouldn't it?

Dr. DAVIS. Because we were concerned about the impact of the minimum wage, we did provide for this pass-through feature.

Mr. ROGERS. I understand. But I am saying still it's an increase and would have some effect, wouldn't it?

Mr. CARTER. Mr. Chairman?

Mr. ROGERS. Let me get an answer to that, if I may.

I think it would vary, would it not?

Dr. DAVIS. We haven't seen any indication of that on which to base a refinement.

Mr. ROGERS. I would like you to look at these figures and apply the minimum wage to them, and I would think it would be a difference in percentage.

Mr. CARTER. On that very thing, not just the payroll but the cost, really it's my feeling that you do penalize the more efficient hospitals. Actually, the lower their costs are, the less revenue they will receive under your 9-percent formula; the more expensive they are, the more revenue they will receive.

For instance, in Lancaster, Kentucky, we have a hospital which charges $60-per-day-per-patient, while the University of Kentucky Hospital, medical school hospital, charges about $200 per day. Nine percent of $60 is $5.40, and 9 percent of $200 is $18. Actually we are penalizing efficiency, are we not?

Dr. DAVIS. I think that is one of the complicating factors is what is that difference, is that really a difference in efficiency or are they treating a different kind of patient at the university hospital than they are at the small community hospital?

Mr. CARTER. This goes for any hospital, no matter where it is, large or small, the more their charge the more revenue your legislation allows them. It doesn't matter whether it's a university hospital, a municipal hospital, or a privately owned hospital. It's 9 percent any way you take it, isn't it?

Dr. DAVIS. Again, it comes back to the basic issue of looking at the levels versus looking at the percentage increases. There is just no question that in the long run you would want to go to a system that looked at levels, but before you can do that you have to have a way of differentiating your university hospital, the types of patients they see, and what is an appropriate cost for them versus that of a smaller community hospital.

Mr. CARTER. You are maintaining it is because it is a university hospital, and I say it applies to any hospital, university, municipal,

private or anything else. Nine percent is 9 percent. You charge $60 and you get, under this bill, a $5.40 increase. If you charge $200 you get $18.

Thank you, Mr. Chairman.

Mr. ROGERS. What about the problem of equipment which requires disposable supplies to keep them operating, and where the manufacturer specifies that to honor warranties on their products you have to use certain brands of disposables. I understand this is quite a large item in hospitals.

Five gallons of a solution used in laboratories from a certain manufacturer costs $17, but you can buy the same solution from another manufacturer for about $7 to $9. Has no thought been given to looking at the problem where they require, to make their warranty good for their equipment, that certain disposables be used?

Dr. KLAR. In some respects the example you are giving is a manifestation of the cost problem that this bill addresses. In the past a hospital could feel fairly certain that the costs it incurred would be reimbursed, and therefore there really was not the incentive to argue with say their distributor, to argue with the manufacturer or other people from whom they get their services and supplies, in order to keep those costs down. They were passing them forward.

Now, given the possibility of having an overall limit placed on their allowable revenues, a hospital administrator may start acting differently, and while I am not familiar with the legal ramifications of warranties and what effect they have on using other than the manufacturer's supplies, I would think there would be some pressure placed by that hospital administrator and others to make sure they do get the same supply and service delivered at less cost if at all possible.

An example of that has been used in the past is sterile water. Bottled water is clearly more costly than much of the sterilization equipment that hospitals in the past used to use for convenience, and since the cost was paid, they purchased it, and I am sure this is the case in many of the examples you use.

We would only hope that the effect of this proposal would be to put pressure on those manufacturers as well as the planners of the facility.

Mr. ROGERS. All right. Just a couple of questions and I will conclude.

How is it handled in a situation where the PSRO says a patient, after looking at the record, should be released from the hospital, but the doctor decides not to because the family has put the pressure on the doctor not to. Would Medicare or Medicaid reimburse?

Mr. O'CONNOR. If the service has been found unnecessary, Medicare and Medicaid could not reimburse.

Mr. ROGERS. So they do not reimburse what the hospital charges. Do they reimburse the doctor?

Mr. O'CONNOR. In most areas the PSRO's are presently dealing with hospital services and not with physician services.

Mr. ROGERS. But I am talking about the physician service keeping the patient there. Is the doctor reimbursed for any services deliv-

ered to that patient in the hospital for the period of time that the determination was made it was not necessary?

Mr. O'CONNOR. I think the question of whether the patient needs to be in the hospital, which is what the PSRO presently addresses, is a separable question from whether the physician services are necessary.

The physician services may well be necessary but not necessarily in a hospital.

Mr. ROGERS. Who keeps him in the hospital, the PRSO, the administrator?

Dr. KLAR. I might add that as much as possible the design of PSRO to be prospective in those kinds of cases is based on the standards published by the PSRO and the reviews that are done in the initial part of that admission, and a review at various intervals during the length of stay. Where there is a problem it's identified in advance.

Where an individual may be staying beyond the standards that were identified by a screen, there would be a look at that individual patient and the individual circumstances surrounding that admission, and a discussion with the admitting physician.

If upon review there is agreement that that patient does not belong in the hospital, I think at that time there would not be future Medicare or Medicaid aid payments made for it.

Mr. ROGERS. To whom?

Dr. KLAR. To the facility and to the physician.

Mr. ROGERS. You would not make it to the physician. I don't think that is true, is it?

Dr. KLAR. Subsequent to that finding by the PSRO, not at the time the review started.

Mr. ROGERS. But after the finding?

Dr. KLAR. That is correct.

Mr. ROGERS. Where the person may well have been out of the hospital by the time you review, right?

Dr. KLAR. In the screens that are done today, that is correct also.

Mr. ROGERS. What I am saying is you say for unnecessary service you penalize the hospital, but there is no like action for the person's doctor. Now, what I am asking is should there be?

Mr. O'CONNOR. Mr. Chairman, many physician services are disallowed every year as medically unnecessary either through the claims review process or through post review procedures.

Mr. ROGERS. But are you getting at the hospital problem where this bill is addressed? Are you doing it in that area?

Mr. O'CONNOR. At the present time we have the PSRO mechanism in most areas to look at the necessity of inpatient hospital services, at the same time we have the regular carriers mechanism to look at the necessity of physician services, submitting them to physician review boards where appropriate.

The long range design of the PSRO is, of course, to extend it beyond the hospital service.

Mr. ROGERS. You are saying no, you are not doing it now?

Mr. O'CONNOR. That is right.

Mr. CARTER. Mr. Chairman?

Mr. ROGERS. Yes, Dr. Carter.

Mr. CARTER. On that very thing, it has been 13 years since I practiced very much in the hospital, but there was a regulation then requiring that if a patient stayed as long as a week, I believe, we had to review the patient's record and see if it was justified. I served on such a board.

Mr. ROGERS. I was just wondering, I know they refuse payments after a certain time if there has been a determination in the hospital. I wondered if also it was the incentive of a like action for the physician whose patient is kept in that hospital?

Dr. DAVIS. Mr. Chairman, I think you have a very good point there, and if it's an unnecessary stay or an unnecessary extra day and the physician charge is attached to that, that is something we would want to look at and see we are not inexorably penalizing the hospital and then not directing it toward the physician.

Mr. ROGERS. If you would let us have your thinking on that.

[The following information was received for the record:]

DENIAL OF PAYMENT FOR PHYSICIAN SERVICES

Question: Do not PSRO's have responsibility for review of the medical necessity for hospital and physician services, and if so, why are the physician services still reimbursed when the facility is denied payment?

Answer. PSRO's do have responsibility for review of the medical necessity for hospital and physician services and, for that matter, for the range of health care services provided by or in institutions. PSRO's have primarily been involved in the review of the medical necessity for hospitalization. They are just now beginning to review ancillary services, and will soon be progressing into the review of physician services.

It is important to recognize, however, that while a hospital level of care may not be necessary, and thus not reimbursable by Medicare or Medicaid, many of the related physician services will often be needed even though they could be provided more appropriately in another setting.

Mr. ROGERS. I believe at page 3 of your testimony you indicate that the language defining cost and the outpatient deficit should be refined. Would you let us have your specific language within the next few days on that, please?

Dr. DAVIS. We will be happy to do that.

Mr. ROGERS. Mr. Preyer?

Mr. PREYER. Mr. Chairman, I have no questions at this time. I am just picking up speed.

Mr. ROGERS. All right, sir. Now let me just ask some questions for the record.

H.R. 8121 provides that any savings could accrue to the outpatient department. Now, many hospitals don't have outpatients. Should there be any indication of where those funds should go? Should they go to an emergency room or should there be no indication as to where those funds go, the incentive payment?

Dr. DAVIS. As I indicated during testimony, we do have some problems with the incentives. We think it is a double payment in the case of charge payers because hospitals could already keep the difference between their charges and their costs if they keep their costs under the 9-percent limit. We do think there are adequate incentives built into our bill, and there is no reason to have a double incentive in the case of those charge patients.

We would be happy to look at the cases of those hospitals that don't have outpatient departments.

Mr. SPAETH. Mr. Chairman, your question, however, was that if you are going to have incentives and there are no outpatient services, you are asking us to suggest alternate places where those funds might be placed consistent with our policies?

Mr. ROGERS. That is correct.

Mr. SPAETH. I don't know whether someone cares to answer that, but we will get that answer to you.

[The following statement was received for the record:]

It would be consistent with our policies to see that these funds are directed toward ambulatory care facilities.

Mr. ROGERS. That will be fine.

Would it be well to rely on the State porogram to approve or disapprove capital expenditures, and HEW simply accept those decisions?

Dr. DAVIS. The experience we have had to date with the health planning program indicates that unless we have some meaningful limits on the dollar value of investments, too many of those are just automatically approved. So we do have a rule for the State health planning agencies in title II of H.R. 6575, and I think that is an appropriate rule.

Mr. ROGERS. I think you state that the capital expenditure ceiling would encourage the purchase of expensive medical equipment in uncovered settings, and I would agree. I wonder should we really deal with that now if that is going to be the result of putting a capital ceiling on?

Dr. DAVIS. We feel this is an area that needs some work. We just don't feel at this time that we are ready to implement it in this bill. We prefer to do it in the renewal of the Health Planning Act.

Mr. ROGERS. By then maybe everyone will have already put in their purchase orders. Could that happen?

Dr. KLAR. It could.

Mr. ROGERS. I thought so.

In title III we require the Secretary to promulgate guidelines within 1 year of enactment for the appropriate supply and utilization of hospital services. Is that a realistic time frame?

Dr. KLAR. Overall guidelines on such things as beds, utilization, major equipment, I think you will see come out with the Department's guidelines this fall. I think the concern that many of us have is not how long it will take to get some of the guidelines out but how long is realistic for a health service area to be able to implement them.

I believe your proposal leaves them with 4 years after which all facilities in the area would be penalized, an amount of revenue would be taken away. The concern might be that individual hospitals may not have the capability of making the adjustment that the whole community will have to make in order to satisfy your provision.

I think over time we will be able to move in guidelines, and clearly over time those pressures will be translated into an area into more conscious planning.

Mr. ROGERS. In other words, you are saying the individual hospital should be looked at rather than applying the penalty to the

region or area. I think that makes sense, because if someone is operating efficiently they shouldn't have to pay a penalty because others aren't.

Thank you so much.

Mr. CARTER. Mr. Chairman, I have one or two questions here, if you please, sir.

Mr. ROGERS. Surely.

Mr. CARTER. What are we going to do about the ceiling on capital spending for national health resource centers, clinics such as Oxner, Josslyn or Mayo?

Dr. DAVIS. I think there are clinics that serve broader populations and not just those within their own State or contiguous States. We really should have some changes made in our title II to reflect the special needs of these kinds of clinics.

Mr. CARTER. That is not in your present bill?

Dr. DAVIS. That is not in the present bill. We would be willing to set aside a small portion of the $2.5 billion, perhaps 10 percent of that amount, to be allocated by the Secretary to special facilities serving a large number of patients beyond their immediate area.

Mr. CARTER. I believe 70 percent of Mayo's patients come from outside its health systems agency. Is that correct?

Dr. DAVIS. I understand that Mayo is one of those clinics.

Mr. CARTER. What have been the causes of increased costs of hospitalizations in the past few years? Why have they increased so tremendously, do you think?

Dr. DAVIS. I think you really have to go to the basic structure of this industry. What has happened since 1950 is a tremendous growth in third party reimbursements for hospital care, and, of course, since the mid 1960's, Federal programs such as Medicare and Medicaid have added to that. We now have a situation where over 90 percent of all of hospital revenues come from third parties. Because of this, hospitals realize that any expenditures they make they can recover from third parties, whether it's through cost reimbursement under Medicare, Medicaid or Blue Cross, or whether it's from charges that they assess to private insurance plans.

So knowing that there is an automatic pass-through of the costs, hospitals have responded to this incentive by upgrading the style of care, adding expensive technology, and haven't really been concerned with whether there are already adequate facilities in their area. This situation has led to much duplication of technology and beds.

Mr. CARTER. Medicare and Medicaid payments are based on the exact hospital cost; is that correct?

Dr. DAVIS. They are based on reasonable costs, yes, sir.

Mr. CARTER. On reasonable costs. You don't think then that actually the tremendous increase in medical technology has helped cause an increase in the cost of hospitalization?

For instance, a CAT scanner, which you mentioned, computerized axial tomography, coronary care, coronary catheterization, bypass surgery, open heart surgery and so on, all have been developed since 1950, as you well know.

You don't think that those technological improvements have caused increases in hospital costs particularly, intensive care units

for premature youngsters, which are saving many premature babies today at tremendous costs? Don't you think that all of these things combined have increased the costs?

Dr. DAVIS. I think you are right. They are very much intertwined. It's really a chicken and egg case, which comes first? I think the third party reimbursements have made it possible for the hospital to adopt this technology, and some of it has been very beneficial when it's the only intensive care unit or the only cardiac care unit. Some of it has duplicated existing facilities and has, in fact, led to deterioration of care, because some of these services are not performed frequently enough.

For example, in the case of coronary care, we have seen studies that show 80 percent of the hospitals doing cardiac care surgery really are substandard, do not have adequate patient volume to maintain minimal levels of care, so that we could both reduce costs and improve quality by trying to consolidate this care and just rely on a few major regional hospitals to do this type of service.

Mr. CARTER. Do you think that this could be taken care of by the PSRO's and HSA's working together?

Dr. DAVIS. I think the health systems agencies and the PSRO can help with this problem. I think trying to put some reimbursement limits on hospitals so they have some economic incentive to share facilities would also be useful.

Mr. CARTER. Thank you , Mr. Chairman.

Mr. ROGERS. Thank you so much. We are grateful to you for being here, and we may have additional questions we would like to have you answer for the record, and if you would let us have the information asked for it would be an aid to the committee.

Thank you for your presence.

We now have three additional panels that we need to cover by about 12 o'clock.

This panel will be composed of Michael Gemmell on behalf of the Honorable Terrance Pitts, Supervisor, Milwaukee County, Wisconsin, on behalf of the National Association of Counties; Mary E. Storm, who is chairman of the Legislative Committee, and William Kopit, who is counsel for the American Association for Comprehensive Health Planning.

We welcome you to the committee and you may proceed as you desire.

Mr. Gemmell, we welcome you, and you may proceed.

STATEMENTS OF MICHAEL K. GEMMELL, LEGISLATIVE REPRESENTATIVE, NATIONAL ASSOCIATION OF COUNTIES; MARY E. STORM, CHAIRPERSON, LEGISLATIVE COMMITTEE, AMERICAN ASSOCIATION FOR COMPREHENSIVE HEALTH PLANNING, ACCOMPANIED BY WILLIAM G. KOPIT, COUNSEL

Mr. GEMMELL. Thank you, Mr. Chairman.

Mr. Chairman, members of the subcommittee, I am Mike Gemmell, legislative representative of the National Association of Counties, NACo. NACo is the only national organization representing county government in America. Its membership includes urban, suburban, and rural counties joined together for the common pur-

pose of strengthening county government to meet the needs of all Americans. By virtue of a county's membership, all its elected and appointed officials become participants in an organization dedicated to the following goals: improving county government; serving as the national spokesman for county government; acting as a liaison between the Nation's counties and other levels of government; and, achieving public understanding of the role of counties in the Federal system.

The purpose of my brief statement is to make Congress and the subcommitte aware of the key problems facing counties in terms of rising hospital costs. We wish to commend the chairman and members of the subcommittee for conducting these hearings on the rising costs of health care and the means to control those costs.

The National Association of Counties represents over 1,500 county governments which together comprise 90 percent of the Nation's population. The vast majority of the counties in this country provide public health and medical care services. Over 75 percent of the 3,000 counties are administratively responsible for providing community health services. Over 68 percent provide medical assistance, 60 percent provide mental health services, 30 percent operate hospitals—nearly half of public hospitals are county operated—38 percent provide emergency medical services, and 26 percent operate long term care facilities.

Counties also provide traditional public health services; immunization programs, sanitation, home health, school health, V.D. clinics, well-baby clinics, alcoholism and drug abuse prevention and treatment, family planning, et cetera. To a large extent, these services are financed by local funds. Census data shows that counties spent $3 billion for hospitals and $1 billion for community health services in 1975. In 1966 counties spent $1.3 billion and $311 million, respectively.

In the interest of time, Mr. Chairman, we would like to summarize our views concerning H.R. 8121. Our position on hospital cost containment was made clear last May when NACo testified before you and Mr. Rostenkowski on this issue. We said then that we supported a revenue cap on hospital costs. Since that time, NACo's Health and Education Policy Steering Committee has adopted a resolution supporting a revenue ceiling type hospital cost containment bill as an initial, short term approach to controlling health costs [see resolution, p. 137].

We also endorse the incentive approach as outlined in H.R. 8121. Counties, Mr. Chairman, need immediate fiscal relief from the drain on local budgets caused by skyrocketting hospital costs. Counties do pay 10 percent of the national Medicaid bill. In addition they pick up costs incurred for treating people who are "unsponsored" or those without Federal or private insurance.

The population served by county facilities include people who are "unsponsored"—without insurance or support for their medical care—or who have needs which are not covered by most insurance packages: alcoholism, drug abuse, mental health, emergency care, and preventive and health promotive services. The population which falls into this "gap" group is broad. It includes the disabled but working person, children of intact families, the underinsured,

the working poor, non-resident aliens, prisoners, and migrants, among others.

County elected officials are also concerned about runaway health costs since counties own more than 10 percent of the hospitals in this country, which represent over 45 percent of the public general hospitals.

The rapid escalation of health care costs in the past few years has forced counties—the providers of last resort, in many instances—to increase the proportion of their scarce property tax dollars they allocate to health care. Local governments are accountable for providing services which are needed and for subsidizing the unsponsored population, but are limited in their capacity to control costs. In most States, local goverments have no influence in establishing eligibility and benefit packages, however, they must pay for all needed services which the Federal and State government and third party payers choose not to pay.

A large portion of these increased costs are brought about by inflation in the hospital sector. Local officials, in allocating scarce local revenues, have been forced to cut back other essential services in order to meet their local match of Medicaid or pay for the bills of unsponsored patients. We feel that since health care costs take on inappropriately large portions of our local, State and national resources, a cap on hospital revenues is essential.

We support the other cost containment provisions of H.R. 8121. We specifically endorse section 1504(a)(1) in title II which places a $2.5 billion limit on hospital capital expenditures. Furthermore, requiring review and determination of need for major medical equipment as well as for institutional health services and facilities is a sorely needed addition to the certificate of need program.

Because most large public hospitals have been operating on locally imposed cost control programs over the last few years and since county hospitals have voluntarily closed beds in order to function within these self-imposed budget ceilings, counties support title III of H.R. 8121. Financial assistance to encourage discontinuation of unneeded hospital beds would help local officials make decisions concerning unneeded or duplicative hospital services under their jurisdiction.

Finally, we wish to bring to your attention that "dumping" unsponsored patients will be a result of the cost containment proposal. Private hospitals and physicians might unload their uninsured or underinsured patients on the public hospitals. The bill, therefore, must contain stronger language requiring private hospitals to at least maintain their present charity patient load. H.R. 8121 must ensure that no hospital reduce its share of care to unsponsored patients. Therefore, Mr. Chairman, all hospitals should be required to:

(1) Maintain their present patient mix in terms of insured and non-insured patients;

(2) Maintain their present bad debt ratio; and,

(3) Maintain their present gross, that is billing, to net, that is receivable revenue ratio.

We admit that changes in the above ratios could only be symptoms and not certain proof of dumping. However, we feel that they might offer some protection to hospitals which are dumped upon.

Section 126, as written, Mr. Chairman, does not protect public hospitals from dumping. Enforcement is based on investigation by local health systems agencies (HSA's) as a result of complaints by hospitals claiming that their share of unsponsored patients has increased. The burden of proof, therefore, lies with those hospitals that treat people who cannot or do not, for whatever reason, seek it in the private sector.

In summary, Mr. Chairman, we would like to see enactment of a short term program that constrains the rate of increase in total hospital inpatient costs by limiting the amount of revenue that may be received per year to 9 or 10 percent. A revenue cap on all hospitals for 12 to 18 months, coupled with an incentive program as called for in H.R. 8121, would lay the groundwork for national health insurance. National health insurance will never be seriously considered until we do something to solve the present medical care cost problems. A revenue cap on hospitals is a first step towards enactment of comprehensive reform.

We thank the chairman and members of the subcommittee for giving us the opportunity to comment on H.R. 8121. NACo stands ready to provide assistance to the subcommittee in reporting out a measure that conforms with the points raised by our testimony.

Thank you, Mr. Chairman.

[The attachment referred to follows:]

Health and Education

RESOLUTION ON HEW PROPOSAL TO CONTAIN INCREASING HOSPITAL COSTS

(H.R.6575; S. 1391)

WHEREAS, county officials must be concerned about the rise of hospital costs which are increasing at 15 percent per year;

WHEREAS, counties pay 10 percent of the $17 billion national medicaid bill;

WHEREAS, counties own more than 10 percent of the hospitals in this country and over 45 percent of 1700 public general hospitals are county owned and operated;

WHEREAS, counties are generally responsible for providing medical care to individuals who cannot obtain it elsewhere, or who have no insurance or federal support for their care or who have needs not covered by public (medicare or medicaid) or private insurance such as alcoholism, drug abuse, mental health, emergency care and preventive and health promotive services;

WHEREAS, this population includes the disabled but working person, children and adults of intact families, the underinsured, the working poor, non-resident aliens, prisoners, transients, among others;

WHEREAS, HEW has proposed a bill (The Hospital Cost Containment Act of 1977) to constrain the rate of increase in total hospital inpatient costs by limiting the amount of revenue that may be received to nine percent a year;

WHEREAS, the proposal to restrain rising hospital costs will negatively impact on counties by requiring counties to continue filling the gaps - both uncovered people and uncovered services;

WHEREAS, skyrocketting medical costs have forced counties to increase the proportion of scarce property tax dollars they allocate to health care;

WHEREAS, NACo supports the concept, but feels that the HEW proposal needs to be strengthened to protect needy patients and public providers by not increasing the costs to local governments;

WHEREAS, NACo recognizes that the variety of problems affecting hospital costs makes a single approach inadequate and/or inequitable.

THEREFORE BE IT RESOLVED that the National Association of Counties urges:

-Congress pass the hospital cost containment bill as an initial approach to controlling health costs with the following amendments:

a) providing payment mechanisms in medicaid, medicare and other third party payors for outpatient care that are comparable to inpatient care;

b) provide payment mechanisms to help public hospitals and their county governments pay for the costs incurred for treating "unsponsored" patients --the increases in publicly provided services brought on by cost containment should be partially or totally financed by the federal government;

c) provide protection against private hospitals "dumping" their uninsured patients on public hospitals;

d) provide exemptions to local governments whose hospitals demonstrate efficiency in hospital administration and operation.

Adopted by the Health and Education Policy Steering Committee
May 20, 1977

Mr. ROGERS. Thank you, Mr. Gemmell, for a very helpful statement.

Miss Storm?

STATEMENT OF MARY E. STORM

Ms. STORM. Chairman Rogers and members of the subcommittee, the American Association for Comprehensive Health Planning welcomes the opportunity to testify this morning on H.R. 8121. AACHP is a national organization dedicated to improved health planning. We have 40 percent of the State Health Planning and Development Agencies (SHPDAs) and 70 percent of the Health Systems Agencies (HSAs) as member agencies.

My name is Mary E. Storm. I am chairperson of the AACHP Legislative Committee, having recently been appointed to that position to replace Mr. Anthony Mott, who is now President-elect of AACHP. I am also Vice Chairman of the Maryland Statewide Health Coordinating Council and the Health Systems Agency of Western Maryland Governing Body. I am accompanied by Mr. William G. Kopit, counsel to AACHP.

We were extremely pleased by the introduction of H.R. 8121. Although we endorse the entire bill, we will limit our comments to titles II and III as our expertise extends largely to the issues covered in those titles. Particularly, we wish to focus on the ways in which the bill improves H.R. 6575.

We strongly support the bill's attempt to add the review of "major medical equipment" regardless of location to the requirements of both Certificate of Need and section 1122 review. The exclusion of such equipment in locations other than health care facilities is a glaring omission in existing law. Rather than restricting capital expenditures, existing law often merely forces such expenditures to take a different form.

We do believe, however, that in addition to including equipment within the scope of Certificate of Need and 1122 review, expenditures for major medical equipment of the kind normally used in hospitals should be included in the expenditure ceiling contained in section 201 of the bill. Otherwise, the loophole in existing law will not be completely eliminated, and expenditures that would have previously been made in hospitals will be made for equipment in free-standing settings.

We strongly support the more stringent sanctions which H.R. 8121 would provide for 1122 review under the bill. The proposed section 1122(b) prohibits payment under titles V, XVIII and XIX of the Social Security Act of any amount for services provided by unapproved equipment as well as direct operating costs for services furnished in unapproved facilities to the extent such costs can be directly associated with particular capital expenditures.

In contrast, existing law merely limits the reduction in funds to depreciation, interest on borrowed funds, and return on equity. Depending on the nature of the expenditure and the patient population of the facility the sanctions may not always be adequate.

We also support the inclusion in the bill of payment authority under the Federal Hospital Insurance Trust Fund so that planning agencies may be compensated for 1122 review. Although this requirement is contained in existing law, HEW has not been compensating agencies for 1122 review under the trust fund since the enactment of Public Law 93-641. A reaffirmation of congressional

policy is important if this situation is to be changed. We do recommend expanding the language of the section to ensure that HSA's are also compensated for the functions which they perform under section 1122.

Additionally, we recommend that the Federal Government retain a right to review a State determination under 1122 at the discretion of the Federal Government in situations where the State agency has not followed the recommendation of the applicable HSA. H.R. 8121 provides for no review of State determinations. Current law does provide for review but only where a State agency has disapproved an 1122 request. Since section 1122 review directly involves expenditures of Federal funds, it is appropriate for the Federal Government to be involved in determinations regarding those funds.

We strongly support, in principal, the provision of incentives to encourage the discontinuation of unneeded hospital services called for in title III of the bill. However, we prefer the approach outlined in our letter of July 14, 1977. Under our approach, incentive payments would be included within Area Health Services Development Funds authorized under Public Law 93-641. The discontinuation of unnecessary hospital services is critical, but it is only one of a variety of health needs within any given health service area. We believe priorities among local needs can best be determined by HSAs acting in accordance with their health systems plans and priorities contained in their annual implementation plans.

Additionally, we do not feel that incentives to discontinue unnecessary hospital services will be sufficient in all cases. Thus, we have also recommended granting State agencies the authority to decertify unnecessary facilities under both 1122 and certificate of need.

We urge you to review the other proposed amendments to H.R. 6575 which we have included in our letter of July 12, 1977. Specifically, we direct your attention to the amendments which would:

(1) Include Federal hospitals within the ambit of review;

(2) Prohibit for-profit hospitals from taking advantage of the investment tax credit for capital expenditures inconsistent with title II;

(3) Require coordination of Federal capital expenditure programs outside of HEW with the requirements of title II;

(4) Provide a mechanism for the allocation of the expenditure ceiling at the local level; and

(5) Strengthen occupancy and supply standards.

We have several technical changes to recommend. Section 201 of the bill should be amended so that the definition of "capital expenditure" included in the certificate of need provisions of the bill is consistent with the definition of "capital expenditure" contained in the section 1122 provisions—section 202—of the bill. This can be done by deleting the exemption for the purchase of existing hospitals currently contained in the certificate of need provisions.

Section 202, which provides for a section 1122(d), should be amended so that the sanctions conform to those included in the proposed section 1122(b).

Section 203(a), which amends section 103 of the Internal Revenue Code of 1954, should be amended so that a disapproval under section 1122 of the Social Security Act would eliminate the tax exempt status of an obligation issued by a State or territory.

Finally, section 204(a) of the bill could be more inclusive if the words "which affects interstate commerce" were substituted for the words "in interstate commerce."

In closing we wish to reiterate our strong support for H.R. 8121 and for the significant improvements which we believe are included in this bill. If enacted, these improvements should do much to slow the precipitous increase in hospital costs.

We appreciate the opportunity to testify before this committee and look forward to working with you towards the enactment of strong and effective legislation.

We would be happy to answer any questions you might have.

Mr. ROGERS. Thank you so much, Miss Storm, for a very clear and concise statement.

Dr. Carter?

Mr. CARTER. Thank you, Mr. Chairman.

In going over this I see you are going to contain all of the costs except those which pertain to HSA's; is that correct?

You would increase those costs, those expenditures?

Mr. KOPIT. I think it's common knowledge, Dr. Carter, that the health planning agencies are largely underfunded, and they haven't been funded at nearly the level included in the authorization level.

Mr. CARTER. We in Congress are constantly met with different systems in different agencies. We never have enough money.

Mr. KOPIT. I am sure that is correct.

Mr. CARTER. You know, in expenditures we find time after time after time that those who would lose Federal funds always oppose legislation. Those who would gain, support it. It just depends on whose ox is being gored.

I certainly support HSA's. However, I think our financial stringency should apply to HSA's as well as to other groups, and if we put a cap on hospitals, then I feel you should wear something similar.

Mr. KOPIT. There is, of course, a cap. We are limited in our appropriations.

Mr. CARTER. You want to remove that cap, I believe, and increase the funds?

Mr. KOPIT. That is correct.

Mr. CARTER. According to this legislation you want to include Federal hospitals within the scope of this review; is that correct?

Mr. KOPIT. Yes, sir.

Mr. CARTER. You don't feel that our veterans should be treated any differently from other people; is that correct?

Mr. KOPIT. I didn't get that.

Mr. CARTER. You don't feel our veterans in our veterans' hospitals should be treated any differently from other citizens of the country?

Ms. STORM. We feel that if there is a cap on the hospitals in the State that are non-Federal hospitals, that there should also be a cap on the Federal hospitals.

For instance, in Maryland, one of the veterans' hospitals spent about $80 million in 1 year, and the non-VA hospitals in the State, as a group, spent about $67 million last year. This shows that one VA hospital is spending more than the other hospitals in the State as a group. We feel there should be a cap on VA hospitals, also; maybe not the same cap but a cap. They should not be totally exempted from the planning process.

Mr. CARTER. You would prohibit for profit hospitals from taking advantage of the investment tax credits for capital expenditures. Why?

Mr. KOPIT. Only those that are inconsistent with the requirements of title II.

Mr. CARTER. Only those that are inconsistent. All hospitals have to apply for a certificate of need anyway, before they commit themselves to a capital expenditure, do they not? If they were granted a certificate of need, would you object to their getting the tax break anyone gets on investment?

Mr. KOPIT. No.

Mr. CARTER. All right.

Thank you, Mr. Chairman.

Mr. ROGERS. Mr. Preyer?

Mr. PREYER. Just one question, Mr. Gemmell.

I can understand how the counties would resent dumping of unsponsored patients on them with your limited tax basis, paying a limited tax and all of the other things you have to do to find the medical costs going up some. But as a matter of economic theory, is it wrong to have the county or the public pay the unsponsored patient bills? Isn't it better that the general taxpayer pay those than that patient in the hospital paying it, just as economic equity?

Mr. GEMMELL We found out that the level of unsponsored patients varies from community to community, and as a consequence, in some of the more urban areas we have a high level of unsponsored patients that are being picked up by the city or the county, and in most instances it is the county. It comes out of the local property tax.

For example, we testified before Mr. Rogers last month on the non-resident aliens, and in some of our counties where the local county taxpayer is being asked to subsidize the care to a group of patients who have entered the country illegally, or through other means, and so we feel this should be spread out and be a national burden as opposed to a local burden.

We have some of the same problems in some of the migrant areas, Mr. Preyer. We feel this should be spread out equally among all of the taxpayers of the country, as opposed to one specific county or city or small jurisdiction.

Mr. PREYER. I can certainly agree with those examples. I am just wondering in the ordinary community where what we are in effect doing right now is asking hospitals to bear the cost of these unsponsored patients. As a matter of economic theory, wouldn't it be better to have the general taxpayer bear those and in that way let the general taxpayer appreciate the cost and relieve more public pressure?

In my community we don't have any "public hospital." There is no place to dump them. They would just simply be frozen into

having to furnish as much care as they are furnishing right now. I can see the county's point of view, but I am not sure from the point of view of economics it's a good thing.

Mr. CARTER. Would you yield?

Mr. PREYER. Surely.

Mr. CARTER. Mr. Chairman, I want to congratulate the gentleman on his well thought out questions, and I certainly agree with him that the cost of unsponsored patients is often borne by the private patient in those private hospitals. I would submit that it's the general public that should really assume this obligation. Of course, it has long been the tradition for county and city hospitals to take care of our poor.

Thank you, Mr. Chairman.

Mr. ROGERS. Mr. Walgren?

Mr. WALGREN. I have no questions at this point, Mr. Chairman.

Mr. ROGERS. Let me just ask a couple of questions quickly, because our time is short.

What are the abilities of the HSA's and State agencies to carry out responsibilities we give such as determining unneeded facilities and so forth?

Ms. STORM. I think they are perfectly capable of doing so; most of them have been in existence for a long period or a longer period of time as comprehensive health planning agencies, and have had some expertise in the area. Many have had certificate of need programs within the State for years, and I think on the whole they are perfectly capable. The ones that are new or didn't have certificates of need are learning from the others, and are becoming capable very quickly.

Mr. ROGERS. You think it is timely then to include decertification authority?

Ms. STORM. Yes, I think it would be appropriate.

Mr. ROGERS. Should the Federal Government penalize these hospitals which would not then follow the HSA's or the health planning recommendations in those regards?

Ms. STORM. Yes.

Mr. ROGERS. If you would let us have your thinking for the record on that and how that should be done, it would be helpful.

Mr. KOPIT. Yes, sir.

Mr. ROGERS. Just for the record.

Mr. KOPIT. We can expand on that.

Mr. ROGERS. That would be helpful, yes.

It has been proposed by some element of the private sector hospitals that we simply have a 2 year moratorium on any capital expenditures, while an overall plan was worked out. Would you let us have your comment for the record on that proposal?

Mr. KOPIT. I can answer that at least in part right now.

We oppose that for the same reasons that they are in favor of it. That is, they say that what we have here is a beginning, in effect, of a permanent program. That is exactly right, and that is why we favor it.

We think we ought to begin right now, and we can put this into place. We think this approach that is in your bill, Mr. Chairman, allows a lot more fine-tuning at the local levels than certainly just saying "no" across the board.

Mr. ROGERS. Mr. Gemmell, if you could let us have your thinking on the 2-year plan, we would appreciate it.

Mr. GEMMEL. I think Mr. Kopit will be surprised to find we are agreeing with the statements, Mr. Chairman.

Mr. ROGERS. Thank you very much. We appreciate your presence here today.

Ms. STORM. Thank you, Mr. Chairman.

[The following letter and attachment were received for the record:]

AMERICAN ASSOCIATION FOR COMPREHENSIVE HEALTH PLANNING

July 22, 1977

Hon. Paul G. Rogers, Chairman
Subcommittee on Health and the Environment
Committee on Interstate and Foreign
Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Rogers:

On July 18, 1977, the American Association for Comprehensive Health Planning testified before the House Interstate and Foreign Commerce Subcommittee on Health and the Environment. During the testimony, we were asked to add material for the record in two instances. First, we were asked to provide our recommendations regarding a moratorium in lieu of Title II of H.R. 8121/H.R. 6575, and secondly, we were asked to provide further information on decertification.

In addition, our testimony referenced a number of AACHP proposed amendments to H.R. 6575. We are submitting, as an attachment, those proposed amendments and respectfully request that they be printed in the record.

Regarding the moratorium issue and the decertification issue, we submit, for the record, the following:

Re: A moratorium in lieu of Title II of H.R. 8121/H.R. 6575

As we indicated in our recent testimony, we strongly support the national capital expenditure ceiling approach called for in Title II of the Administration's hospital cost containment legislation. Such an approach will be both more effective and more sensitive to local conditions and differences than a blanket moratorium. Exceptions would be required in any moratorium and a rational set of exceptions, in our opinion, would

probably have to approximate the expenditure, supply, and occupancy limits contained in Title II. A national capital ceiling accompanied by supply and occupancy limits appears to be a more straightforward and direct approach.

Moreover, a moratorium, of necessity, would be of limited duration. It would only postpone, and ultimately increase, the cost of many capital expenditures. In contrast, Title II, with its national ceiling, can form the basis of permanent and more effective health planning. It forces the type of local and state priorities setting and trade-off which are needed if we are truly to develop an effective planning structure for resources allocation. For these reasons, we believe Title II to be clearly preferable to a moratorium.

Decertification

During our testimony of July 18 regarding H.R. 8121 we urged the consideration of authority to decertify services, facilities, and equipment upon a demonstration that such services, facilities, or equipment were no longer needed. We are resubmitting for the record all of the referenced legislative proposals including our proposal for decertification which appears in our amendments to the Certificate of Need program contained in section 201(a) of H.R. 8121.

This brief discussion is in response to Congressman Rogers' request that we submit additional information regarding our views on this important issue.

There is substantial data regarding the excess of hospital beds in many areas in this country. The cost implications of these excess beds are beyond dispute. As a result, we believe that there is a need for some kind of legal authority authorizing the decertification of excess beds. The difficulty is in designing an authority that will be effective, workable and equitable and will withstand both political and legal attack.

Clearly, the most effective method of providing for decertification - at least in those states which intend to adopt Certificate of Need programs meeting federal requirements - would be to amend such federal requirements to include decertification authority in a state's Certificate of Need program. At the same time, the Certificate of Need program would be linked to the supply and occupancy standards contained in H.R. 8121. If this were done, the decertification sanctions would be the normal sanctions used in the state's Certificate of Need program - i.e., loss of license, injunctions, etc.

This approach is the one which we adopted in our proposed amendment. However, that amendment merely provided authority of a general nature. It did not directly address several of the important issues which should be resolved.

The first of these issues is whether the decertification authority would apply to services, facilities and equipment which were in

place prior to the adoption of the decertification authority. Limiting the applicability of the authority to facilities, services, and equipment put in place subsequent to the enactment of the provision would be perceived as the more equitable option - particularly if compensation for decertification was not included - and would be more likely to withstand legal attack. However, the overriding objection to this option is that it would do nothing about existing excess capacity. It would merely provide greater flexibility to deal with a worsening of the problem in the future.

Regardless of the determination made on the foregoing issue it would seem appropriate to include some minimum period of validity - perhaps five years - governing Certificates of Need. Thus, once an initial Certificate of Need were granted, or reapproved, mandatory decertification proceedings could not be initiated for a period of at least five years, although the need for a particular facility or piece of equipment may have decreased substantially in the interim. Without the inclusion of such a minimum time period facilities would find it difficult, if not impossible, to plan with any certainty.

Of couse, no decertification proceeding could be undertaken without appropriate due process standards. Moreover, where there is more than one facility or piece of equipment within a particular class the health systems agency and the state agency should be required

to justify their proposed decertification of the particular facility or piece of equipment within the class. Additionally, as we indicated in our testimony, the "stick" of decertification should be accompanied by the "carrot" of conversion payments to facilities which are converted to needed uses. These conversion payments should be made by HSAs from funds appropriated under the Area Health Resources Development Funds in accordance with applicable HSPs and AIPs.

As indicated above, the major difficulty with the Certificate of Need approach to decertification - particularly as applied to existing services, equipment and facilities - is a claim of unfairness and the consequent legal risks. These concerns could be mitigated by the inclusion of authority to pay the balance of any loan outstanding after the sale, disposition or conversion of facilities or equipment. While the inclusion of mandatory payments would clearly be only a small portion of a community savings realized from such closures and conversions, the federal expenditures involved would not be insignificant. Moreover, there would not be complete insulation from legal attack - perhaps from for-profit institutions - claiming that the level of compensation is inadequate.

Another approach would be to include the decertification authority in section 1122, and not Certificate of Need. Because the sanction would be a reduction in Medicare and Medicaid reimbursement as

opposed to the loss of licensure, etc., the likelihood of successful legal challenge would be reduced. The weakness in this approach is that in some cases the sanction might not be significant enough to produce the desired effect. This would be particularly true if the revenue reduction could be offset by loading extra charges onto private patients. While discriminatory charges could be prevented, at least in theory, there would be nothing to prevent across-the-board rate increases, at least to the extent that they did not result in violations of Title I.

If the sanctions in section 1122 were expanded to cover private payors as well as Medicare and Medicaid, there would be substantially more impact. But for this very reasons the likelihood of successful legal attack would also increase significantly.

Another approach that might be employed is an amended version of Title III of H.R. 8121. While this approach would be temporary and short-term, it could reduce the existing excess capacity. It would represent an excellent step in the right direction.

We would modify the sanctions of Title III so that determinations of non-compliance are made through the existing section 1122 or Certificate of Need process and only offending facilities are penalized. Additionally, we would change the amount of the penalty so that it corresponded to the penalties proposed for section 1122 under Title II. As indicated above we also favor having the conversion payments under Title III made by HSAs under

the authority of the Area Health Resources Development Funds.

We recognize that we have not provided an answer to the difficult problem. We hope we have at least discussed the considerations involved in the formulation of an answer.

Finally, we join with you in believing that we must start now to address this serious problem. We are prepared to support any approach which takes the first step.

Sincerely,

Mary E. Storm
Mary E. Storm, Esq.
Chairman, Legislative Committee

William Kopit
William G. Kopit, Esq.
Counsel

Enclosure

AMERICAN ASSOCIATION FOR COMPREHENSIVE HEALTH PLANNING

(Proposed Changes and Amendments to H.R. 6575/S. 1391, The Hospital Cost Containment Act of 1977.

(Deletions are lined through; changes and additions are underlined)

PART C-DEFINITIONS AND MISCELLANEOUS PROVISIONS

DEFINITION OF HOSPITAL

Section 121. (a) For purposes of this title (subject to subsection (b) of this section), the term "Hospital", with respect to any accounting year, means an institution (including a distinct part of an institution participating in the program established under title XVIII of the Social Security Act) which --

(1) satisifes paragraphs (1) and (7) of section 1861 (e) of the Social Security Act, and

(2) had an average duration of stay of 30 days or less in the preceding accounting year.

(b) An institution shall not be considered a "hospital" during any part of a period subject to this title if with respect to such period it --

~~(1) is a Federal hospital~~

(2) (1) has met the conditions specified in subsection (a) (under present and previous ownership) or less than two years before such period; or

~~(2)~~ (2) derived more than 75 percent of its in-patient care revenues on a capitation basis, disregarding revenues received under title XVIII of the Social Security Act, from one or more health maintenance organizations (as defined in section 1301(a) of the Public Health Service Act).

TITLE II-LIMITATION ON HOSPITAL CAPITAL EXPENDITURES

Section 201. (a) Part A of title XV of the Public Health Service Act is amended by adding at the end thereof the following new section:

"Section 1504. (a)(1) Before the beginning of the fiscal year beginning

October 1, 1977, and at least 60 days before the beginning of each succeeding fiscal year, the Secretary shall promulgate a sum as a hospital capital expenditure limit applicable to such fiscal year. The sum promulgated as a limit under the preceding sentence for any period shall be amount which may not exceed $2,500,000.

"(2) The Secretary shall apportion the sum promulgated under paragraph (1) for any fiscal year among the various States on the basis of the population of the various States; except that for any fiscal year beginning more than 18 months after the date of enactment of this section the Secretary shall apportion the sum promulgated under paragraph (1) for such fiscal year among the various States, taking into account the population of the various States; and also taking into account, to the extent feasible, variations among the States in the costs of construction, population patterns and growth, the need for hospital facilities and equipment and for modernization of existing hospital facilities and equipment, and other factors important to the equitable apportionment of such sum.

"(b)(1) At the time the Secretary promulgates under subsection (a) a hospital capital expenditure limit the Secretary shall also promulgate for the fiscal year to which such limit is applicable --

"(A) a national ceiling for the supply of hospital beds within health service areas established under section 1511 (hereinafter in this title referred to as the 'supply ceiling'), and

"(B) a national standard for the rate of occupancy of hospital beds within such areas (hereinafter in this title referred to as the 'occupancy standard').

"(2) The supply ceiling promulgated for any fiscal year under paragraph (1)(A) in any health service area shall take into account the special characteristics of each health service area, but such supply ceiling may not exceed the ratio of 4 hospital beds per 1,000 of population.

"(3) The occupancy standard promulgated under paragraph (1)(B) for any fiscal year shall take into account the special characteristics of each health service area but such occupancy standard may not be less than 80 percent in any health service

area.

(b)(1) Part C of title XV of the Public Health Service Act is amended by adding at the end thereof the following new section:

"CERTIFICATE OF NEED PROGRAM

"Section 1527. (a) The certificate of need program required by section 1523(a)(4)(B) shall provide for the following:

"(1) Review and determination of need under such program of institutional health services, health care facilities, and health maintenance organizations regardless of ownership shall be made before the time such services, facilities, and organizations are offered or developed or substantial expenditures are undertaken in preparation for such offering or development and periodically thereafter as appropriate.

"(2) The program shall be administered in such a manner that only those services, facilities, and organizations which are found to be needed or which continue to be needed shall be developed or offered in the State in which the program applies.

"(3) In issuing a certificate of need for any such service, facility or organization, the State shall specify in the certificate the maximum amount of capital expenditures which may be made for such service, facility, or organization under such certificate.

"(4) The aggregate of the maximum amounts of capital expenditures authorized in a fiscal year in accordance with paragraph (3) for hospitals may not exceed the portion of the sum promulgated under section 1504 (a)(1) and apportioned to the State under section 1504 (a)(2) for such fiscal year, as adjusted in accordance with this paragraph. For any fiscal year the sum apportioned to a State under section 1504 (a)(2) shall (A) if the aggregate of the maximum amounts of capital expenditures authorized by the State in the preceding fiscal year in accordance with paragraph (3) for hospitals was less than the portion of such sum so apportioned to the State for such fiscal year, the difference between such authorized maximum amounts and the

sum so apportioned shall be added to the sum so apportioned to the State for the fiscal year following such fiscal year, and (B) if in the fiscal year there was a closure of a hospital (or part thereof) through which institutional health services found under section 1523 (a)(6) to be inappropriate were provided, then the amount by which the historical cost (as defined for purposes of Title XVIII of the Social Security Act) of such hospital or part exceeds the total amount of depreciation of such hospital or part claimed for purposes of establishing the reasonable costs of services provided by the hospital for purposes of receiving reimbursement under Title XVIII of the Social Security Act shall be added to the portion of such sum so apportioned to the State for such fiscal year.

"(b)(1) Under such a certificate of need program a certificate of need may not, except as provided in paragraph (2), be granted for an institutional health service or health care facility within a health service area established under section 1511 if the development of such service of facility under such certificate would result in a number of hospital beds within such area which is in excess of the applicable supply ceiling promulgated under section 1504 (b)(1)(A).

"(2) If in a health service area the number of hospital beds is in excess of the supply ceiling applicable to a fiscal year, then a certificate of need may be granted for such a service or facility the development of which would result in a number of new hospital beds which is not more than one-half of the number of hospital beds removed permanently from service in such area in such fiscal year.

The amount by which the number of new hospital beds with respect to which certificates of need may be issued in a fiscal year under the preceding sentence is less than the number of new hospital beds with respect to which certificates of need were issued in such fiscal year may be added to the number of new hospital beds with respect to which certificates of need may be issued in the succeeding fiscal year.

(3) Under such a certificate of need program a certificate of need may not be granted within a health service area if any hospital capital expenditure involved

exceeds the portion of the aggregate maximum amounts of capital expenditures authorized in a fiscal year for hospitals under Section 1504 (a)(1) which have been apportioned to the State under Section 1505 (a)(2) for such fiscal year which, on the basis of the formula used by the Secretary under Section 1504 (a)(2), is attributable to such health service area unless such expenditure has been approved by the health systems agency within such health service area, and any other health systems agency which would have its allotment reduced as a result of such expenditure; provided that the Statewide Health Coordinating Council may reverse the disapproval of any health system agency which would have its allotment reduced, and provided further that nothing contained herein would be construed to permit any hospital capital expenditure which is otherwise prohibited.

"(c)(1) Under such a certificate of need program a certificate of need may not, except as provided in paragraph (2), be granted for an institutional health service or health care facility within a health service area if the development of auch service or facility could reasonably be expected to produce a number of hospital beds which would result in a hospital bed occupancy rate within such area which is less than the applicable occupancy standard promulgated under section 1504 (b)(1)(B).

"(2) If in any fiscal year the hospital bed occupancy rate within a health service area is less than the occupancy standard applicable for such fiscal year, then a certificate of need may be granted for a service or facility the development of which would result in a number of new hospital beds which is not more than one half of the number of hospital beds removed permanently from service in such area in such fiscal year. The amount by which the number of new hospital beds with respect to which certificates of need may be issued in a fiscal year under the preceding sentence is less than the number of new hospital beds with respect to which certificates of need were issued in such fiscal year may be added to the number of new hospital beds with respect to which certificates of need may be issued in the succeeding fiscal year.

"(d)" No certificates of need under such a program shall be granted if they are inconsistent with the priorities of the State health plan. In granting certificates of need under such a program a State shall take into account priorities of all affected health system agencies.

(2) The second sentence of section 1523(a) (4) of the Public Health Service Act is repealed.

(c) Section 1531 of the Public Health Service Act is amended (1) by striking out "For purposes of this title" and inserting in lieu thereof, "Except as otherwise provided for purposes of this title," and (2) by adding after paragraph (5) the following new paragraphs:

"(6) For purposes of section 1504 and 1527, the term 'hospital,' with respect to any accounting year, means an institution (including a distinct part of an institution participating in the program established under title XVIII of the Social Security Act) which --

(A) satisfies paragraphs (1) and (7) of section 1861(e) of the Social Security Act, and

(B) has an average duration of stay of 30 days or less in the preceding accounting year,

except that for any fiscal year such term does not include a facility or an institution which during such fiscal year derived more than 75 percent of its inpatient care revenues on a capitation basis, disregarding revenues received under title XVIII of the Social Security Act, from one or more health maintenance organizations (as defined in section 1301(a)).

"(7) For the purposes of section 1504 and 1527, the term 'Capital expenditure' means an expenditure which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance and which (A) exceeds $100,000, (B) changes the bed capacity of the facility with respect to which such expenditure is made, or (C) substantially changes

the services of the facility with respect to which such expenditure is made, except that such term includes expenditures for obtaining a facility or part thereof, or equipment for a facility or part, under a lease or comparable arrangement ~~but not including~~ or the acquisition of an existing hospital facility. ~~If such acquisition does not involve a change in the ownership of such facility or such acquisition~~ For purposes of clause (A) of the preceding sentence, the cost of the studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of the plant and equipment with respect to which such expenditure is made shall be included in determining whether such expenditure exceeds $100,000. If a person makes an acquisition of equipment for a hospital and donates it to the hospital, the expenditure for such acquisition shall be considered a hospital capital expenditure for purposes of sections 1504 and 1527.

"(8) For the purposes of section 1504 and 1527 any capital expenditure which meets the criteria of paragraph (7) which is made for the purchase of equipment commonly used in a hospital or which is the result of a result of a lease or comparable arrangement for such equipment shall be considered a hospital capital expenditure.

(d) Section 1532 (b)(2) of the Public Health Service Act is amended (1) by striking out "ninety days" and inserting in lieu thereof "one year", and (2) by adding before the period "or longer then such shorter period from such date as the Secretary may prescribe."

Section 202. (a)(1) Section 1122 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(j)(1) Except as provided in paragraph (2), in determining the Federal payments to be made under titles V, XVIII, and XIX with respect to services furnished in a health care facility located in a State --

"(A) which has not entered into an agreement with the Secretary under this section, or

"(B) which does not have a certificate of need program approved under title XV of the Public Health Service Act, the Secretary shall not include an amount equal to ten times any amount which is attributable to depreciation, interest on borrowed funds, and return on equity capital (in the case of proprietary facilities) or other expenses related to capital expenditures after September 30, 1977, for such health care facility unless the Secretary has approved, in accordance with procedures and criteria established by the Secretary, such expenditures after taking into account any recommendation made by a State agency designated under section 1521 of the Public Health Service Act. With respect to any organization which is reimbursed on a per capita or a fixed fee or negotiated rate basis, in determing the Federal payments to be made under titles V, XVIII, and XIX, the Secretary shall exclude an amount which in his judgment is a reasonable equivalent to the amount which would otherwise be excluded under this subsection if payment were to be made on other than a per capita or a fixed fee or negotiated rate basis.

"(2) Paragraph (1) shall not apply with respect to determination of Federal payments to be made under title V, XVIII, or XIX with respect to services furnished in a health care facility located in a State which has a certificate of need program, approved by the Secretary for purposes of this section, which applies to capital expenditures for hospitals and with respect to which such capital expenditures meet the requirements of section 1527 of the Public Health Service Act."

(2) Subsection (e) of such section 1122 is amended by striking out "subsection (d)" and inserting in lieu thereof "subsection (d) or (j)."

(3) Subsection (b) of such section 1122 is amended by inserting before the period at the end thereof the following: "or does not meet any applicable requirement of subsection (a)(4), (b), or (c) of section 1527 of the Public Health Service Act."

(4) Subsection (d) (1) of such section 1122 is amended by striking out "any amount" in the matter following subparagraph (B) of the first sentence of such section and inserting in lieu thereof "an amount equal to ten times any amount.".

(5) A new subsection (d)(3)(e) is added to read "If, the Secretary determines, the determination of any planning agency notwithstanding, that any capital expenditure is not consistent with appropriate standards, criteria or plans, he shall not include the amount described in subsection (1) in determining the federal payments under titles V, XVIII, and XIX."

(b) The amendments made by subsection (a) shall apply with respect to capital expenditures made after September 30, 1977.

Section 203. (a) Section 103 of the Internal Revenue Code of 1954 (relating to exclusion from gross income of interest on certain governmental obligations) is amended by redesignating subsection (f) as subsection (g), and by inserting after subsection (e) the following new subsection:

"(f) Obligations Supporting Increases in Acute Care Hospital Beds. -- Any obligation issued by a State or territory for an institutional health service, health care facility, or health maintenance organization--

"(1) the development of which would result in a number of hospital beds within a health service area which number is in excess of the applicable supply ceiling for such area promulgated under section 1504(b) (1) (A) of the Public Health Service Act, or

"(2) for which a certificate of need has not been issued under a certificate of need program approved under title XV of the Public Health Service Act or under section 1122 of the Social Security Act shall be treated as an obligation not described in subsection (a) (1)."

(b) The amendments made by subsection (a) shall apply with respect to taxable years beginning after the date of the enactment of this Act.

Section 204. Section 38 of the Internal Revenue Code of 1954 (relating to investment tax audits) is amended by adding a second sentence of subsection (a) to read "No credit shall be provided for any capital expenditure as defined in Section 1531 of the Public Health Service Act if such expenditure would result in a number of hospital beds within a health service area which

is in excess of the applicable supply ceiling for such area promulgated under Section 1504(b) (1) (A) of the Public Health Service Act, or if such expenditure has been disapproved under Section 1122 of the Social Security Act or under a certificate of need program approved under Title XV of the Public Health Service Act.

Section 205. A new section 1537 of the Public Health Service Act is added to read "No federal department or agency shall approve any application for a loan, loan guarantee, or mortgage insurance to or on behalf of any hospital for any capital expenditure under any authority contained in federal saw, including but not limited to 7 U.S.C. 1926, 1932; 12 U.S.C. 1715 Z-7, 171 7(b), 1721 (g); 15 U.S.C. 636(a) and (b), and 42 U.S.C. 6701 unless the Secretary, after consulting with all appropriate health systems agencies and state health planning and development agencies, has reviewed and approved any such application."

Section 206. Section 1513 (c) is amended as follows:

(3) The agency shall, in accordance with the priorities established in the AIP, make grants to public and private entities and enter into contracts with individuals and public and private entities to assist them in planning and developing projects and programs which the agency determines are necessary for the achievement of the health systems described in the HSP or as part of a plan to convert or close underutilized hospital facilities. Such grants and contracts shall be made from the Area Health Services Development Fund of the agency established with funds provided under grants made under section 1640. No grants or contracts under this subsection may be used (A) to pay the costs incurred by an entity or individual in the delivery of health services (as defined in regulations of the Secretary), or (B) for the cost of construction or modernization of medical facilities unless such construction or modernization has been approved by the

Secretary. No single grant or contract made or entered into under this paragraph shall be available for obligation beyond the one year period beginning on the date the grant or contract was made or entered into. If an individual or entity receives a grant or contract under this paragraph for a project or program, such individual or entity may receive only one more such grant or contract for such project or program."

Mr. ROGERS. The next panel is made up of Dr. Edgar T. Beddingfield, who is Chairman of the American Medical Association's Council on Legislation; John Alexander McMahon, President, American Hospital Asssociation accompanied by Dr. Leo Gehrig, Senior Vice President of the American Hospital Association.

We are delighted to see you.

STATEMENTS OF EDGAR T. BEDDINGFIELD, M.D., CHAIRMAN, COUNCIL ON LEGISLATION, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY HARRY N. PETERSON, DIRECTOR, DEPARTMENT OF LEGISLATION, AND DANIEL HILL, ASSISTANT DIRECTOR; AND JOHN ALEXANDER McMAHON, PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, ACCOMPANIED BY LEO J. GEHRIG, M.D., SENIOR VICE PRESIDENT

Dr. BEDDINGFIELD. Shall I proceed?

Mr. ROGERS. You may proceed as you desire, Dr. Beddingfield. We are always delighted to see Mr. Peterson here. He is a long time friend of the committee.

Dr. BEDDINGFIELD. Thank you, Mr. Chairman.

I am Edgar T. Beddingfield, Jr., M.D., a physician in medical practice in Wilson, North Carolina, and I serve as Chairman of the American Medical Association's Council on Legislation. With me is Harry N. Peterson, Director of the AMA Department of Legislation, and Dan Hill, Assistant Director.

Mr. Chairman, the American Medical Association is pleased to respond to your invitation to participate in these continued hearings on the subject of hospital cost containment. Our Association and the medical profession share the strong public concern with the rising costs of hospital care. As you know, we have had an intense interest in the administration bill, H.R. 6575, on this subject.

We testified on May 13, 1977, at joint hearings held by this subcommittee and the Subcommittee on Health of the Committee on Ways and Means. We submit a copy of that statement and ask that it be made a part of our presentation on H.R. 8121.

Mr. ROGERS. Without objection, so ordered [see p. 166.]

Dr. BEDDINGFIELD. We will not restate that previous testimony, but proceed to the changes that the present bill incorporates.

As we point out later in our statement, the new bill, while adding several new sections, primarily extends the authority of the Secretary to regulate the purchase of new major medical equipment, to provide incentives to hospitals to eliminate services, and to award hospitals for restraining costs.

INCENTIVES FOR HOSPITALS TO CONTAIN COSTS

A new part D is added to the original title I of H.R. 6575 to provide for hospitals to contain cost increases. This provision would allow a hospital to apply for a lump sum incentive payment payable from the Federal general revenue, if its inpatient revenues for the year increased less than the allowable percentage increase limit that was promulgated for the year. The amount of the "incentive" available to any hospital would be the lesser of a specified fraction—one-third—of the difference between certain actual and projected inpatient amounts or the amount of the outpatient deficit of the hospital.

We support the idea of providing incentives to hospitals and other encouragement to hospitals to become more efficient. We believe that incentives are appropriate to assure that hospitals maintain not only the highest level of technology but also the best level of care commensurate with effective operations. While seeking to achieve this goal the incentive program as proposed under this new part does raise several questions.

First of all we note that the incentive would be the lesser of some fraction of savings or the amount of the hospital outpatient deficit. We note further that the descriptive material accompanying the introduction of the bill refers to deficits of hospital outpatient departments. However, not all hospitals have an outpatient department, nor does every hospital which provides an outpatient department have a deficit. In such instances the lesser amount of the incentive formula would, by definition, have to be zero. Thus an incentive for such a hospital to increase its efficiency would not exist. Moreover, while we recognize the desire to restrain outpatient deficits, we question the merits of tying the inpatient incentives to outpatient services. It appears that outpatient deficits are encouraged to a certain extent.

Furthermore, we note that incentive payments would be payable out of general revenues of the Federal Government. We question the appropriateness of the contemplated payments from the General Treasury. As the program is proposed under the bill, revenue increase limitations are based upon total inpatient revenues of the hospital, which would include patients whose care was paid under Medicare, Medicaid or Maternal and Child Health, and from private sources. In order to determine whether revenues have increased less than the allowable increase limit, all revenues on an inpatient basis must be considered. Likewise, determination of any outpatient deficit must consider all costs irrespective of who paid the costs. Any incentive payment made to a private institution would therefore cover all inpatients, not merely Federal beneficiaries. Should Congress pay out of the General Treasury amounts to hospitals for providing services for which the Federal Government otherwise has no obligation to pay? We believe that such a provision

would provide what would constitute a special "gift" from the Federal Government, and raises Constitutional questions.

We are thus concerned with the program that would allow in effect Federal subsidies to potentially all hospitals. To emphasize the issue, under the bill a hospital need not have any Medicare, Medicaid, or Maternal and Child Health patients, yet it could be eligible for an "incentive" amount payable from the Federal Treasury. We believe that such a program should be examined closely before adoption.

MAJOR MEDICAL EQUIPMENT

H.R. 8121 would extend the application of the certificate of need program under Public Law 93-641 to major medical equipment regardless of location of that equipment. Thus equipment purchased for use in physician offices would be subject to certificate of need restrictions. (It is not clear, moreover, whether the $150,000 requirement as a "capital expenditure" refers to a single piece of equipment or the aggregate of expenditures over a year.)

Furthermore, the term "health care facilities" is added to the areas covered by the certificate of need provisions, in addition to the phrase "institutional health services." We see here a potential repetition of past attempts to control physician offices through addition of this term, and believe that such an attempt would be improper.

Mr. Chairman, we hope you and the members of this committee will agree with the view that any initial inroads into medical practice seeking to control physician offices or the acquisition of practice equipment would jeopardize the independent practice of professionals. Such an action could only lead to more stringent controls eventually controlling practice locations and extent of services available and affecting quality of care. Medical practice—the physician's office in particular—should not be treated as a public utility. Moreover the same rationale for controlling expenditures in hospitals does not apply to independent medical practices. Physician office controls should not be subject to a measure intended to control hospital costs.

We of course share the concerns of this committee about increasing costs. Medical care costs are indeed rising, but it would not be desirable to institute controls which would have the practical effect of curtailing modern equipment intended to provide the highest level of quality care. We recommend that the certificate of need program not be extended to physicians' offices.

NEW LIMITATIONS UNDER SECTION 1122

Other new provisions to title II of the original bill revise the present section 1122 of the Social Security Act. The new provisions would allow the Secretary to enter into agreements with the Governor of a State for 1122 review to be carried out by the State health planning agency designated under the National Health Planning Act. Failure of the Governor to enter into an agreement within 1 year would result in termination of all Federal Medicaid funds payable to the State. If a capital expenditure was made for major

medical equipment or a health care facility, no reimbursement under title V, XVIII, or XIX for services provided by use of the equipment, for depreciation, or for direct operating costs could be made unless the State agency had reviewed and found a need for such equipment or facility. Failure of a Governor to enter into an agreement would allow the Secretary directly to make determinations of need under section 1122 for purposes of reimbursement of costs.

A capital expenditure would be one exceeding $150,000 for major medical equipment or, as to a facility, an expenditure which is $150,000, changes bed capacity, or substantially changes services of the facility.

We believe the extensions under H.R. 8121 should not be supported. Especially objectionable is the provision which would terminate all Federal Medicaid payments to the State if the Governor of the State failed to enter into an agreement with the Secretary to comply with new 1122 review procedures. Such termination of funds would be grossly unfair as they would most affect needy persons on Medicaid. To support authority in the Secretary to terminate all Medicaid payments whether for medical care, for hospitalization or for any other eligible care included in the State Medicaid plan, is to us an extreme and undesirable exercise of Federal power to force a State into complying with a Federal program by impairing delivery of care to low income individuals. No justification has been shown for imposing such an onerous provision which would be so far-reaching in its effect upon the provision of needed medical care to Medicaid recipients.

Concerning the requirement of review and approval by the State agency of major medical equipment, we believe this would be inappropriate if interpreted to include equipment within a physician's office. The determination by the State of the equipment which may or may not be used by a physician in his own office is in fact precluding the patient from receiving the care by his physician in the manner which the physician believes most appropriate for the patient.

Another provision would be added to title II which would prohibit certain sales of medical equipment, costing more than $150,000, without planning authority approval for such equipment. Any person who sold the medical equipment in violation of this provision would be subject to a civil penalty of up to five times the sales price of the equipment. We question the fairness of such a provision. Should the Federal Government impose upon the seller of a product a penalty for selling that product only because a third party did not comply with some requirement of the law? Aside from the harshness of the penalty, we believe that such a penalty should not be placed on the seller.

DISCONTINUANCE OF HOSPITAL SERVICES

A new title III is added to the original H.R. 6575. This new title would establish a 4-year program for the purpose of encouraging the discontinuance of certain hospital services. The Secretary would establish guidelines pertaining to the maximum appropriate supply

ceilings within each HSA for hospital beds and the minimum appropriate rate of hospital occupancy. Each HSA would identify the actions that were needed to comply with the applicable guidelines issued by the Secretary. Any hospital which met the program requirements by discontinuing of services, by closing units in the hospital, or by converting an identifiable unit, could apply for either debt payments, incentive payments, or conversion payments.

Upon application the HSA would review and make a determination of the need for the services. Its recommendation would be reviewd by the State planning agency which in turn would make a recommendation to the Secretary of HEW. Certain incentive payments made to a hospital would also entitle the HSA to receive a payment equal to 10 percent of the hospital award. Payment for incentives under this program would be paid out of Federal general revenues.

If upon the expiration of the period of the program, the health service area was not in compliance with any applicable guideline promulgated by the Secretary, then the amount of reimbursement to each hospital in the area would be reduced by 5 percent under titles V, XVIII, and XIX until the area came into total compliance with the guidelines. This time period could be extended upon special request by the HSA and approval of the Secretary.

We believe that these programs for "incentives" are more realistically incentives to the Secretary as well as to the HSA to close hospitals, identifiable units of hospitals, or services of hospitals. The emphasis in this provision with respect to establishment of guidelines by the Secretary changes the originally stated intent of the planning act to provide for local planning and local determination of need along with the local determination of a health plan. If now the Secretary is to establish the "guidelines" which the HSA would be mandated to follow and which all hospitals in the area would, through the threat of a potential penalty at the end of 4 years, be forced to follow, is not the result Federal regulation rather than community planning? Is this not contrary to what the advocates of planning have long pointed out as the essential characteristic of local health planning?

We believe that health planning can be successful on a voluntary local basis and that it should be utilized. We do not believe, however, that the Secretary can more appropriately establish requirements for hospitals in a community than can the community. The imposition of this title, especially in a bill which imposes strict revenue increase limitations on all hospitals, emphasizes further that hospitals are expected to phase out services. After restricting the income, after threatening the hospital with potential penalties for exceeding the revenue limitation, after subjecting the hospital to consequences of new and more stringent review under certificate of need as well as section 1122, and after setting up additional incentives to control costs—which incentives are unrealistic—the bill in addition thrusts upon the hospitals the additional pressure from the Secretary, from the State, and from the HSA of closing or converting its facilities. In addition the HSA, through financial incentives, would have an interest to assure that the hospital is closed or a unit of the hospital is phased out. As an additional point, once again

questions concerning the use of general revenues to assist private institutions, in this case in effect to liquidate assets or obligations, or to terminate functions, should be considered carefully.

We believe that these provisions are unwise and would result in a distinct lowering of access to health care and a lowering in quality care available to all citizens.

CONCLUSION

In our view H.R. 8121 should not be supported in its present form because of its potential undesirable effects upon patient care.

Mr. Chairman, we would like to point out the desire in our statement to analyze and to emphasize what we see to be the effects of H.R. 8121 upon patient care. We recognize that the sponsors of this bill are seeking to address responsibly the acute problems of rising costs of health care, and this subcommittee's activity in holding hearings and in bringing into public discussion the issues in this legislation should prove beneficial.

The AMA is also addressing these issues, and seeking answers to the complex factors involved, through its National Commission on the Cost of Medical Care, whose activities we described in some detail in our earlier appearance on H.R. 6575. The final report of that commission, with its recommendations, is due in January 1978 and will be available at that time. Pending the issuance of that report, however, the AMA is also anxious and desirous of working with Congress in developing appropriate measures. We again offer our assistance in that development.

Mr. Chairman, at this time we will be pleased to respond to any questions you may have.

[The statement on H.R. 6575 referred to follows:]

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION, PRESENTED BY RAYMOND T. HOLDEN, M.D., AND EDGAR T. BEDDINGFIELD, JR., M.D.

Honorable Chairmen and Members of the Subcommittees, I am Raymond T. Holden, M.D., a practicing physician in Washington, D.C. I am Chairman of the Board of Trustees of the American Medical Association and am pleased to present on behalf of the Association its views on H.R. 6575, the Hospital Cost Containment Act of 1977, introduced on behalf of the Administration. Participating with me in this presentation is Edgar T. Beddingsfield, Jr., M.D., who is in medical practice in Wilson, North Carolina. Dr. Beddingfield is Chairman of the AMA Council on Legislation. Accompanying us is Harry N. Peterson, Director of our Department of Legislation.

BACKGROUND

At the outset we want to express, on behalf of the AMA, appreciation for this opportunity to appear at this joint subcommittee hearing on the proposed legislation concerning cost constraints on hospitals. As you know, the American Medical Association is strongly concerned with all issues involved in the delivery of our nation's health care. We have appeared on numerous occasions before subcommittees of both Houses of Congress concerning the important issue of costs for health services.

The American Medical Association shares your strong concern with the present problem facing our country with respect to rapidly rising increases in health care costs. Because of our concern with this problem, we have convened a National Commission on the Cost of Medical Care. The Commission is broadly based and draws its membership from leadership of all sectors: economics, government, labor, business and the public. That Commission, which has been meeting since early last year, has been charged with the responsibility to provide the AMA's Board of Trustees with a final report by January, 1978 to contain: (1) A description of the health care delivery system; (2) identification of the factors underlying the rising costs of medical care; (3) a review and evaluation of existing research of the causes of medical care cost inflation; (4) an evaluation of the impact of pending or future health programs on the health care delivery system and medical care costs; (5) recommendations on policies that will contribute to containment of medical expenditures while providing quality medical care to the public; and (6) recommendations and direction for future research programs.

The AMA has also recognized that hospital care is by its nature expensive for a variety of reasons, including the necessity for having available technologically advanced equipment and services, and indeed for meeting a morass of federal, state and local laws and regulations. It is a fact that costly, but desirable, services and facilities are demanded by the community in its desire to have its hospital provide high quality service on virtually a 24-hour basis, seven days a week, every week of every year. Few other service industries must comply with such strict public and governmental demands. Can it be surprising then that hospital costs escalate?

In the face of this unique situation, compounded by such federal programs as Medicare and Medicaid instituted to assure access to care to millions of individuals, the government in the past has attempted to restrain costs by paying practioners and provides in many instances less than its proper share of the costs; yet it insists upon full service. We have seen this attempt through legislation arbitrarily limiting federal reimbursement, through federal programs encouraging special modes of delivering health care, and through regulations attempting to categorize institutions. Still vivid in our memory are the now discredited controls attempted through imposition of the economic stabilization program in 1971. Of particular concern was the opprobrious retention of those cost controls in phase IV the the health field while removing the controls from other segments.

We believe that at least a significant portion of the recent inflationary increases in hospital charges, and generally in health care costs in our economy, is a reaction to, among other things, the various ceilings imposed on the rate of increases in the health sector.

While these means have been unsuccessful, the legislation again singles out one segment in our economy for the imposition of special controls. It proposes to control health care expenditures by limiting inpatient revenue of virtually all hospitals from all sources. This approach is somewhat similar in effect to that attempted under the economic stabilization program.

For these and the reasons set out below we recommend that the bill before you not be adopted. We say this notwithstanding our desire to see undesirable inflation curbed. But in our view this legislation would not be in the best interests of patients.

HOSPITAL COST CONTAINMENT PROPOSAL

H.R. 6575, the Hospital Cost Containment Act, contains three major programs. One would establish a formula for limiting increases in hospital inpatient revenues from all sources. Another would provide for a national limit on hospital capital expenditures. The third would provide that the Secretary of HEW would submit to Congress by March, 1978 a report setting forth his recommendations for permanent reforms in the delivery and financing of health care to replace the program limiting hospital revenues. (This it should be kept in mind that the program for capital expenditure limitation is apparently intended as a permanent one.)

As to the "caps" on inpatient hospital revenue, the bill would establish for each year a limit on annual increases. This limit contemplates a formula based on the general price trends in the economy. The limits on increases in revenues would apply to payments from all payors, including both private and public.

All hospitals would be included with the exceptions of long term care hospitals, new (less than two year old) hospitals, and those institutions receiving at least 75% of their revenues from certain health maintenance organizations.

The Secretary of HEW would have authority to grant certain exceptions to individual hospitals under the cost containment provisions of the bill; however such exceptions would apply only to the extent that the hospital provides evidence of its cost of increase in excess of the cap as a result of changes in admission beyond a specified range or changes in capacity or character of inpatient services. In addition, a hospital requesting an exception would have to show that the revenue otherwise available is insufficient to assure the solvency of the hospital.

Another exception to the limitation would be costs attributable to wage increases to non-supervisory personnel.

Enforcement of the hospital cost containment revenue limit would be implemented through the disallowance by the Medicare, Medicaid, and Maternal and Child Health programs of any payment in excess of the cost containment limits. In addition, payment by cost payors, or receipt by hospitals of revenues in excess of the limitation would subject both the payor and the hospital to a federal excise tax at the rate of 150% of the excess (unless such excess amount was placed in escrow to be applied to the next year's revenues) and to exclusion from the Medicare and Medicaid programs.

The second major program of H.R. 6575 would impose a limitation on hospital capital expenditures. These provisions would require the Secretary of HEW to establish a national limit on total hospital capital expenditures. The Secretary would apportion the sum among the states on the basis of population. In addition, the Secretary would be required to establish a national ceiling for the supply of hospital beds and a national standard for the rate of occupancy of hospital beds to be applicable to each HSA. The bill defines the ratio of 4 hospital beds per 1,000 population and rate of occupancy for hospital beds of not less than 80% at the national standards to be applied by the HSA.

Enforcement of the limitation on hospital capital expenditures would be carried out by amending the certificate of need requirement under Title XV of the Public Health Service Act and amending Section 1122 of the Social Security Act to provide that with respect to services furnished in a health care facility which is not covered under a certificate of need program, or 1122 review, the Secretary would not include in federal reimbursement an amount equal to ten times the amount otherwise recognizable as program payment for depreciation, interest on borrower funds, or return on equity capital or other expenses related to capital expenditures, unless the Secretary had approved such capital expenditures.

The Internal Revenue Code would also be amended to provide that any obligation issued by a State or a territory for an institutional health service, health care facility, or HMO which would result in an excess in the bed supply ceiling or for which a certificate of need had not been issued would not be eligible for treatment as a tax exempt bond.

Mr. Chairmen, while all of us are concerned about the cost of health care, we must not be concerned only with the cost in terms of dollars. The AMA is concerned over the impact that this legislation would have on the quality and availability of hospital care for the American people. It seems inescapable to us that the "cap" on spending will result in second-rate care, and some care may simply become unavailable for many people.

This proposed legislation would, as we will point out in more detail, have the effect of limiting the extent of quality care available and would result in restriction of access to quality hospital care.

I would now like to have Doctor Beddingfield present our further comments on the pending legislation.

STATEMENT OF EDGAR T. BEDDINGFIELD, JR., M.D.

Mr. Chairman, at this time we would like to comment in greater detail on the major provisions in H.R. 6575. In general our views reflect the observation that the bill, as proposed, does not support incentives for efficiency, perpetuates inefficiency in hospital care, creates a rigid program which in the long run would be unresponsive to improving quality of hospital care, discourages increased access to care, and penalizes institutions which seek to respond to increased community health needs.

PERMANENT PROGRAM; REPORT

I will first address the implicit issue found in section two of the bill entitled "Report on Permanent Reform in the Delivery and Financing of Health Care". The thrust of this section states that no later than March 1, 1978 the Secretary of HEW shall submit to Congress a report on his recommendations for "permanent reforms in the delivery and financing of health care", which reforms will supposedly "increase the efficiency, effectiveness and quality of health care" in this country and which would replace the transitional provisions of the bill.

While the language in section two is not specific concerning all elements to be included in the report, it apparently contemplates that the Secretary consider the whole sweep of the health care segment of the economy and propose "permanent reforms" in the delivery and financing of that health care.

This provision must be given careful analysis in relation to other provisions of the bill. If it is intended through this legislation that "permanent" proposal would be made "no later than" six months after the "transitional" program takes effect, why, then, should Congress pass a temporary program only to consider permanent proposals? We believe that it would be wiser to await the proposals for permanent change in order to evaluate more fully the real direction of the more important Administration considerations. This course would avoid the disruptive effects which are certain to occur under H.R. 6575 and its adverse effects upon health care. Such a course would be especially desirable since the permanent proposal is to "increase the efficiency, effectiveness and quality of health care" in this country. As to the contemplated report, we believe that some provision should be made in the legislative language for the Secretary to utilize a select advisory committee to be composed of representatives of all segments of health care. Use of such an advisory committee would help to assure, we believe, that any report would carry better balance and would take into consideration the views of all segments affected.

We urge the Subcommittees to change this section by requiring that the report be completed prior to adoption of any temporary program, and utilizing the advice and consultation provided by a special and select advisory committee.

"TRANSITIONAL" HOSPITAL COST CONSTRAINT PROVISIONS

We will now turn to the more detailed provision of H.R. 6575. A program limiting total hospital revenues for virtually each hospital in the United States would be established. A failure to comply with the federally determined limitation on hospital revenue would result in serious penalties. The limitations on the hospital revenue would be calculated through a complicated formula which itself is based on the GNP deflator increase over a base year.

We would like to point out clearly at this time that the "transitional" provisions of the bill are on their face permanent since there is no termination date of the program in the absence of future Congressional action. The formula is self-executing and mandatory year after year.

We believe that such limitations on hospital revenues as included in the program are inappropriate. Artificial limitations, irrespective of how generous or how restrictive, are unrealistic. In order to provide an uninterrupted flow of quality hospital care which the American people demand, a hospital must keep pace with current technological advances. This often means the purchase of expensive equipment. This often also means the necessity to expand hospital

services. No patient wishes to be admitted to a hospital which he believes is not a modern hospital. A reimbursement limitations on hospitals which does not allow increases reflecting true cost increases could have the effct of unfairly and inappropriately restricting increases in hospitals when those increases are due to increased service, better equipment, or more highly skilled staff.

The costs in the health care sector do not necessarily react in the same manner as does the GNP. In the case of health care there occurs a circumstance which is unlike many other segments of the economy. The health care sector is labor intensive and is technologically highly sophisticated. There are very few other segments of the economy in which such a concentration of expensive and complex technology is combined with a highly trained and educated group of people as occurs in the hospital. When this is combined with the general case of operating on a non-profit basis, one can readily see how hospital costs can react differently from the other portions of the economy. Unlike a manufacturer who does not have the most modern processes and yet can operate efficiently and with no adverse effect on the public, hospital must quickly obtain the most modern technology in order to make available the best care to individuals. A failure to do so can have adverse impact on the public. However, this bill would in effect limit the physical plant and technological increases of any hospital by limiting revenues. We believe that such limitation as proposed by H.R. 6575 would be quite detrimental to individual hospitals which seek to remain in the mainstream of modern medical treatment and care. Such a limitation is also compounded when one considers, as we discuss later, the new capital expenditure limitation which the bill proposes.

As to the specific formula under the bill for determining revenue increases, we note that it is based on inpatient hospital revenue per inpatient admission. It is expected that in the first year the formula would allow a 9% increase in gross inpatient revenues. This increase would be allowed for a particular hospital, however, only where the number of admissions did not increase over 2% or decrease in excess of 6%, as compared to the base year. On the other hand, if a hospital should exceed the 2% of 6% limitations, the amount allowable would be increased only by ½ of such amount for each admission over the 2%, and ½ the per patient allowable would be deducted from revenue if over the 6%. Slightly different percentages would be applicable to smaller hospitals. For larger, absolute limits in extra revenue would be established. In other words, the hospital is expected to provide any and all care which it is able to provide for any and all admission increases over the prior base year (up to a percentage) for no extra revenue and a ½ price for any admission above the allowable percentage increase. Moreover it even runs the risk, at higher percentages, of a penalty of 150% of inpatient revenues.

The obvious question is exactly how can a hospital survive and continue to provide quality services in proper facilities under such limitations? The amount of allowable increase in revenue could be easily offset by cost increases just to maintain the level of care given in the base year, even though total admission may have increased. Who pays the increased cost? Will the supplier of the hospital reduce his charges? Is the equipment expected to be donated? Is new construction done gratis? Costs cannot be shifted by the hospital since the formula affects total revenue from *all* inpatients irrespective of who pays the bill.

What sort of incentive is this? Under the formula a hospital might be encouraged to cut down on service and patients in order to maximize charges in order to maintain its ability to admit patients. It would have an equal incentive to admit only those patients with relatively less need for hospitalization since it must maintain its general admission levels as reflected in the formula.

We believe that the formula is manifestly unfair. It could in fact penalize efficient hospitals and reward inefficient hospitals. Furthermore, in our opinion, it could have the effect of discouraging hospitals in communities, especially in rural areas, from increasing its costs by improving its services through desirable means such as seeking additional necessary medical or nursing personnel. A basic fault of the bill is that hospital revenue is fixed without proper relevance to total patient admissions. Thus the more admissions a hospital has above its base year, the more likely it is to be penalized. A small hospital or a hospital in a shortage area would be devastated if a new physician located in the community and began to admit patients. Increases over the base year would in effect be subsidized by the hospital.

However, from the standpoint of the individual patient, the administration proposal assures no relief from full inflationary increases. There is no specific limitation on the increase in amounts which an individual may have to pay for hospital care, since these new provisions all go to restraining total hospital revenues. It is indeed ironic that the government should publicize a "cost containment" program purportedly limiting increases to 9% but which in fact could result in greater increased costs to the individual.

We also note that a 150% excise tax is applicable to "excess" revenues as received by any hospital or as paid by any third-party payor. We believe that such a provision, in effect constituting a penalty, is offensive to the concept of fairness, and we believe such a provision should bee stricken. The federal government should not seek to impose such a penalty upon hospitals or payors under the guise of a tax or any other method. If such a "tax" were applied, the impact would fall upon quality care of patients.

We also note that the bill attempts to exempt certain hospitals from provisions in this act, most noticeable of which is a federal hospital. Also certain HMO hospitals are exempt from the provisions. While we believe that the provisions of this bill should not be applicable to any hospital, we also believe that if limitations are applicable, they should be equally applicable to all hospitals. Why should hospitals which deliver health care and presumably meet the same cost requirements as a non-federal or non-HMO hospital be exempt from the "benefits" of this bill?

A further exemption from revenue limits under the bill would be for any amounts for wage increases for nonsupervisory personnel. Again, while we do not advocate that wages should be subject to such an onerous bill, we question the reason for the exemption if in fact hospital costs are sought to be contained. One of the factors for rapid hospital increases in recent years has been the rapid increase in salaries and wages of non-supervisory personnel. Furthermore, the bill discriminates in its treatment and recognition of increases for supervisory and non-supervisory personnel.

We believe that the Administration's proposal for limitations on revenues of all hospitals should not be adopted.

LIMITATION ON HOSPITAL CAPITAL EXPENDITURES

These limitations are clearly permanent under the bill. We believe that these provisions are unwise since they would have the effect of placing artificial, absolute and unrealistic limitations on capital expenditures seeking to improve hospital services and facilities.

Mr. Chairmen, we believe that the capital expenditure limitation as proposed under the Administration's bill is a clear example of federal control over the community. The National Health Planning and Resources Development Act was presented as fostering local planning and local determination of local needs. Yet now the Administration seeks to use it as a vehicle for further refining federal control over local decision making. Capital expenditure limitations as contemplated under the bill are unrealistic in that they attempt to state in advance the aboslute limit by which capital expenditures may increase within a state and impose minimum occupancy rates of hospitals and fix the ratio of beds to population.

Furthermore we believe that absolute limitations on the amount of capital expenditures within an area would again benefit inefficient hospitals, by preventing competition. As noted above, inefficient but costly hospitals would be allowed the same percentage increase in permissible revenues as an efficient hospital. Inefficiency would thus be perpetuated by sanction of the revenue and capital limitation programs.

We believe that the capital expenditure limitation provision of the bill should be stricken.

As to the proposed amendments to Section 1122, the proposal would authorize the Secretary to invoke new and severe penalties. The proposed penalty could mean that legitimate patient care funds would be decreased because a hospital did not comply with Section 1122 or certificate of need requirements by virtue of the fact that the state did not have such programs in effect. While a case perhaps can be argued for disallowing amounts for depreciation or other related expenses from being included in Medicare payment in the event a hospital built without approval, we fail to see any justification for allowing funds (in the amount of ten times the otherwise amount payable for depreciation, etc.) to be taken from the legitimate patient care reimbursement as such penalty. In such instances the real victims of the penalty are not the hospital but the patients. This provision should also be deleted.

In conclusion, we recommend that H.R. 6575 should not be adopted.

At this time we will be pleased to respond to any questions which you may have.

Mr. ROGERS. Thank you.

Mr. McMahon, you may proceed as you desire. Your complete statement will be made a part of the record [see p. 175.]

STATEMENT OF JOHN ALEXANDER McMAHON

Mr. MCMAHON. Thank you, Mr. Chairman.

I am John Alexander McMahon, President of the American Hospital Association. With me today is Dr. Leo J. Gehrig, Senior Vice President of the Association.

We appreciate the opportunity to appear at this hearing and to share with you our views on H.R. 8121, as well as our views on other proposed hospital containment legislation.

We are gratified at your efforts through the introduction of H.R. 8121 to introduce incentives toward increased cost effectiveness in the provisions of H.R. 6575. We especially wish to commend your efforts to assist hospitals in the closure or conversion of underutilized facilities and services and the expansion of certificate-of-need coverage. I will comment specifically on these as well as other provisions of H.R. 8121 later in this testimony.

On pages 2 and 3 of our testimony, Mr. Chairman and members of the committee, we have set out some reasons for hospital cost increases, paying particular attention to the impact of inflation on the rest of the economy and the improvement of hospital care which responds to a demand broadened by the availability of insurance coverage.

Hospitals do resent, Mr. Chairman, the allegations of obesity, if you like, and inefficiency. A recent study we have made which we would be glad to submit to the committee shows that hospitals individually across the country are making efforts to stretch every dollar as far as it will go, and clearly incentives are better ways to support this kind of effort than allegations of inappropriate conduct.

There are some earlier questions that you put to the administration witnesses, and we would be pleased to expand upon those in the question period.

On pages 3 and 4 we have noted many of the activities now going on that tend to restrain hospital costs. These include a commitment to comprehensive health planning, including the development of strong certificate of need laws; the elimination of fraudulent activities under Medicare and Medicaid, which is the goal of H.R. 3; improved review of the utilization of health care and further development of medical audits, and so forth.

The complexities in the interaction of many of these activities can be illustrated and were illustrated earlier today when the administration witnesses found themselves unable to respond to some of your direct questions. If they, the architects of this legislation, cannot answer your questions, imagine the confusion at the institutional level.

On page 4 we noted that these activities now going on—planning, utilization review, and so on—already are having an effect on the rate of increase in hospital costs and across-the-board costs generally.

Our preliminary analysis of recent data indicates that the rate of hospital cost increases is beginning to moderate. Admissions and days of care, when considered in conjunction with the growth of the population, are also decreasing. Our review of such experience is not completed, but as this analysis is accomplished we will be pleased to share our findings with the committee.

Now I would like to turn to the provisions of H.R. 8121, recognizing our continuing problem with anything that has a cap approach in it, and again referring to the problems with H.R. 6575 and the basic cap approach that we outlined to this subcommittee and the Subcommittee on Health of the Ways and Means Committee on May 13, during the joint hearings dealing with hospital cost containment.

We have given attention to the new provisions in title I on pages 4 to 6 of the written testimony, Mr. Chairman, and we give attention first to the deletion of section 114(c). This removes an incentive that we think is particularly important, and we suggest a reintroduction of section 114(c) if this approach is to be followed.

It may be, Mr. Chairman, for some hospitals, as I think the administration witnesses indicated, the only way to survive under a 9-percent approach.

On page 5 we have given attention to the incentives for good performance by hospitals in containing cost increases, part D of title I. This would provide an incentive payment to hospitals that are able to restrain their cost increases to a level below the limit for increases in inpatient revenues. But there is a very limited application to hospital having outpatient deficits, and we have suggested in our testimony the broadening of that because as we noted at the bottom of page 5, if an incentive is provided for good performance it should be available to all hospitals which meet the performance requirements.

At the top of page 6 and from there to page 7 we have given attention to the new provisions in title II, limitations on capital expenditures. As I noted at the outset, we vigorously supported community health planning and worked actively and constructively in the implementation of this important law, just as we had encouraged the development of new strong State certificate-of-need laws earlier.

At the outset, we have already expressed our concern to the Department of Health, Education, and Welfare regarding their attempts to develop the guidelines that you inquired about earlier this morning. We have concern in this bill with the reliance on Federal guidelines and the requirement that those guidelines be followed by the health systems agencies.

We have supported planning because of its local decision-making emphasis. If this is to be changed to a following of Federal guidelines, we suggest that we are going to restrict and inhibit the development of appropriate plans which give attention to local needs.

At the bottom of page 6 we give attention to our problem with a specific capital expenditure ceiling in your bill and the administration's bill of $2.5 billion a year. We think this would endanger the hospital industry's ability to maintain its present facilities, to

comply with present and future codes and safety standards, to provide when appropriate and consistent with the planning process those improvements and new developments in services and facilities that patients will demand.

Toward the bottom half of page 7 we give attention to two of the changes that you proposed to title II. We are particularly pleased to note the extension of certificate of need to all expenditures for medical equipment in excess of $150,000, regardless of ownership or location, and that ought to be clarified to make sure what is being focused on by the committee, and what we think is appropriate, is the problem of proliferation or unnecessary duplication of equipment.

We think failure to impose a requirement for approval of all capital expenditures wherever located, as long as we are talking about the same kind of expenditures, would have a deleterious effect on the planning process.

We also note an increase in the duties and responsibilities of HSA's and State agencies both in your bill and in H.R. 6575. While in the past we have supported increased appropriations for these entities, we believe further priority attention should be given to the provision of adequate financial support in their behalf. We have some concern about asking too much too quickly from them for fear it will undermine their ability to move toward the development of an appropriate plan.

Finally on pages 8 to 10 we have given attention to the new title III in your bill, H.R. 8121. This title begins by providing within 1 year of enactment guidelines would be developed and required to be used in the planning process. I have previously expresed my concern with that.

We have then given attention to the form of hospital incentive payments proposed. The first would provide incentive payments to hospitals which discontinue all inpatient services if these services are unneeded. We have given attention specifically to the limitation in the way those incentive payments could be used, and believe some broadening could be used, some broadening that would add to the incentive.

I would like to note particularly the paragraph at the bottom of page 8. The fact that the closure of underutilized facilities, which we have no quarrel with, will add a patient load to other institutions in the same service area. If there is an incentive for the closure of facilities and it runs into conflict with a limitation or a lack of encourgement for other institutions in the area to pick up the slack that is going to come about, we have a conflict. We have analyzed the cap, institutions are going to be intentionally discouraged from increasing admissions. If that is the case, that, we are saying, is inconsistent with the encouragement in title II to close down underutilized facilities, because other institutions may very well in a particular area resist picking up the slack.

At the top of page 9 we have noted the second form of incentive, to encourage the discontinuance of an unneeded service. We indicate that broadening of the incentive to make it like the closing of an entire institution would be appropriate.

The third form of incentive proposed under this title would encourage the conversion of an identifiable part of a hospital which

is underutilized into a needed long-term or ambulatory care facility. There we have suggested the possibility of broadening this so that any conversion project approved by the planning agency would be eligible for support.

At the bottom of page 9 we have given attention to two of the other incentive provisions. The problem of the HSA receiving a payment of 10 percent of the amount of incentive payments made to hospitals in its area for closure of identifiable inpatient units or total inpatient services presents a problem.

We are not sure until the new health planning structure develops appropriate plans that further encouragement should be given to developmental activities.

Then we have noted the inequitability of the provision for a 5-percent reduction for each hospital in an area which is not in compliance with any applicable planning guideline. We think this would present problems because some hospitals might be doing everything they could and yet be penalized because of the fact that other hospitals have prevented, or the area itself has done some things that have inhibited, the achievement of the goals.

Mr. Chairman, finally we recognize the difficulty of devising incentives within the structure of H.R. 6575. Because as we have indicated over and over again, the health care delivery system is complex, it is interactive and it must be dealt with with great care. Because of the limited time we have had to review your proposal we would ask permission to submit further comments and suggestions as we continue our study.

At your convenience we will be pleased to respond to questions.

[Mr. McMahon's prepared statement follows:]

AMERICAN HOSPITAL ASSOCIATION
444 NORTH CAPITOL STREET, N.W., SUITE 500, WASHINGTON, D.C. 20001 TELEPHONE 202-638-1100
WASHINGTON OFFICE

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION
TO THE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
OF THE HOUSE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE
ON H.R.8121, THE HOSPITAL COST CONTAINMENT ACT OF 1977

July 18, 1977

Mr. Chairman, I am John Alexander McMahon, President of the American Hospital Association. With me today is Leo J. Gehrig, M.D., Senior Vice President of the Association. The AHA represents more than 6,500 member institutions, including most of the hospitals of the country, extended and long-term care institutions, mental health facilities, hospital schools of nursing, and over 24,000 personal members. We appreciate the opportunity to appear before this hearing and to share with you our views on H.R.8121, as well as our views on other proposed hospital cost containment legislation.

We are gratified, Mr. Chairman, at your efforts through the introduction of H.R.8121, to introduce incentives toward increased cost effectiveness in the provisions of H.R.6575. We especially wish to commend your efforts to assist hospitals in the closure or conversion of underutilized facilities and services and the expansion of certificate-of-need coverage. I will comment specifically on these as well as other provisions of H.R.8121 later in this testimony.

As you know, and as we have previously testified, the hospitals of this country have strongly opposed H.R.6575. I should like to restate very briefly several key policies and positions of the AHA with respect to this legislation, not for the sake of repetition, but to remind the Committee of the Association's perspective on the critical

issue of containing health care costs and what approaches we have been advocating and continue to advocate to alleviate this problem.

HOSPITAL COST INCREASES

As I have stated previously before this Committee, the fact that hospitals and health care costs are increasing at a rapid rate is not in dispute. Hospitals are concerned and are working actively to restrain health cost increases within their control. Health care cost increases are a complex problem. To address the issue requires the combined efforts of all providers, consumers, and government and other third-party payers. Therefore, as we seek to bring the increase in health care costs more in line with the growth of the general economy, it is essential that the actions taken be constructive to this end, and it must be recognized that this objective cannot be accomplished in a relatively short time.

I scarcely need to review in depth once again the many vectors that cause increases in hospital costs. They include the impact of general inflation; a growing public demand for health care services, which in itself is a complex issue; the intensification of services, meaning the kinds and volume of services used by patients as related to the sophistication and expansion of medical technology; the modernization and maintenance of hospital service capacity; the reliance on patient care revenues for the training of health manpower in hospitals; and the impact of the ever-increasing imposition of governmental regulations on hospital operations.

We oppose H.R.6575 and its counterpart in the Senate, S.1391, because we are firmly persuaded that the arbitrary limit this legislation would impose on inpatient revenues of hospitals would seriously jeopardize the present and future ability of hospitals to provide quality care to the American people. The legislation is inequitable because it ignores the fact that hospitals must acquire goods and services

from segments of the economy that are uncontrolled and experience high rates of inflation. It disregards the manifold differences between hospitals, not only of varying types but even of the same types. The proposal, moreover, would screw down increases in hospital inpatient revenues over time, eliminating all ability to incorporate improvements in care, and would fail to keep up with the known rate of inflation in the hospital market basket. We believe the legislation, were it to be enacted, would be virtually impossible to administer.

ALTERNATIVE APPROACHES

Mr. Chairman, I trust that our adamancy about a cap or percentage limit on inpatient revenues is not interpreted by members of the Committee as a defensive avoidance of the problem. We are by no means negativistic with regard to viable alternatives for the containment of health care costs. We are as committed as the federal government to seeking adequate solutions in the public's best interest. Accordingly, the AHA and its member hospitals have supported a variety of programs aimed at conserving the nation's health care resources, some of which are in place, some in developmental stages, and others yet being formulated through legislative and administrative initiatives, state and federal.

As I explained in detail at joint hearings held by this Committee and the Health Subcommittee of the House Committee on Ways and Means last May, we have been involved in numerous alternative ways of dealing with the cost issue. These include a commitment to comprehensive health planning, including the development of strong certificate-of-need laws; the elimination of fraudulent activities under Medicare and Medicaid, which is the goal of H.R.3; improved review of the utilization of health care and further development of medical audits; the collection and public disclosure of hospital financial information by selected public entities; changes in the method of payment to hospitals through recognized voluntary or statutory

state rate review programs and, in the absence of a rate review program in a state, reform of Medicare and Medicaid reimbursements, as approached by H.R.7079 and S.1470; efforts to control demand for services, primarily aimed at increasing cost consciousness related to use of health care services; avoidance of the imposition of governmental regulations which add to hospital costs without commensurate benefits; and the continuation and expansion of programs to help the public overcome poor health habits.

Obviously, and as I have already indicated, Mr. Chairman, hospitals are hardly unmindful of the dimensions of the cost issue. We are convinced that activities already underway and being improved are having an effect on cost increases. Our preliminary analysis of recent data indicates that the rate of hospital cost increases is beginning to moderate. Admissions and days of care, when considered in conjunction with the growth of the population, are also decreasing. Our review of such experience is not completed, but as this analysis is accomplished we will be pleased to share our findings with the Committee.

I now would like to turn to the provisions of H.R.8121.

TITLE I
"TRANSITIONAL HOSPITAL COST CONTAINMENT PROVISIONS"

Part B--Deletion of Section 114(c)

Section 114 of H.R.6575 addresses the problem of providing an incentive to close a service determined not to be essential to a community's health needs. Such a closure would, of course, reduce the cost of health care. The incentive which would be provided consists of retaining in the base year the amount of the revenues derived from the services which are discontinued. This incentive would be allowed only if the planning agency determined that the service to be discontinued was inappropriate.

This provision also would work to prevent the shifting of such services (unbundling) to independent contractors.

H.R.8121 would delete Section 114(c) on the grounds that other incentives for closure of services, which we will discuss later, are provided under Title III of the bill. It is our concern that the other incentive payments would not assist hospitals in operating within the very strict revenue increase limits that would be imposed. We agree with your purpose--improving incentives for closure of unneeded services. However, we recommend the retention of Section 114(c).

Part D--"Incentives for Good Performance by Hospitals in Containing Cost Increases"

H.R.6575 approaches the reduction of hospital cost increases in a purely punitive fashion, penalizing hospitals that exceed the revenue limit and, contrary to its apparent objectives, provides no immediate incentive to raise revenues less than the limit allows. Part D of Title I would provide an incentive payment to hospitals that are able to restrain their cost increases to a level below the limit for increases in inpatient revenues. Such incentive payments would be limited to hospitals which are incurring outpatient deficits. By so restricting incentive payments, only a limited number of institutions could consider the possibility of obtaining them. This is evident when one considers that in 1976 only one-third of all acute care hospitals (2,028 of 5,857) had organized outpatient departments. Moreover, many of the major urban hospitals experiencing large outpatient deficits would have great difficulty in being able to restrain their inpatient revenue costs sufficiently to be eligible for the incentive payments.

We believe that if an incentive is provided for good performance in containing cost increases, it should be available to all hospitals which meet the performance requirements. While reduction of an outpatient deficit is a very worthy goal, there are many others, such as reduction of debt, support of inpatient charity care and bad

debts, and improvements in needed services. Therefore, we further recommend that such incentive payments be available for a broad range of appropriate purposes.

TITLE II
"LIMITATION ON CAPITAL EXPENDITURES"

AHA has vigorously supported community health planning and urged enactment of P.L. 93-641. We have worked actively and constructively in the implementation of this important law, just as prior to its passage we encouraged the development of strong certificate-of-need laws at the state level as a necessary component of effective health planning. Such mechanisms are vital to maximize the efficiency of the system and to avoid duplicative or unneeded health resources.

At the outset, we would like to express some concern about the extent to which federally developed guidelines may impose rigid ceilings, ratios, and standards on Health Systems Agencies (HSAs) and state planning agencies. Narrow national formulas are not appropriate for every community and state, and could interfere with sound planning for community health services and facilities. We believe that within federal guidelines there must be sufficient latitude for local and state planning agencies to consider local factors in planning for health needs.

Title II of the Administration's cost containment bill would establish a permanent capital expenditure ceiling for acute general hospitals of $2.5 billion a year, which we believe would endanger the hospital industry's ability to maintain its present facilities, to comply with present and future codes and safety standards, and to provide, when appropriate, those improvements and new developments in services and facilities that patients will demand. The proposed $2.5 billion ceiling would be about half the current amount of such expenditures, and over time--as a result of inflation--the fixed dollar amount would further decrease the real dollars available for capital needs. Even more disturbing is the proposal's failure to

permit exceptions for capital projects required for licensure, as a condition of participation under federal health programs, and compliance with Life Safety Code and other regulations. Further, there is no assurance in this legislation that operating expenses which result from some approved capital projects would be reflected in the amount of revenue permitted by the limitations imposed through Title I of the bill. These operating expenses would be considered under Title I only through an exceptions process which is totally inadequate and inequitable.

We believe that meaningful limitations can be placed on capital investment in the health care system which will further restrict such expenditures, while recognizing the need to maintain needed resources and provide for reasonable advances in health care delivery. However, the Administration's bill fails to recognize this need.

Changes Proposed in H.R.8121

Your bill, H.R.8121, Mr. Chairman, makes several revisions to Title II. We particularly are pleased to note the extension of certificate of need, or Section 1122 review, of all expenditures for medical equipment in excess of $150,000, regardless of its ownership or location. The proliferation of medical technology has a significant impact on overall health care expenditures. Failure to impose a requirement for review and approval of all such capital expenditures has a very deleterious effect on the planning process and permits unnecessary duplication of services and equipment. The AHA supports this change in the scope of certificate-of-need coverage.

We also note, both in the Administration's bill and in your proposal, an increase in the duties and responsibilities of HSAs and state agencies. While we have in the past supported increased appropriations for these entities, we believe that further priority attention should be given to the provision of adequate financial support on their behalf in view of the additional responsibilities that would be placed upon them.

TITLE III
"PROGRAM TO ASSIST AND ENCOURAGE THE DISCONTINUANCE OF
UNNEEDED HOSPITAL SERVICES"

H.R.8121 would add a new title--Title III--to H.R.6575. This Title provides that within one year of enactment of the legislation, guidelines for identifying excess hospital capacity would have to be promulgated and, thereafter, HSAs and state agencies would be required to use these guidelines. We would like to suggest that, in the interest of expediting effective results from the planning process, consideration be given to developing a system of priorities for these planning efforts. As we approach the total task, emphasis should be placed initially on areas in which early results are most likely to produce the most significant improvements in cost effectiveness.

Three forms of hospital incentive payments are proposed under this Title. The first would provide incentive payments to hospitals which discontinue all inpatient services if these services are unneeded. It would provide funds to retire existing indebtedness attributable to equipment and facilities. It also would provide an incentive payment of up to 5 percent of revenue reported during the last Medicare reporting period, not to exceed $500,000. However, the use of the incentive payment appears to be limited to three major purposes. We believe that other costs of closure will be incurred and should be recognized within the incentive payment. We support this provision and urge that it be considered favorably, with our suggested modification.

It should be noted in this context that closure of an underutilized facility usually adds a patient load to other institutions in the same service area. Thus, providing incentives for the closure of facilities is inconsistent with the penalty in Title I for increasing hospital admissions.

A second form of incentive proposed under this Title is to encourage discontinuance of unneeded services in an identifiable unit of a hospital. This provision seems to deal with the issue less adequately than the bill does with respect to total closure of inpatient services. There is no specific provision for debt retirement. This deficiency, in combination with the limitation on the level of incentive payment, may render a hospital unable to meet the costs of closure. We recommend that the financial support for the costs of closure of an identifiable unit of a hospital be similar to the provisions we have supported for the closure of all inpatient services of a hospital.

The third form of incentive proposed under this Title would encourage the conversion of an identifiable part of a hospital which is underutilized into a needed long-term or ambulatory care facility. The payment would amount to 50 percent of the cost of conversion. While we strongly support this provision, we recommend that the incentive include conversion projects, approved by the planning agency, to meet other community needs.

Two other incentive provisions are incorporated in Title III. Under one of these, the HSA would receive a payment of 10 percent of the amount of incentive payments made to hospitals in its area for closure of identifiable inpatient units or total inpatient services. While we support full funding of the needed costs of HSAs, P.L. 93-641 specifically authorizes funds for developmental activities which an HSA may wish to support, and we believe that such appropriations should be adequate for this purpose. We would recommend, therefore, the deletion of this provision.

A second provision calls for a 5 percent reduction, four and one-half years after enactment of this legislation, of Medicare-Medicaid and Title V reimbursement due each hospital in an area not in compliance with applicable planning guidelines. While

the penalty may be deferred, we suggest further consideration of whether such a penalty is appropriate or fair. Such penalties imply that when a plan is not fully achieved there are clearly guilty parties. This is by no means necessarily true, however. For example, one or more hospitals within an area may have made all possible efforts to close or prevent unneeded capacity, and yet suffer this penalty because the goal of the area plan is not achieved. We, therefore, recommend deletion of this penalty.

Mr. Chairman, we recognize the difficulty of devising incentives within the structure of H.R.6575. Because of the limited time we have had to review your proposal, we would request the Chair's permission to submit any further comments and suggestions we may develop as we continue to study it. We will be pleased to respond to any questions you may have.

Mr. ROGERS. Thank you very much for a very helpful statement and for suggestions which the committee will take into consideration.

Dr. Carter?

Mr. CARTER. How can we enlist the energies of America's doctors in our cost containment efforts?

Dr. BEDDINGFIELD. I am sorry, I could not understand.

Mr. CARTER. How can we enlist the energies of America's physicians in their cost containment efforts?

Dr. BEDDINGFIELD. You have our attention very strongly with the legislation that has been introduced. As I indicated in our statement, the physicians of this country are concerned. In our large professional organization, AMA, we have a commission composed of not only physicians but representatives of government, leaders of industry and commerce, other health organizations and members of the public, and we have a very expert staff of people serving that commission, and we are making our own studies. Every State medical society that I know of, every responsible medical publication hammers away at this. The concern is as evident in professional circles as it is in government circles.

Mr. CARTER. Would the PSRO's be helpful in this regard?

Dr. BEDDINGFIELD. Yes; particularly when PSRO's come to full fruition. This has been slow. The concept has been with us, as you know, for 5 years but funding has been slow, development of

techniques has been slow, but I think we are on the threshold in the next year of PSRO's being a very effective mechanism in this.

I think this is one of the things we see happening in health legislation. We have a concept, we put it on the books, appropriations do not come anywhere near the authorization, implementation is slow, and before you give it a chance you come along with another massive piece of legislation which is a bit bewildering to us who spend most of our time treating patients.

Mr. CARTER. Would you have any suggestions as to ways to increase the involvement of PSRO's, or to improve their cost containment efforts?

Dr. BEDDINGFIELD. I would repeat things we have addressed to this committee earlier. I do not believe the primary thrust of PSRO's should be cost control or cost containment. I believe that the intent of the original PSRO legislation showed emphasis on the quality of care, the appropriateness of care, and while I think these things have a bearing on cost, I do not believe the PSRO's should be allowed to undergo a metamorphosis into exclusively an enforcement agency on cost control. Our first concern is with adequate quality treatment of our patients in these institutions.

Mr. CARTER. You advocate quality control rather than cost control?

Dr. BEDDINGFIELD. I do not think the two are mutually exclusive, Dr. Carter.

Mr. CARTER. I would suggest that you actively enlist the assistance of the PSRO's in both quality and cost control. I think that is extremely important in the future.

Thank you very much.

Dr. BEDDINGFIELD. Thank you, sir.

Mr. ROGERS. Mr. Preyer.

Mr. PREYER. I particularly want to welcome Dr. Beddingfield from my home State. I am proud of his role in AMA,and Mr. McMahon, who received much of his training in our State.

I was very encouraged with your comment on page 4, Mr. McMahon, about recent information indicating that the rate of hospital cost increases is going to moderate. That is the first suggestion that maybe these costs are going to plateau out some, which would be good news indeed. Do you know when your study might be available?

Mr. MCMAHON. We are hard at work right now, Mr. Preyer. The difficulty here is that there are so many different people taking different looks in different time sequence, but the latest figures do indicate a moderation, a moderation we have been long expecting, because when you begin to reduce as we have in constant dollars, in any event the rate of capital expenditures, that is going to bring down the rate of increase in hospital costs overall.

Moreover, as we look at it we see that with very slight changes in admissions and days of care at least as the population grows, while it may not change the cost per admission, it is certainly reducing that one single item of cost that is most appropriate, the cost per thousand people in an area.

We will do this just as rapidly as possible, and we hope that within a week or 10 days we will be able to give the committee further information about that.

Mr. PREYER. I think you both gave us some very good suggestions and some good testimony. I appreciate it.

Mr. ROGERS. Mr. Walgren.

Mr. WALGREN. I notice, Mr. McMahon, in the factors that you attribute to inflation in hospital costs you do not list the problem that there is literally so little competition in the field that is the traditional restraint on increase in cost, and in addition, to so little competition there is the fact that we have a reimbursement system, which is ready to pay whatever is billed.

The question I have really is, although hospitals take the position that they are strenuously involved in keeping down the hospital costs, when you have a statement that avoids coming to grips with that problem, it makes me wonder whether the approach that is being brought to it by the local levels is sufficient to make progress on the problem and when the evidence is that hospital costs continue to rise or at least it is said they continue to rise at the rate of $200 million a day, or something like that, can the local levels really handle this?

I am sorry if that is a rhetorical question.

Mr. MCMAHON. I am very pleased to have a chance, Mr. Walgren, to respond to it. The reason we did not mention competition or the impact of retrospective cost reimbursement is because we do not believe either of those have a marked effect on cost increases. One tends to forget—and I know your area of the country, having been born there and visited there last week—those hospitals are effectively competing with one another to provide better and better service. They are governed by very interested boards of trustees and made up of individual members of the community. Those trustees feel a competitive urge to do the best they can for their patients.

Therefore, when such allegations are made, the reason I reiterate inflation and patient demand and increasing intensity of services, is to offset some of the inappropriate and wrongful explanations of the reasons for increases in the cost of care. Hospitals, wherever they may be—in multiple institutional communities like ours or in a single institution—are trying to do the best they can for their patients. Governed as all of them are by public spirited intensely interested community leaders, they are not wasteful and they will not let the hospital get away with anything they want to. They are not going to do things just because there is cost reimbursement. What really impacts the cost of care are patient demands that say: The hospital that I relate to I want to have every potential service and facility available—all of which is encouraged by insurance. Plus, of course, tremendous inflation and the inflationary market basket we pointed out—energy, malpractice and now I suspect we will have an increase there because of the weather conditions of the summer as well as the winter.

Mr. WALGREN. Is there any perspective that can be brought to the coordination among hospitals—and I cannot recall the position you took on the provisions in this bill which would essentially lean on all hospitals to join in whatever cutbacks are made in fear that they will be penalized because any one hospital might be out of balance in that. I know that one of the problems I gather traditionally has been that although these people are public spirited, they are often-

times focused on one institution and we seem to develop because of our origins in different charitable and religious institutions' vested interests in each having a very extensive and growing and developing medical service provision system.

I know in my home town, which is Pittsburgh, we have a street there lined with a number of different institutions, and the coordination is beginning but it still is not there.

Some people have left town I understand because after bringing everybody together and saying, "Are we going to make this one institution?" the interests of the various groups just were not able to be brought together and each continued to pursue the enhancement of its own institution even though they are only a block apart.

Mr. McMAHON. There are several things to which I would respond.

I think the Pittsburgh area and Western Pennsylvania generally have been at the business of hospital planning and the coordination of the expansion of facilities and services longer than most areas of the country.

In addition, there have been evidences there as well as in other areas of the sharing of services, joint purchasing and other kinds of activities, attention to which we have paid in our testimony of May 13, that indicates there is a cooperation going on.

It is quite true that there are areas not only in Pittsburgh but elsewhere throughout the land where hospitals tend to cluster together. They do it for a convenience of patient and convenience of physician reason as well, because then some of the travel time that would lead to inefficiency can be reduced.

The other thing is that, yes, there are differences in sponsorship, different religious interests, and different community interests reflected in this vast field. But it has always seemed to us that while we recognize we pay a price for it, we don't want to go the other direction and determine our institutions and medical staffs and hospital care as a cookie cutter. We ought to be encouraging some of this diversity, recognizing with a few percentage points increase that this is also the very kind of system that has been encouraged to try new things, to be innovative, to be experimental and to find new ways of doing things for more people.

We have often said, I have often said, that part of the problem we have today was the marvelous response hospitals and physicians made to the message of the 1960's, "Find more ways to take more care of more people," and that we did.

Now the bill is coming in for that response, a response that went out to institutions of all kinds and to their medical staffs, and the reaction to that response is now one thing which is leading to the substantial increases in costs.

As I said in the response to the question from Mr. Preyer, we know that there is concern out there among doctors and among hospitals with the rate of increase, because if we are to continue to out-pace the gross national product, at some point health care costs would be a percentage of the gross national product that would not be acceptable to the American people.

The problem today is that we haven't reached that limit, apparently, because patients are still demanding more care and more

services, and that is the biggest single cause perhaps. I am not sure it's controllable by our present insurance mechanism, but it is one of the biggest reasons for the increase not only in hospital costs but in health care costs, so there is a lot going on.

The fact it doesn't quickly change, this ship that is moving forward, this ship of the health care delivery system that is moving forward in a given direction, is because the Congress of the United States and the people of this country put it in motion, said do these things, and now we are going to have to be very gentle about the way we slow it down or we are going to create havoc.

Mr. WALGREN. I appreciate the answer. Thank you.

Mr. ROGERS. Mr. Scheuer?

Mr. SCHEUER. Thank you, Mr. Chairman.

Mr. McMahon, I have known you and I respect you as one of the really impressive and knowledgeable people in the field of health care and hospital care, but I must say that your description of the way these hospital boards operate does not conform to the real world as I know it. My experience in New York is that there are competitive egos at work and that every hospital wants its CAT scanner and its own heart surgery unit and that they resist being planned, and they resist to the death being coordinated, and they resist having any kind of overview into which they are asked to fit.

Hospital boards do their thing with very little regard to overall efficiency, with great hostility to being asked or invited to conform to some kind of master plan. I must say that in my experience the activities of the people on the board do not fit the description at all that you have pictured.

I am sure that they are dedicated people trying to do the best they can for their own institution. But from the point of view of a comprehensive overall health planning and rationalization of health costs, this dedication to what they perceive to be the interests of their own institution can be disastrously inconsistent with bringing any kind of rationality into the picture.

I also feel that both the hospital professionals and we here in Congress have failed to bring rationality into the situation.

Why is it that there is so much in the way of unnecessary hospital stays, such as people being brought into hospitals on Friday for an operation that is going to take place Monday or Tuesday? Are the hospital administrators bringing pressures on doctors to fill up those hospital beds because they have to collect the per diem?

Why are they doing so little to skewer the treatment of people who can be treated on an outpatient ambulatory basis but most frequently, are not?

I think it's a problem all of us have to face, we on this side of the table as well as you. I feel we have got a long ways to go.

Mr. MCMAHON. May I turn that statement into a question?

Mr. SCHEUER. Please do.

Mr. MCMAHON. I find it interesting and one of the dimensions of complexity to which I continue to refer, that the basis of your question is there is so much competition, and the basis of Mr. Walgren's question was there isn't enough.

Now, it is that, you see, that begins to put us in a real difficult situation. What is the situation, no competition or excessive competition?

Mr. SCHEUER. Let me just say there I don't think Mr. Walgren was talking about competition in the sense that there is competition in the terms of fees. Each hospital wants to do the whole job, but when it comes to costs the taxpayer is paying for all of the duplication, and I see very little evidence hospitals are competing in terms of rationalizing costs to the ultimate person who pays the bills, which is the taxpayer.

They are competing in that each wants the newest CAT scanner, but they are not competing in any sense to provide the most finely tuned service for the most reasonable costs, are they?

Mr. MCMAHON. Because the direction of the Congress and the direction of people who have gotten insurance, and there are more people covered through employment based insurance than any other mechanism, have all been going the other way.

Mr. SCHEUER. I agree.

Mr. MCMAHON. That is where the demand is that says let's increase the services so that my physician and my hospital will have all of the things to take care of me or my family when we get sick.

There is no question about the fact, my second point, that the City of New York has great problems. It also has a substantial number of medical schools, a situation not duplicated anywhere except perhaps in my own city of Chicago. I understand that situation too. If we are going to train young people in the practice of medicine, clearly they must be able to see all kinds of activities going on.

That generally means they ought to have in some kind of available way an opportunity to treat patients under different kinds of care, and I trust, Dr. Carter, you can continue this discussion when you get into the markup sessions to explain some of the reasons for proliferation.

If we are going to do all of the things that have been asked of us then very clearly we are going to have to pay the price of some duplication.

I find as I travel throughout the country, however, that there are problems peculiar to the city of New York, though you have been struggling for years.

Mr. SCHEUER. Let me get back to New York City because I think we have a good prototypical problem there. Everybody who has thought about it and analyzed it agrees we have 5,000 too many hospital beds in New York City. Yet the job of closing down hospitals—and that is just exactly how it is going to have to happen—is one we don't seem to be able to cope with, because every hospital has this dedicated board of trustees you have described who want to keep that institution going at all costs.

It has its professionals who want to keep their pattern of life and livelihood and although everybody knows intellectually that we must close down X number of hospitals and reduce and phase out 5,000 beds, we sit there traumatized. We are totally incapable of coping with what clearly and indisputably has to be done.

Can you give us a modus vivendi through which we can approach that problem, by which steps we can actually close down enough hospitals to eliminate 5,000 beds and not only get far cheaper care

95-756 O - 77 - 13

but get better care? Many of the people who are getting care now in hospitals that are less than the best would be getting care in a first class health environment.

Mr. McMahon. The only answer, as we see it, is comprehensive community health planning, but because of all of those pressures that are there do continue, it isn't easy to come by. Some progress is being made. The thing is I would argue for some slowness and for some deliberation in the process rather than bringing about the results by a squeeze on their budgets, figuring some institutions will then fall by the wayside, because you don't know whether the right institutions are going to fall by the wayside or not.

It may be the only ones that will survive the squeeze period will be those that have substantial endowments or certain other kinds of backgrounds, and in the city of New York hospitals have been pretty well squeezed out by the inadequate reimbursement mechanisms of the State of New York through the Department of Hospitals.

Further support, as we have said to this committee before, further support of the comprehensive health planning process is essential, recognizing it is going to be slow, recognizing that it cannot work miracles, recognizing that some of the problems of those 5,000 excess beds went back to assumptions that were valid in their time that are no longer workable.

We don't think there is any solution other than that, and the solution of trying to use a procrustean bed of a 9-percent cap, Mr. Scheuer, we say is not the way to bring about a sound system when the squeeze period is on.

Mr. Scheuer. I don't think anybody thinks that this is more than an interim stop-gap while we work toward some more rationalized overall solution.

We need some kind of planning to bring under control this incredible proliferation of technology in private doctors' offices.

The CAT scanner is a perfect example. When we get equipment up in the hundreds and hundreds of thousands of dollars we should plan for its placement so that we can ask people to go to centrally located places for the use of this incredibly expensive technology. Don't ask the taxpayers to pay if you want to go to your neighborhood physician who has a CAT scanner that does not have a place in some kind of urban or metropolitan health care plan.

Dr. Beddingfield, don't you feel that we have the right to ask for some kind of rational planning with this incredible proliferation of technology?

Dr. Beddingfield. Mr. Scheuer, I certainly could not disagree with the concept of rational planning.

On the other hand, I know of a few areas, I don't know how many private physicians have CAT scanners, that seem to be the main prototype of expensive equipment we are talking about right now—

Mr. Scheuer. That is symbolic.

Dr. Beddingfield. Okay. That is the main symbol then in the offices. I do know of one or two areas where the hospital either could not or would not have this facility in their area, and in concert and with the approval of their hospital board.

Mr. SCHEUER. Then they wouldn't have any problem getting a certificate of need. If it wasn't available then the private physician wouldn't have any problem getting a certificate of need from the local health planning agency.

Dr. BEDDINGFIELD. I don't believe every citizen of the United States needs to have a CAT scan of his head. On the other hand, I believe that there could be overkill in a restrictive effort, so this very valuable diagnostic tool is denied to people who need it.

Mr. SCHEUER. Nobody wants that, of course.

Dr. BEDDINGFIELD. I think there is some danger of that.

Mr. SCHEUER. We are trying to rationalize its availability and not have it duplicated many times over. Don't you feel society has a right to have some kind of rational plan for the availability of this technology so it would be easily and conveniently available, but not duplicated at the cost to the taxpayers?

Dr. BEDDINGFIELD. I think if a decision is made on a local level with local planning that society does have a right. However, I feel in provisions of this bill where the Secretary establishes guidelines and ground rules and direction the HSA, they said these are the parameters within which you must operate, you cannot deviate from these, then you don't have a local plan. This is the Catch 22 approach.

Mr. SCHEUER. Thank you, Mr. Chairman.

Mr. ROGERS. Thank you very much.

I think the gentleman makes a good point, if your guidelines are the only consideration to be given, I think that would be a problem that ought to be looked at.

As I understand it, though, both of you feel proper planning is necessary; is that correct?

Dr. BEDDINGFIELD. Yes, sir, I would agree proper planning is in order.

Mr. ROGERS. That was my concern about AMA's suit against the planning bill. We tried to design a bill to bring planning and start it at the local area, and yet we are meeting resistance.

What are we to do about health costs? Should we try to address it through the planning process? Should we use that as one mechanism and, of course, PSRO as another, would you think Dr. Beddingfield?

Dr. BEDDINGFIELD. I think a variety of approaches, Mr. Chairman, as I indicated in my answer to Dr. Carter. I think there is some hope for PSRO becoming more effective than it has up to this date. I am a strong believer in local planning, and the fact AMA is involved in litigation about the planning action does not for a moment mean AMA is against planning, and there are some things on record in the testimony about the Planning Act that indicate our concerns with that particular law.

I think there is a strong argument for public education, for education of the consumer, for education of the provider in the most economical ways. I think there is a strong argument for prevention that we have discussed here. And finally, I think that the bottom line of all of this is we are going to have to come down to the point that the Federal Government cannot do everything for everybody in this country.

We would agree, as some of the members of this committee have stated, there is not enough money in the Federal Treasury to provide the total technology, the most sophisticated, for everybody in this country. Therefore, I think that as a matter of national health policy we have got to decide just what can we allocate toward health care for our population, for selected groups as we have it now, or for across the board as we are talking about. Then I think as to that package of health benefits, say this is what your Government can provide for you, and that we are going to see that we get our dollars worth for what we spend.

You cannot severely restrict the number of dollars and say "we want everything for everybody, and you providers do it, and if you don't you aren't doing a good job." We providers can't come up with that tab.

Mr. ROGERS. I think the intent so far of the planning law is to bring the planning to the local area. That was the whole intent of the law, to let your local HSA's do the planning for their area. This is who I think we should depend on.

Mr. MCMAHON. Mr. Chairman, back to your basic question, as I have said in the testimony, we think the things are under way, that proper planning clearly is necessary, and we think it's having its effect. Yes, there are a lot of beds there that probably in retrospect in some communities we wish were not there, but they were made in good faith, as I say, at the time.

One of the reasons for the rates decreasing in capital expenditures, at least in constant dollars, is the fact that planning is beginning to take hold, is making institutions look at whether or not they need something as well as the community. Clearly the PSRO development, if too much is not expected too quickly, will have its impact. We think utilization review has already made its contribution in the reduction of admissions and lengths of stay and so on.

Finally, what Dr. Carter talked about the other day, an expansion of the State level rate review activities and the broader the better—mandatory, voluntary, regional, anybody that can come up with a feasible planning plan that is looking at ways to focus more attention on the costs of health care—we will support, and think it will help because they do it in different ways. It can be evaluated and will continue to have its impact.

Mr. ROGERS. If we can do the planning, then, as I understand it, you feel the PSRO looks at the quality of care, and when it is overutilized, and you support that, as I understand.

Dr. BEDDINGFIELD. Yes.

Mr. ROGERS. Should it be for all patient care, the PSRO?

Dr. BEDDINGFIELD. I think it ought to start out as it has, for inpatient care, with the present federally sponsored programs, but I think this type of review, with discretion for expansion; ultimately might be applied by responsible institutions and medical staff to all its inpatients.

Mr. ROGERS. So they have that overview.

Now, what do we do or what should we do where there is excess in beds, where there would be excess in very expensive equipment and under-utilization? What procedures should we use? What do you suggest, Dr. Beddingfield?

Dr. BEDDINGFIELD. Mr. Chairman, I think you have to look at it on a case by case basis. For example, if you had a hospital with a 60 percent occupancy rate and this were a statistic or a pin on a map, that is one thing. If you go to some areas of this country and find that is the nearest hospital for 100 miles in either direction, that is quite another matter to the people in that area.

I think in a situation such as that, innovations such as conversion of part of those beds to an extended care facility, is quite an appropriate innovation to undertake, and we would support that.

I think where there is, in your PSRO activities, where there is evidence of inappropriate levels of care, inappropriate admissions or prolonged lengths of stay, there are mechanisms built into the PSRO mechanism to correct that situation, and it really hasn't had time to become fully operational.

Mr. ROGERS. Where you don't give payment for that over-utilization?

Dr. BEDDINGFIELD. That is correct.

Mr. ROGERS. Should that also apply to the hospital as well as to the physician where there is a determination by the PSRO that it is over-utilized?

Dr. BEDDINGFIELD. Should it apply to the physician as well as the hospital?

Mr. ROGERS. Yes.

Dr. BEDDINGFIELD. This same question, of course, came up with the administration witnesses who were here.

Mr. ROGERS. Yes.

Dr. BEDDINGFIELD. I think I would like to respond in this way: Even with our utilization review committees which we have had as the precursors of the PSRO and practicing activity in a hospital, I cannot remember a single example where this became a problem in any way.

We have seen examples where utilization review said the continued hospitalization is not justified. Well, the Government doesn't, the utilization review committee doesn't, discharge the patient from the hosptial, they simply say they are not going to pay for it any more.

Mr. ROGERS. I understand.

Dr. BEDDINGFIELD. Then the physician has to go to the patient and say "Under the regulations of the hospital and the Federal Government, they are going to not pay your bill any more, so I am going to have to discharge you or you are going to have to pay the bill." In every case I know of the patient and/or the family has made other arrangements to either go into an extended care facility or go home.

Mr. ROGERS. What I am thinking about is say where he is under Medicare or Medicaid, and they say no, it's generally a review after the fact for the most part, isn't it?

Dr. BEDDINGFIELD. I think most institutions have ongoing review. It's required for recertification periodically under Medicare.

Mr. ROGERS. Yes, I understand that. But often it may be that then the payment, after that period of time, is not reimbursed to the hospital. What I am saying is should Medicare or Medicaid or third party payer also pay the doctor's fees if the patient stays in longer?

Dr. BEDDINGFIELD. I was trying to develop that point in my answer, and I am trying to separate medical services from hospital services. For example, if I discharge a patient who is convalescing, who is ill, from the hospital and he moves next door to an extended care facility, he no longer needs the hospital services, but he still needs me as a physician. That is point one.

Point two, if the patient stays in the hospital, most hospital bylaws require that every patient be under the care of a physician, so no matter who his third party sponsor is, whether Medicare or Medicaid is paying for him, if he is in the hospital and he is, for example, under Dr. Beddingfield's service, Dr. Beddingfield has to see him every day or get kicked off the hospital staff. In addition, Dr. Beddingfield may be legally responsible for what happens to that patient. I think under these circumstances he should receive compensation for his services.

Mr. ROGERS. Even though you may have been the one who recommended his continued stay, which your PSRO says no?

Dr. BEDDINGFIELD. I think you are continuing to equate the necessity for hospital care with the necessity for professional medical care, which isn't the same.

Mr. ROGERS. I can understand the difference. What I am saying is you have a pattern of keeping your patients in beyond the stay which PSRO will not reimburse the hospital; what incentive is there for you to get your patient out on time where you can maybe let him come by for an office visit, or have a nurse go by and see him?

Dr. BEDDINGFIELD. I understand your question.

Mr. ROGERS. At home rather than taking up your time.

Dr. BEDDINGFIELD. First of all, there would be considerable peer pressure on me because these patterns of practice are clearly evident, and I would be called on the carpet by my hospital. Second, if payment for hospital service is denied and it became general knowledge in my patient population that Dr. Beddingfield keeps patients in and Medicare doesn't pay such bills and patients have to pay him, I assume I would soon not have very many patients.

Mr. ROGERS. If you are the only doctor in town you might.

I won't pursue that.

Mr. PETERSON. Mr. Chairman, I want to add, as I recall there are provisions now in the PSRO law for dealing with physicians who may in particular have the pattern of practice you have indicated so there are provisions where the physician can be dealt with under the Medicare and Medicaid law. Actually I think the provisions are that physicians may be denied participation in program services.

I did want to make one point that seemed to be perhaps obscure, and that is when the decision is made, that continued hospitalization is unnecessary—and I say continued hospitalization because it is made prospectively because of the certification and recertification requirement—then there are provisions which allow for, I think, three additional days of stay, and it's that period that Dr. Beddingfield is referring to, then, that permits the adjustments so that the families can make arrangements.

Mr. ROGERS. Let me ask you what should we do where there are too many beds or duplication of unneeded facilities in a community. What do we do?

Mr. MCMAHON. Mr. Chairman, there are a number of things that can be done. Our concern in the past with decertification has been two-fold. First, that plans ought to be developed first, adequate plans, before you know what the situation is, because what sometimes looks as though it's an excess of beds, because of in-migration of patients turns out not to be at all.

The second thing is there is a very real capital problem here. If you decertify a number of beds, a facility or service, and make no provision for the payment of the capital costs that were incurred in good faith, we would bring capital expenditures pretty rapidly to a close, because nobody would invest in an institution, lend it money or invest in the investor owned sense, if that danger were added.

So I think that the answer to your question is, what we need is a combination of planning, of the provision for capital costs of closed facilities, and perhaps coupled with the kind of incentives that you have. I don't know whether you make incentive for something, as well as you do in providing a mechanism for getting out from underutilized service or facility that has been identified as unnecessary in the planning process, I don't think you need anything more than provision for the payment of those capital costs plus some encouragement for the movement of overhead from that, as I indicated in the testimony.

Mr. ROGERS. Is it well for the health planning agency to identify which hospital should make a change in its facility and impose a penalty for inaction on that particular hospital rather than the hospitals of the area?

Mr. MCMAHON. Mr. Chairman, I do not know of any other way to proceed.

Mr. ROGERS. I think you make a good point on that.

Mr. MCMAHON. Voluntary efforts, as we have observed, are hard to come by because there is no question about the fact that the institution and its people, trustees, medical staff and administrative staff, are aware of the service they are providing. It may be 50 percent occupied, but to one of the patients in that 50 percent of the beds that are occupied, that institution is 100 percent of his health care needs. So they are not easy decisions. It seems to me the best place to go is back to the HSA and if some encouragement, paying off the capital costs——

Mr. ROGERS. In other words, you think HSA is the appropriate body to deal with that problem?

Mr. MCMAHON. In time, when you come to hearings, as Dr. Beddingfield suggested, both the AMA and AHA will have suggestions to make; but as far as the principle is concerned of local comprehensive planning, there is no other place to make the decision.

Mr. ROGERS. Thank you.

Dr. GEHRIG. Because of the way H.R. 8121 is structured, I would add one other thought. There is a penalty provision there which would decrease the payment of service under Medicare, Medicaid and title V. I think the Congress has already had some experience

with that type of penalty when it is expected that these beneficiaries would continue to be provided care but the reimbursement would be decreased, it presents very real problems.

Mr. ROGERS. It does, but also it provides a pretty good incentive because many States are subject to being penalized. We anticipate giving them 6 months to come into compliance. I think they will do it because they saw the law was going to be enforced only when the Congress came in to give them that 6 months' additional time. I agree some States complied except for one or two hospitals.

Mr. MCMAHON. The disincentive ought to be aimed at the State, not the provider. What Dr. Gehrig is saying, we are not sure we can carry this burden. We understand what you are aiming at.

Mr. ROGERS. Of course, if the State is the one who is the beneficiary, then perhaps so, and they are the beneficiary of Medicaid funds, whereas maybe we should just continue looking at the beneficiary or whoever really benefits.

Dr. GEHRIG. Mr. Chairman, the example I was referring to is the repeal of section 111 because it brought out very clearly the inability to provide services to those people when they become the penalty mechanism. In other words, no or low reimbursement for their care. Presently we are experiencing inadequate Medicaid reimbursement in our area. This sort of penalty raises real problems.

Mr. ROGERS. We understand hospitals frequently use funds received to subsidize operations. Should there be some restriction of hospital funds on depreciation such as worn-out hospital plant and equipment?

Mr. MCMAHON. Mr. Chairman, when a hospital uses that portion of its expense statement that was attributable to depreciation, it means there was a deficit there. I do not know what you do to provide that deficit. It means the revenues do not equal the costs, so you must use the cash flow that is attributable to depreciation to do some of these other things. I am not sure what you do because it is the deficit. You say, all right, you cannot use this any longer to subsidize bad debts or charitable allowances or other kinds of writeoffs, then the patients that give rise to some of these problems then cannot be taken care of in the hospital because we cannot make money.

Mr. ROGERS. All hospitals do not operate at a deficit. They still get depreciation.

Mr. MCMAHON. Oh, yes, no question about that.

Mr. ROGERS. That is what I am saying.

Mr. MCMAHON. Then I misunderstood the question, because the hospitals that use depreciation funds to do something else do it because they would otherwise be incurring a deficit.

Mr. ROGERS. Not necessarily. Why would they do that? I know numbers of hospitals that make money not in deficit that may use their depreciation because they do not have any need to use it. Their hospital is up and they do not need new equipment.

Mr. MCMAHON. I do not know of any. Because they are setting aside that depreciation for the next round of capital expenditures. If they have an operating excess of revenues over expenses, they do not need to use depreciation for anything except to——

Mr. ROGERS. Except for higher salaries and for other things. You mean to tell me they do not ever raise their salaries or perhaps use funds from depreciation? I know some administrations that I think have done that. You are not aware of those?

Mr. MCMAHON. If they do that, they are not operating with an excess of revenues over expenses because they are costs too.

Mr. ROGERS. I understand, but that is not a needed change, which is what I am saying. Should it be for needed equipment or for upgrading the needs of the hospital itself and not to be allocated for salaries?

Mr. MCMAHON. I am suggesting under the traditional accounting approaches we are not talking about the same kind of thing. They get that whatever they do. They put it in the costs, and if you want to limit that, you do not do it by going into depreciation. Even if you require the depreciation be funded, it works inequitably in some cases because those depreciation funds are being used to provide needed services.

Mr. CARTER. Wouldn't depreciation remain in the capital account instead of for payment of salaries?

May I ask a question or so?

Mr. ROGERS. Surely.

Mr. CARTER. If we put a cap, Dr. Beddingfield, on what a physician may have in his office—although I doubt if such action is constitutional—but suppose we did, of $150,000, would we ever have a Leahy or a Mayo Clinic developed?

Dr. BEDDINGFIELD. I think it would certainly blunt the future development of that type of fine institution. I think it would be very unlikely.

Mr. CARTER. How many hospitals might become insolvent and yet not be eligible for an exception under the provisions of this proposal? Mr. McMahon?

Mr. MCMAHON. Dr. Carter, are you referring to that very limited exception process that has a current asset/liability ratio tests?

Mr. CARTER. Yes.

Mr. MCMAHON. We do not understand the current asset/liability ratio, frankly, so I cannot answer the question. It is not related to insolvency. The limitation to being in the bottom quartile is obviously going to mean a very limited exception process, and a limited exception process that will penalize hospitals that with certificate of need and planning approval have moved ahead to expand facilities and services, and now they are going to find because of prudent management in the past they would not be entitled to an exception. I do not know how many more would get to insolvency. Most of them get to the brink of insolvency in a hurry.

Mr. CARTER. I believe it is estimated that we now have an increase in beds each year, causing the number of excess beds to rise from some 60,000 to 100,000 excess beds in the United States. Someone pulled out of the air that each one of those beds cost $20,000 to $30,000 per year, at a total cost to the Nation at the present time, using the $20,000 figure of $200 million per year. Is the Congress partially responsible for this? Did we cause part of it by appropriating that money for excess beds?

Mr. MCMAHON. Yes, Dr. Carter, by Hill-Burton, by the expansion of demand, by the creation of financing mechanisms like Medicare

and Medicaid and child health, but it has always been my contention that the statement of costs is overstated because any reasonable hospital administrator is going to reduce his staffing, as you know from your own experience, to the beds he is likely to have occupied. Where we have a hospital with 60 percent occupancy, it would be hard-pressed to deal with, even 70-percent occupancy if it happened in a short period of time, because the staffing is cut back. So very clearly the Congress has a substantial responsibility for this. We think that planning plus some finanancing mechamism that will take these so-called unneeded facilities out of service is a far better approach.

Mr. CARTER. You really think perhaps these excess beds should be converted perhaps to skilled nursing or intermediate care; is that correct?

Mr. MCMAHON. I think in some cases the answer is very clearly yes, where the skilled nursing and other kinds of long-term facilities are necessary. But again as we say, our rationalization for community health planning says that may not be the problem. Something else may be the problem or another kind of facility or even closure and conversion to a more custodial care than nursing facility might be appropriate. The more this is left to local decision-making under sound planning, the more acceptable it will be to all of the people involved, patients as well as the hospitals and the physicians.

Mr. CARTER. Do you think it is reasonable to apply an "admission load formula" to a hospital if you make no attempt to ascertain whether the hospital is operating at, or near, the margin?

Mr. MCMAHON. I think, as I indicated in the testimony, that the formulas are not appropriate. One of the problems in the city of New York goes to a length of stay that is much longer than you and Dr. Beddingfield and I know in the area of the country I came from and far more than it is on the west coast. We do not know why it is so much higher in the city of New York. We do not know why it is so much lower in California. To use some of these national formulas and then require that they be applied is, it seems to us, the wrong way to go.

The approach must be a little more delicate than that, taking into consideration patterns of practice, exchanging views, trying to find out what the reasons are for higher utilization, and then zeroing in on that. That is far better than some across-the-board kind of formula that is not going to apply usefully in various parts of the country with various patterns of medical practice and various kind of patient mix.

Mr. CARTER. In New York City, Sloan-Kettering Memorial and Mt. Sinai all have large cytology facilities, and facilities for treating cancer, leukemia, and so on, and they have exotic equipment duplicated in each hospital. I would like to ask the distinguished gentleman from New York which hospital he would have closed, but he is not here.

Why do you think, Dr. Beddingfield, we have had such an explosion in medical costs over the years? What are the factors that have gone into this?

Dr. BEDDINGFIELD. Dr. Carter, I would again recite the general inflationary trend, the expanding technology. That is an important

factor. We can do more and it costs more. The public's expectation is stimulated by the type of things Mr. McMahon just recited, sometimes by Congress from the Federal sector. In response to your question, I think all of these have an important part in it.

Mr. CARTER. Thank you very kindly.

Thank you, Mr. Chairman.

Mr. ROGERS. Thank you very much. Your testimony has been most helpful to the committee.

The next panel will be Mr. Daniel Pettengill, who is representing the Health Insurance Association of America. He is Vice President of Aetna Life and Casualty Company; also Mr. Neil Hollander, who is Vice President for Health Care Services, Blue Cross Association, Chicago.

We welcome you gentlemen to the comittee. Your statements will be made a part of the record in full and you may proceed.

STATEMENTS OF DANIEL W. PETTENGILL, ON BEHALF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA, AND NEIL HOLLANDER, VICE PRESIDENT FOR HEALTH CARE SERVICES, BLUE CROSS ASSOCIATION.

Mr. PETTENGILL. I am Daniel W. Pettengill, Vice President, Group Division, Aetna Life and Casualty. I appear on behalf of the Health Insurance Association of America.

We have reviewed H.R. 8121 and, on balance, believe it to be a better bill than H.R. 6575. However, like H.R. 6575, it unfairly discriminates against States with programs for containing hospital costs. For this and other reasons, it needs amending before passage.

As we testified on May 12, 1977, the best way to contain the escalation of hospital costs is through carefully coordinated efforts of the escalation of hospital costs is through carefully coordinated efforts of the PSRO, the HSA, the State certificate of need agency and a State agency to review and approve hospital budgets and rates. Congress has done much to assist and stimulate the first three of these entities but not the fourth.

In section 117, H.R. 8121 gives lip service to the idea of a State hospital budget and rate review agency but then unfairly discriminates against such agencies by limiting the percentage increases they may approve to just that promulgated by the Secretary under section 112(b), while the Secretary himself can grant additional increases by reason of section 115 (Establishment of Exemptions) and section 124 (Exemption of Nonsupervisory Personnel Wage Increase from Revenue Limit).

Justice alone, to say nothing of the fine record which the States of Connecticut and Maryland have already established in containing hospital costs, demands that this discriminatory aspect of H.R. 6575 and H.R. 8121 be eliminated.

Specifically, we recommend that the discrimination caused by section 124 be eliminated by the deletion of that section from the bill. The hospitals that actually need to raise their standards of wages for nonsupervisory personnel should secure an exemption through the mechanism of section 115. Then, because we believe section 115 is essential to the bill, we would minimize its potential

for discrimination against the States by authorizing the States, with agencies meeting Federal standards, to use a slightly higher limit than that set by the Secretary pursuant to section 112(b). An extra allowance of 2 percent might be reasonable. If this solution is adopted, then the phrase "plus 2 percent" should be inserted after the phrase "section 112(b)" in line 23 on page 5 and in line 24 on page 18 of the bill.

We urge that you go beyond the elimination of discrimination against and actually encourage the formation of State programs for containing hospital costs which meet Federal standards. Specifically we recommend that the requirement that such programs be "in effect for at least one year" be deleted from sections 102(f) and 117(a)(1) of H.R. 8121, and that Federal funds be made available to pay a portion of the start up and operating expenses of such State programs during the first 2 years of their existence.

There is one other part of H.R. 8121 with which we are in serious disagreement. I refer to the new part D of title I. While we are in favor of incentives for good performance by hospitals, we regret to say that we believe the incentive proposed in this part D, as modest as it is, could do more harm than good.

There is no doubt but what questionable and sometimes even unnecessary ancillary services are driving up not only the cost per inpatient admission but more importantly the total hospital bill and hence incentives to eliminate these questionable or unnecessary ancillary services are definitely desirable. However, there is another important factor in the excessive hospital costs equation, namely the many short confinements for diagnosis and for minor surgery that are totally unnecessary because the tests or the surgery could have been done just as safely and at less expense on an outpatient basis.

Now, if the only reward is for cutting the cost of the per inpatient admission, the hospital can reap this reward simply by doing virtually all diagnostic testing and minor surgery on an inpatient basis. This is so because the numerator (the hospital's total costs) will be increased less than the denominator (the number of admissions), and hence the cost per inpatient admission will be lowered. In the meantime all those unnecessary days of confinement will have caused the Nation's total hospital bill to have skyrocketed worse than ever. Furthermore the unnecessary ancillary services may still be there.

I know of no reliable incentive to reduce unnecessary ancillary services. The combined efforts of PSRO's, HSA's certificate-of-need agencies and State budget and rate review and approval agencies will probably be necessary when a hospital will not eliminate them voluntarily.

There is an incentive to eliminate unnecessary hospital admissions, and H.R. 8121 already contains it in section 113. Therefore, we recommend retention of section 113 but complete deletion of Part D.

With regard to Title II, we believe the differences between H.R. 8121 and H.R. 6575 represent improvements except for the change from $100,000 to $150,000 in the minimum size capital expenditure that requires a certificate of need. We appreciate the need to

recognize inflation. However, we suggest that this be done by using the figure of $100,000 the first year and then adjusting this amount each year thereafter by the gross national product deflator.

We are pleased with, and fully supportive of, the new title III—the program to assist and encourage the discontinuance of unneeded hospital services.

We appreciate this opportunity to present our views on this most important piece of legislation and will be glad to try to answer any questions.

Mr. ROGERS. Thank you very much for a very helpful constructive statement. We are grateful to you.

Mr. Hollander.

STATEMENT OF NEIL HOLLANDER

Mr. HOLLANDER. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, I am Neil Hollander, Vice President of the Blue Cross Assocition, the national coordinating agency of the 70-member Blue Cross Plans in the United States and Puerto Rico.

As stated in our recent testimony on H.R. 6575, "The Hospital Cost Containment Act of 1977," the Blue Cross Association (BCA) strongly believes that there is an immediate need for enactment of a transitional program to contain costs in the health care delivery system.

I thank you for the opportunity to share with you our thoughts on H.R. 8121. As many of the sections of H.R. 8121 have been carried forward from the administration's bill H.R. 6575, our comments presented will be on the following: section 132 (Incentives for Good Performance by Hospitals in Containing Cost Increases Eligibility for Incentive Payment), section 1527 (Certificate of Need Program), section 1122 (Limitation on Federal Participation for Capital Expenditures), and title III (Program to Assist and Encourage the Discontinuance of Unneeded Hospital Services).

I would like now to present our specific reactions to the above noted sections but first let me say that we believe that H.R. 8121 has made several major position proposals.

TITLE I - TRANSITITIONAL HOSPITAL COST CONSTRAINT PROVISIONS

Section 114(c)—Base Inpatient Hospital Revenue (H.R. 6575)

Establishment of Hospital Cost Containment Program, section 114(c) has been deleted. We agree with the deletion because it preserves the comparability of services included in the base year and in the accounting year for which the limitation is applied.

Section 131-133—Incentives for Good Performance by Hospitals in Containing Cost Increases

This section is an important addition. We strongly support the principle of providing an incentive to contain directly the rate of increase in hospital costs. Containing hospital costs directly has long-term significance. A program that controls costs has a better

chance to contain escalation of revenues. One program reinforces the other.

We are concerned that it may be possible to achieve apparent savings in costs, through accounting allocations, without a real change in behavior. The Secretary in promulgating the information required to implement the provisions of this section should take this concern into account.

In addition, an incentive payment limited to outpatient deficits as proposed may be less effective than an arrangement without such a limitation. We suggest consideration of a provision that would permit the Secretary to establish guidelines for possible uses of incentives. The incentive payment program should not, however, result in permanent additions to inpatient costs, or in any way be a basis for a later claim for an exception from a limitation on revenues.

Examples that may be considered for approval include a one-time bonus to employees, reduction of long-term debt—which would have the effect of reducing interest charges—funding community health education programs, and similar public interest projects. The provider making a claim for an incentive payment would be required to show that its use of the incentive would be in the public interest and would not add to its cost projections for later years.

Although we have not had a chance to study the extent to which the size of the incentive and the method of its calculation will affect hospitals specifically, we believe the principle of the incentive should be supported.

TITLE II—LIMITATION ON CAPITAL EXPENDITURES

As regards title II, we have previously testified that a moratorium be placed on capital expenditures until amendments to Public Law 93-641 are considered later this year. However, in view of the congressional interest in a capital limit program, I would like to make the following comments on proposed title II changes.

Section 201(b)—certificate of Need Program

This section of the bill amends section 1527 of Public Law 93-641, to require that federally approved certificate-of-need programs review and determine the need for *major medical equipment*—and, as previously provided, institutional health services, health care facilities, and health maintenance organizations.

BCA supports the extension of CON program coverage to major medical equipment, regardless of the setting in which such equipment is located.

Paragraph (c) of this section, defines the term "capital expenditure," such that the dollar review threshold for such expenditures is $150,000. BCA supports this dollar threshold as opposed to the originally proposed $100,000 threshold. Such a threshold is appropriate since most capital expenditures that can be expected to generate substantial future health costs will exceed this amount and since such a threshold will effectively control major medical equipment expenditures in non-institutional settings.

Section 202—Limitation on Federal Participation for Capital Expenditures

This section amends section 1122 of the Social Security Act in a number of important respects that differ from amendments proposed in H.R. 6575.

First, section 1122(a)(1) would require the Secretary to enter into 1122 review agreements with the Governors of the States to assure that funds appropriated under titles V, XVIII, and XIX are not used to support unnecessary capital expenditures for health care facilities and major medical equipment. BCA supports mandatory section 1122 review programs in each State and the extension of such review authority to cover major medical equipment expenditures. We question, however, the exclusion of health maintenance organizations from this paragraph. Reviews under this section would be governed by procedures and criteria promulgated pursuant to section 1532 of Public Law 93-641. We feel that such procedures and criteria—and the Final Rules issued January 21 pursuant to section 1532—appropriately require that adequate consideration be given to the special needs of HMO's. Thus, we suggest that HMO's be included within the scope of the section 1122 review program.

Section 1122(a)(3) would be amended to require that if the Governor of a State has not entered into a review agreement with the Secretary within 1 year of the enactment of the bill, Federal payments under title XIX will be withheld. Section 1122(b) would be amended to require that, in the absence of a finding of need by the State Health Planning and Development Agency in accordance with the section 1122 review agreement, the following reimbursement penalties would be applied to unauthorized expenditures:

(1) Major medical equipment or a health care facility—no amount for services provided by such equipment would be paid under titles V, XVIII, and XIX.

(2) Services furnished in such health care facility—reimbursement under titles V, XVIII, and XIX would not include any amount attributable to depreciation, interest on borrowed funds, a return on equity capital—in the case of proprietary facilities—or any other expense related to such capital expenditure, *or* for direct operating costs associated with the provision of such services.

Generally, we find these sanctions to be appropriate. We have, however, the following specific comments. First, we have suggested above that health maintenance organizations be included under the proposed section 1122 review program. Section 1122(a)(3) should be amended to reflect appropriate reimbursement penalties for such organizations. The penalty provided under paragraph (d) for such organizations would be satisfactory. Second, in paragraph (b), the meaning of the phrase "...major medical equipment or a health care facility..." is unclear. Is it intended that services rendered with major medical equipment, regardless of location, be denied reimbursement for the full cost of such services? Third, the word "or" in paragraph (b)(2), [italicized above] should more appropriately be "and".

Paragraph (e) of this section sets forth a $150,000 capital expenditure threshold for section 1122 reviews. As noted above, BCA supports such a threshold.

Section 203—Amendment to the Internal Revenue Code of 1954

Paragraph (f), Obligations Supporting Increases in Acute Care Hospital Beds proposes to eliminate the tax-exempt status for tax-exempt bonds associated with specific unapproved capital expenditures. Exemption from this penalty is provided for capital expenditures which have received a certificate-of-need under a federally approved certificate of need program. This exemption should be expanded to include capital expenditures approved under section 1122 programs.

Section 204—Constraint on the Sale of Medical Equipment

This section would establish penalties to be imposed on suppliers of major medical equipment in instances when major medical equipment not approved under either the section 1122 review program or a federally approved certificate-of-need program is sold. We are not opposed to these penalties.

TITLE III—PROGRAM TO ASSIST AND ENCOURAGE THE DISCONTINUANCE OF UNNEEDED HOSPITAL SERVICES

BCA supports legislative initiatives which address the problem of excess hospital service capacity in an equitable and effective manner. Title III contains a number of provisions which authorize payments to hospitals that eliminate unnecessary capacity. Generally, we find these payment provisions to be both equitable and necessary. Title III also provides for incentive payments to HSA's in whose areas incentive payments for the discontinuance of all of the services of a hospital are made. We support such an incentive payment, particularly since such payments will become part of the HSA's Area Health Service Development Fund.

Certain provisions of title III do concern us. As proposed, the Secretary would be authorized to promulgate, as part of the National Health Planning Guidelines, the maximum appropriate supply of hospital services and the minmum appropriate rate of use of these services for each health service area. For example the reimbursement penalties associated with non-compliacne with these standards have far-reaching effects. We also question the Secretary's ability to promulgate such standards within the time period specified, particularly since he must examine the unique circumstances in over 200 health service areas within a year from enactment. We, therefore, suggest that there be extensive discussion of this issue as part of amendment hearings for Public Law 93-641 later this year.

Thank you very much, Mr. Chairman.

Mr. ROGERS. Thank you, Mr. Hollander.

I think the suggestions you have both made will be helpful to the committee and we will look carefully at them. I think they do leave more flexibility in the local health planning areas from the guidelines. I think the other suggestions that you have made will guide us in making good judgments, so we are grateful to both of you for being here. Thank you so much. This I believe concludes the list of witnesees today. Therefore the committee stands adjourned.

[The following statement and attachments were received for the record:]

STATEMENT

THE AMERICAN PSYCHIATRIC ASSOCIATION
and
THE NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS
presented to the
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE
UNITED STATES HOUSE OF REPRESENTATIVES
on
H.R. 8121
HOSPITAL COST CONTAINMENT ACT OF 1977

July 18, 1977

The American Psychiatric Association, which represents 23,000 psychiatrists in the United States, and the National Association of Private Psychiatric Hospitals, which represents 178 free-standing psychiatric facilities, containing 15,000 beds, commend Chairman Paul Rogers in his efforts to effect hospital cost-containment through his careful examination and consideration of the problems and proposed solutions, interim and permanent, and through his introduction of H.R. 8121.

In testimony presented jointly by our associations on May 12 before the Chairman's Subcommittee and the Subcommittee on Health of the Committee on Ways and Means, and again on June 10 before the Senate Health Subcommittee of the Committee on Finance, we stressed the importance of the National Health Planning and Resources Development Act (P.L. 93-641) in arriving at permanent solutions to stem the tide of rapidly escalating hospital care costs. We also

believe PSRO must play an important role in this process.

Our associations also pointed out the intrinsic differences in the operation of private psychiatric hospitals, stating that costs in these facilities are not nearly so high as they are in medical/surgical facilities. The average per diem rate in psychiatric hospitals runs between $58 to $174, as compared with $250 to $350 for medical/surgical hospitals. This is the case because psychiatric hospitals do not have to share the higher costs of other hospital services, including the sophisticated medical technology and expensive testing that psychiatric units in general hospitals must help defray.

Moreover, the utilization of psychiatric care has been minimal because of the low reimbursement of psychiatric services in Federal, and other programs whose expenses are borne through third-party payors. For example, Medicare and Medicaid denies inpatient psychiatric treatment to Medicaid recipients, age 22-64 in any facility other than a state mental hospital or a general hospital.

Only recently have some states mandated psychiatric coverage in health insurance policies, and as a result more persons who require psychiatric treatment for mental and emotional illness (conservatively estimated to be 10% of our population) receive any treatment.

We are concerned that placing cost strictures on psychiatric

treatment at this time, when some improvement is being made would be ill-conceived and counterproductive for two reasons: (1) Only the most minimal percentage of the American people suffering from mental and emotional illness has access to treatment because of severely limited anachronistic federal benefits, and archaic attitudes towards mental illness and; (2) It has been demonstrated that from 50% to 75% of those who present themselves to physicians for treatment suffer from a component of mental or emotional illness. We believe if these citizens were treated for their mental and emotional illness in the first instance a substantial cost-savings in the health care delivery field would result from the reduction in medical/surgical care. Treatment of the mentally and emotionally ill does not require nearly as extensive or expensive technology as does the treatment of physical illness. Yet those who need psychiatric treatment and are denied it tend to return time and again for inappropriate and costly medical treatment.

As we recommended to the Senate Finance Committee, we strongly urge your Committee to authorize a demonstration project, subject to rigorous, ongoing, organized review, to determine, as we believe it will, that appropriate psychiatric intervention and treatment does reduce medical care costs. We believe this to be true not only for Medicare and Medicaid, but for the entire spectrum of health care delivery.

Private psychiatric hospitals, because of their relatively small size, specialization, and insignificance relative to the dramatic rise in medical care costs, should be exempt from this and any other cost-containment legislation.

The partial results of a survey being conducted by the National Association of Private Psychiatric Hospitals show that of 59 private psychiatric hospitals, 22 have a length of stay of less than 22 days; 32, a length of stay of over 30 days; 2, of 30 days, and; 3 of longer term. 15 of the 22 with a length of stay less than 30 days, had an average length of stay of from 25 to 29 days. The total number of admissions in these 59 hospitals was 46,997, or an average of close to 800 admissions per hospital. It has been stated in Congress that the great bulk of the high escalating costs are derived from institutions with 4,000 or more admissions.

Since psychiatry has held a relatively disadvantaged position in the medical community relative to the other services, we believe that cost-containment legislation, if enacted, would also hurt the delivery of inpatient services in general hospitals. Additional costs of the necessary specialized mental health personnel, essential to the psychiatrists' treatment of the mentally ill -- psychiatric nurses, psychologists, and social workers -- would become a target for accountants' cutbacks as a result, as would the inpatient psychiatric units of general hospitals.

The APA and the NAPPH also are concerned with the incentive feature of H.R. 8121 which enables savings in inpatient services to be placed in the treatment of outpatients, since many general hospitals do not have outpatient facilities for psychiatric treatment.

Psychiatry has been in the vanguard of treating mentally and emotionally ill patients within the community on an outpatient basis, despite the severe problems in reimbursement of outpatient psychiatric services. Nevertheless, the specialty of psychiatry remains wedded to outpatient treatment whenever possible.

As these associations so testified before the Senate Health Subcommittee of the Committee on Finance on June 10 on the Medicare-Medicaid Administrative and Reimbursement Reform Act, we strongly believe that cost-savings will result by lifting the unfortunate and anachronistically low outpatient psychiatric benefits in Medicare (of $250, or 50% of cost, whichever is lower), as well as the other inequities in the treatment of the mentally and emotionally ill in Medicare and Medicaid. The benefit strictures on psychiatric hospitals in Medicare encourage the treatment of mental patients in much more costly general hospitals. The severe restriction of outpatient benefits in Medicare cause the exacerbation of mental conditions, often requiring hospitalization. It is understandable that physicians wishing to treat patients without outpatient psychiatric benefits will tend to hospitalize them.

To remedy these inequities is totally consonant with the administrative reform which is part and parcel of cost-containment.

In summary, the American Psychiatric Association and the National Association of Private Psychiatric Hospitals recommend to your Subcommittee that private psychiatric hospitals be exempt from cost-containment legislation because of their relatively small size, specialization, and insignificance relative to the escalation of health care costs.

We also urge this Subcommittee to consider a demonstration project to determine that appropriate psychiatric intervention and treatment does reduce medical care costs.

Medical Care
January-February 1967, Vol. V, No. 1

Psychiatric Services and Medical Utilization in a Prepaid Health Plan Setting

William Follette, M.D.,*

Nicholas A. Cummings, Ph.D.**

In two previous studies[5, 6] the psychiatric practitioner's contention that emotionally disturbed patients do not seek organic treatment for their complaints following the intervention of psychotherapy have been investigated. Although it has long been recognized that a large number of the physical complaints seen by the physician are emotionally, rather than organically, determined, the more precise relationship between problems in living and their possible expression through apparent physical symptomatology has been difficult to test experimentally. As noted in the previous study, the GHI Project[1] demonstrated that users of psychiatric services were also significantly frequent users of medical services, but the Project was not able to answer the question of whether there is a reduction in the use of medical services following psychotherapy.

Because the facilities and structure of the Kaiser Foundation Health Plan accord an experimental milieu not available to Avnet, the original pilot project in San Francisco was able to demonstrate a significant reduction in medical utilization between the year prior to psychotherapy, and the two years following its intervention. Certain methodologic problems inherent to the pilot study indicated caution and the need for refinement and replication to avoid arriving at premature conclusions. The lack of a control group of what might be termed psychologically-disturbed high-utilizers who did not receive psychotherapy was a serious omission in the first

* Chief Psychiatrist, Kaiser Foundation Hospital and the Permanente Medical Group, San Francisco, Cal.

** Chief Psychologist, Kaiser Foundation Hospital and the Permanente Medical Group, San Francisco, Cal.

Presented at one of the Contributed Papers Sessions sponsored by the Medical Care Section at the 94th Annual meeting of the American Public Health Association, San Francisco, Cal., October 31–November 4, 1966.

This study was primarily financed by Grant PH 108-64-100 (P), U. S. Public Health Service. The authors gratefully acknowledge the assistance and cooperation of Mr. Royal Crystal, Deputy Chief, Health Economics Branch. Secondary financial support for this study was through Grant No. 131-7241 Kaiser Foundation Research Institut

This paper is a report of the first of two investigations seeking to develop and test methods of assessing the effect of psychiatric services on medical utilization in a comprehensive medical program. Part II deals with prospective, rather than retrospective, methodology, and will be reported later.

experiment.† Furthermore, an error in the tabulation of inpatient utilization was discovered after the experiment had been concluded.†† In addition, the question was raised whether the patients studied might, subsequent to the two years following psychotherapy, revert to previous patterns of somatization or, as a new pattern, merely substitute protracted and costly psychotherapy for previous medical treatment.

The Problem

This study investigated the question of whether there is a change in patients' utilization of outpatient and inpatient medical facilities after psychotherapy, comparing the patients studied to a matched group who did not receive psychotherapy.

Psychotherapy was defined as any contact with the Department of Psychiatry, even if the patient was seen for an initial interview only. The year prior to the initial contact was compared with the five subsequent years in both groups.

The problem can be stated simply: Is the provision of psychiatric services associated with a reduction of medical services utilization (defined as visits to other medical clinics, outpatient laboratory and x-ray procedures, and days of hospitalization)?

Methodology

The setting: The Kaiser Foundation Health Plan in the Northern California Region is a group-practice prepayment plan offering comprehensive hospital and professional services on a direct service basis. Professional services are provided by the Permanente Medical Group—a partnership of physicians. The Medical Group has a contract to provide comprehensive medical care to the subscribers, of whom there were more than a half million at the time of this study. The composition of the Health Plan subscribers is diverse, encompassing most socio-economic groups. The Permanente Medical Group comprises all major medical specialties; referral from one specialty clinic to another is facilitated by the organizational features of group practice, geographical proximity and use of common medical records. During the years of this study (1959-1964), psychiatry was essentially not covered by the Northern California Health Plan on a prepaid basis, but in some areas of the Northern California region psychiatric services were available to Health Plan Subscribers at reduced rates. During the six years of the study, the psychiatric clinic staff in San Francisco consisted of psychiatrists, clinical psychologists, psychiatric social workers, resident psychiatrists at the third- or fourth-year level, and psychology interns, all full-time. The clinic operates primarily as an outpatient service for adults (age eighteen or older), for the evaluation and treatment of emotional disorders, but it also provides consultation for non-psychiatric physicians and consultation in the general hospital and the emergency room. There is no formal "intake" procedure, the first visit with any staff member being considered potentially therapeutic as well as evaluative and dispositional. Regardless of professional discipline, the person who sees the patient initially becomes that patient's therapist unless there is a reason for transfer to some other staff member, and he continues to see the patient for the dura-

† The authors acknowledge their debt to Dr. M. F. Collen for this and other suggestions, and to Mr. Arthur Weissman, Medical Economist, Kaiser Foundation Medical care entities, for his expert consultation.

†† At that time days of hospitalization per patient and by year were tabulated from each patient's outpatient medical records. Subsequent investigation has revealed that only about a third of the outpatient charts reviewed contained summaries of hospital admissions, and that tabulation of inpatient utilization must be made directly through the separately-kept inpatient records.

tion of the therapy. An attempt is made to schedule the first interview as soon as possible after the patient calls for an appointment. There is also a "drop-in" or non-appointment service for emergencies so that patients in urgent need of psychiatric help usually can be seen immediately or at least within an hour or two of arrival at the clinic.

One of the unique aspects of this kind of associated health plan and medical group is that it tends to put a premium on health rather than on illness, i.e., it makes preventive medicine economically rewarding, thereby stimulating a constant search for the most effective and specific methods of treatment. The question of how psychiatry fits into comprehensive prepaid medical care is largely unexplored; there are not many settings in which it can be answered. Another feature of group practice in this setting is that all medical records for each patient are retained within the organization.

Subjects: The experimental subjects for this investigation were selected systematically by including every fifth psychiatric patient whose initial interview took place between January 1 and December 31, 1960. Of the 152 patients thus selected, 80 were seen for one interview only, 41 were seen for two to eight interviews (mean of 6.2) and were defined as "brief therapy," and 31 were seen for nine or more interviews (mean of 33.9) and were defined as "long-term therapy."

To provide a control group, the medical records of high medical utilizers who had not presented themselves to the Department of Psychiatry were reviewed until a group was selected which matched the psychotherapy sample in age, sex, socioeconomic status, medical utilization in the Kaiser Health Plan membership interval at least the years 1959 through 1960, and criteria of psychological distress. Thus, each experimental patient was matched with a control patient in the criteria above, but without reference to any other variable. Both samples ranged in age from 21 to 62, with a mean of 38.1. Of these, 52 per cent were women and 63 per cent were blue-collar workers or their dependents. The satisfaction of so many criteria in choosing a matched control group proved to be a tedious and time-consuming procedure.

Review of the medical records of the psychiatric sample disclosed consistent and conceptually useful notations in the year prior to the patients' coming to psychotherapy, which could be considered as *criteria of psychological distress*. These consisted of recordings, made by the physicians on the dates of the patients' visits, which were indicative of those patients' emotional distress, whether or not the physicians recognized this when they made the notations. These (38) criteria were assigned weights from one to three in accordance with the frequency of their appearance in medical records and in accordance with clinical experience about the significance of the criteria when encountered in psychotherapeutic practice. The criteria, with weights assigned, are presented in Table 1. In comparing the charts of the psychiatric patients with those of Health Plan patients randomly drawn, it was determined that although some criteria were occasionally present in the medical records of the latter, a weighted score of three within one year clearly differentiated the psychiatric from the non-psychiatric groups. Accordingly, therefore, in matching the control (non-psychotherapy) group to the experimental (psychotherapy) group, the patients selected had records which indicated scores of three or more points for the year 1959. The mean weights of the three experimental groups and the control group in terms of the 38 criteria of psychological

TABLE 1. *Criteria of Psychological Distress with Assigned Weights*

One point	Two points	Three points
1. Tranquilizer or sedative requested.	23. Fear of cancer, brain tumor, venereal disease, heart disease, leukemia, diabetes, etc.	34. Unsubstantiated complaint there is something wrong with genitals.
2. Doctor's statement pt. is tense, chronically tired, was reassured, etc.	*24. Health Questionnaire: yes on 3 or more psych. questions.	35. Psychiatric referral made or requested.
3. Patient's statement as in no. 2.	25. Two or more accidents (bone fractures, etc.) within 1 yr. Pt. may be alcoholic.	36. Suicidal attempt, threat, or preoccupation.
4. Lump in throat.	26. Alcoholism or its complications: delirium tremens, peripheral neuropathy, cirrhosis.	37. Fear of homosexuals or of homosexuality.
*5. Health Questionnaire: yes on 1 or 2 psych. questions.	27. Spouse is angry at doctor and demands different treatment for patient.	38. Non-organic delusions and/or hallucinations; paranoid ideation; psychotic thinking or psychotic behavior.
6. Alopecia areata.	28. Seen by hypnotist or seeks referral to hypnotist.	
7. Vague, unsubstantiated pain.	29. Requests surgery which is refused.	
8. Tranquilizer or sedative given.	30. Vasectomy: requested or performed.	
9. Vitamin B_{12} shots (except for pernicious anemia).	31. Hyperventilation syndrome.	
10. Negative EEG.	32. Repetitive movements noted by doctor: tics, grimaces, mannerisms, torticollis, hysterical seizures.	
11. Migraine or psychogenic headache.	33. Weight-lifting and/or health faddism.	
12. More than 4 upper respiratory infections per year.		
13. Menstrual or premenstrual tension; menopausal sx.		
14. Consults doctor about difficulty in child rearing.		
15. Chronic allergic state.		
16. Compulsive eating (or overeating).		
17. Chronic gastrointestinal upset; aerophagia.		
18. Chronic skin disease.		
19. Anal pruritus.		
20. Excessive scratching.		
21. Use of emergency room: 2 or more per year.		
22. Brings written list of symptoms or complaints to doctor.		

* Refers to the last 4 questions (relating to emotional distress) on a Modified Cornell Medical Index—a general medical questionaire given to patients undergoing the Multiphasic Health Check in the years concerned (1959-62).

TABLE 2. *Scores for Criteria of Psychological Distress, for the Experimental Groups and the Control Group during the Year Prior to Psychotherapy (1959)*

Group	Total score	No. of patients	Average score
One session only	264	80	3.30
Brief therapy	134	41	3.27
Long-term therapy	246	31	7.94
All experimental (psychotherapy) groups	644	152	4.24
Control (non-psychotherapy) group	629	152	4.14

distress are presented in Table 2: note that there was no significant difference between this dimension of the two groups in 1959.

In order to facilitate comparison of the experimental (psychotherapy) and control (non-psychotherapy) groups, one last criterion for inclusion in the matched group was employed. Each subject in the control group had to be a Health Plan member for the first three consecutive years under investigation inasmuch as the experimental group, though demonstrating attrition in

TABLE 3. *Utilization of Outpatient Medical Services (Excluding Psychiatry) by Psychotherapy Groups for the Year Before (1-B) and the Five Years After (1-A, 2-A, 3-A, 4-A, 5-A) the Initial Interview, and the Corresponding Years for the Non-psychiatric Group*

Group	1-B	1-A	2-A	3-A	4-A	5-A
One session only, unit score	911	815	612	372	321	217
No. of pts.	80	80	80	57	53	49
Average	11.4	10.2	7.7	6.5	6.1	4.4
Brief therapy, unit score	778	471	354	202	215	155
No. of pts.	41	41	41	32	30	27
Average	19.0	11.5	8.6	6.3	7.2	5.7
Long-term therapy, unit score	359	323	279	236	151	108
No. of pts.	31	31	31	27	24	19
Average	11.6	10.4	9.0	8.7	6.5	5.7
All experimental (psychotherapy) groups, unit score	2048	1609	1245	810	687	480
No. of pts.	152	152	152	116	107	95
Average	13.5	10.6	8.2	6.4	6.4	5.1
Control (non-psychotherapy) group, unit score	1726	1713	1718	1577	1611	1264
No. of pts.	152	152	152	127	111	98
Average	11.4	11.5	11.3	12.4	14.5	12.9

continued membership after that time, remained intact for those years.

Dependent variable: Each psychiatric patient's utilization of health facilities was investigated first for the full year preceding the day of his initial interview, then for each of the succeeding five years beginning with the day after his initial interview.

The corresponding years were investigated for the control group which, of course, was not seen in the Department of Psychiatry. This investigation consisted of a straightforward tabulation of each contact with any outpatient facility, each laboratory report and x-ray report.* In addition a tabulation of number of days of hospitalization was made without regard to the type or quantity of service provided. Each patient's utilization scores consisted of the total number of separate outpatient and inpatient tabulations.

* These procedures were counted as one event if there were more than one laboratory or x-ray report in the chart.

Results

The results of this study are summarized in Table 3, which shows the differences by group in utilization of outpatient medical facilities in the year before and the five years after the initial interview for the psychiatric sample, and the utilization of outpatient medical services for the corresponding six years for the non-psychotherapy sample.

The data of Table 3 are summarized as percentages in Table 4, which indicates a decline in outpatient medical (not including psychiatric) utilization for all three psychotherapy groups for the years following the initial interview, while there is a tendency for the non-psychotherapy patients to increase medical utilization during the corresponding years. Applying t-tests of the significance of the standard error of the difference between the means of the "year before" and the means of each of the five "years after" (as compared to the year before), the following results obtain. The declines in outpatient (non-psychiatric) utilization for the "one ses-

TABLE 4. *Comparison of the Year Prior to the Initial Interview with each Succeeding Year, Indicating Per Cent Decline or Per Cent Increase (Latter Shown in Parentheses) in Outpatient Medical (Non-psychiatric) Utilization by Psychotherapy Grouping, and Corresponding Comparisons for the Control Group, with Levels of Significance*

	1-A		2-A		3-A		4-A		5-A	
Group	% change	*Signif.*	% change	*Signif.*	% change	*Signif.*	% change	*Signif.*	% change	*Signif.*
One session only	10.5	*NS*	32.8	*.05*	44.75	*.05*	46.5	*.05*	61.4	*.01*
Brief therapy	39.5	*.05*	53.2	*.05*	66.8	*.01*	62.1	*.01*	70.0	*.01*
Long-term therapy	10.0	*NS*	22.3	*.05*	25.0	*.05*	43.0	*.05*	50.9	*.05*
All experimental (psychotherapy) groups	21.4	*.05*	39.2	*.01*	48.2	*.01*	52.3	*.01*	62.5	*.01*
Control (non-psychotherapy) group	None	—	None	—	(8.8)	*NS*	(27.2)	*.05*	(13.2)	*NS*

sion only" and the "long-term therapy" groups are not significant for the first year following the initial interview while the declines are significant at either the .05 or .01 levels for the remaining four years. In the "brief therapy" group, there are statistically significant declines in all five of the years following the initial interview. As further indicated in Table 4, there is a tendency for the control group to *increase* its utilization of medical services, but this proved significant for the "fourth year after" only.

The question was raised as to whether the patients demonstrating declines in medical utilization have done so because they have merely substituted protracted psychotherapy visits for their previous medical visits.

As shown in Table 5, the number of patients in the one-session-only group who return in the third to fifth years for additional visits is negligible. Comparable results are seen in the brief-therapy group. In contrast, the long-term-therapy group reduces its psychiatric utilization by more than half in the "second year after," but maintains this level in the succeeding three years. By adding the outpatient medical visits to the psychiatric visits, it becomes clear that whereas the first two psychotherapy groups have not substituted psychotherapy for medical visits, this does seem to be the case in the long-term psychotherapy group. These results are shown in Table 6, and indicate that the *combined* outpatient utilization remains about the same from the "year before" to the "fifth year after" for the third psychotherapy group, while declines are evident for the first two psychotherapy groups. As regards the combined (medical

TABLE 5. *Average Number of Psychotherapy Sessions per Year for Five Years by Experimental Group*

Group	1-A	2-A	3-A	4-A	5-A
One session only	1.00	0.00	0.00	0.02	0.06
Brief therapy	6.22	0.00	0.09	0.57	0.52
Long-term therapy	12.33	5.08	5.56	5.88	5.05

TABLE 6. *Combined Averages (Outpatient Medical plus Psychotherapy Visits) of Utilization by Years Before and After Psychotherapy for the Experimental Groups, and Total Outpatient Utilization by Corresponding Years for the Control (Non-psychiatric) Group*

Group	1-B	1-A	2-A	3-A	4-A	5-A
One session only	11.4	11.2	7.7	6.5	6.1	4.5
Brief therapy	19.0	17.7	8.6	6.4	7.7	6.2
Long-term therapy	11.6	22.7	14.1	14.3	12.4	10.8
All experimental (psychotherapy) groups	13.5	15.3	9.2	8.3	7.9	6.2
Control group	11.4	11.5	11.3	12.4	14.5	12.9

plus psychiatric) utilization, the long-term psychotherapy group is not appreciably different from the control (non-psychiatric) group.

Investigation of inpatient utilization reveals a steady decline in utilization in the three psychotherapy groups from the "year before" to the "second year after," with the three remaining "years after" maintaining the level of utilization attained in the "second year after." In contrast, the control sample demonstrated a constant level in number of hospital days throughout the six years studied. These results are shown in Table 7, which indicates that the approximately 60 per cent decline in number of days of hospitalization between the "year before" and the "second year after" for the first two psychotherapy groups is maintained to the "fifth year after"; this decline is significant at the .01 level. The inpatient utilization for the "long-term therapy" group in the "year before" was over twice that of the non-psychiatric sample, and about three times that of the first two psychotherapy groups. The significant (.01 level) decline of 58 per cent from the "year before" to the "second year after" is maintained through the "fifth year after," rendering the inpa-

TABLE 7. *Number of Days of Hospitalization and Averages by Psychotherapy Group for the Year Before and the Five Years After Psychotherapy, and the Corresponding Period for the Non-psychotherapy Group*
(Note: Health Plan average is .8 per year for patients 20 years old or older.)

Group	1-B	1-A	2-A	3-A	4-A	5-A
One session only, days/year	117	78	52	32	33	31
No. of pts.	80	80	80	57	53	49
Average	1.46	0.98	0.65	0.56	0.62	0.63
Brief therapy, days/year	66	44	31	24	23	23
No. of pts.	41	41	41	32	30	27
Average	1.61	1.07	0.76	0.75	0.77	0.85
Long-term therapy, days/year	153	37	19	18	16	13
No. of pts.	31	31	31	27	24	19
Average	4.91	1.09	0.61	0.67	0.67	0.68
All experimental (psychotherapy) groups, days/year	336	159	102	74	72	67
No. of pts.	152	152	152	116	107	95
Average	2.21	1.05	0.68	0.64	0.67	0.71
Significance		*.05*	*.02*	*.05*	*.05*	*.05*
Control (non-psychotherapy) group, days/year	324	307	477	255	208	197
No. of pts.	152	152	152	127	111	98
Average	2.13	2.02	3.07	2.02	1.87	2.01
Significance		*NS*	*.05*	*NS*	*NS*	*NS*

tient utilization of the third psychotherapy group comparable to that of the first two psychotherapy groups.

In terms of decline in use of inpatient services (days of hospitalization), however, the long-term psychotherapy group and the control group are different, in that the former patients significantly reduce their inpatient utilization from the "year before" to the "fifth year after." However, the small size of the samples limits the conclusions that can be drawn.

Discussion

The original pilot study of which this project is an outgrowth was proposed by the senior author as an aid in planning for psychiatric care as part of comprehensive prepaid health-plan coverage. It had long been observed that some of this psychiatric clinic's patients, as well as many patients in the hospital for whom a psychiatric consultation was requested, had very thick medical charts. It was also repeatedly noted that when these patients were treated from a psychiatric point of reference, i.e., as a person who might have primarily emotional distress which was expressed in physical symptoms, they often abandoned their physical complaints. It seemed reasonable to expect that for many of these people, psychiatrically-oriented help was a more specific and relevant kind of treatment than the usual medical treatments.

This would be especially true if the effects of psychiatric help were relatively long-lasting, or if a change in the patient affected others in his immediate environment. In the long run, the interruption of the transmission of sick ways of living to succeeding generations would be the most fundamental and efficient kind of preventive medicine. It therefore seemed imperative to test the intuitive impressions that this kind of patient could be treated more effectively by an unstructured psychiatric interview technique than by the more traditional medical routine with its directed history.

The Balints[2, 3] have published many valuable case reports which describe the change in quantity and quality in patients' appeals to the general practioner after the latter learns to listen and understand his patients as people in distress because of current and past life experiences. It would be difficult, however, to design a statistical study of those patients and of a matched control group treated for similar complaints in a more conventional manner.

Psychiatry has been in an ambivalent position in relation to the rest of medicine: welcomed by some, resented by others, often, however, with considerable politeness which serves to cover up deep-seated fears of and prejudices against "something different." In a medical group associated with a prepaid health plan, conditions are favorable for integrating psychiatry into the medical fraternity as a welcomed and familiar (therefore unthreatening) member specialty. The inherent ease of referral and communication within such a setting would be much further enhanced by the factor of prepayment, which eliminates the financial barrier for all those who can afford health insurance. For many reasons, then, this setting provides both the impetus and the opportunity to attempt an integration of psychiatry into general medical practice and to observe the outcome. In the past two decades, medicine has been changing in many significant ways, among which are prepaid health insurance, group practice, increasing specialization, automation, and a focus on the "whole person" rather than on the "pathology."

Forsham[7] and others have suggested that at some not-too-distant date the patient will go through a highly automated process of history, laboratory procedures and phys-

ical tests, with the doctor at the end of the line doing a physical examination but occupying mainly the position of a medical psychologist. He will have all the results of the previously completed examinations which he will interpret for the patient, and he will have time for listening to the patient, if he wishes to do so. The "Multiphasic Health Check,"[4] which has been used for many years in the Northern California Region in the Kaiser Foundation Medical Clinics and which is constantly being expanded, is just such an automated health survey, and Medical Group doctors are in the process of becoming continually better psychologists. Eventually many more of the patients who are now seen in the psychiatric clinic will be expertly treated in the general medical clinics by more "compleat physicians."

A study such as this raises more questions than it provides answers. One question alluded to above is whether, with an ongoing training program such as Balint has conducted for general practitioners at Tavistock Clinic, internists might not be just as effective as psychiatric personnel in helping a greater percentage of their patients. A training seminar such as this has been conducted by Dr. Edna Fitch in the department of Pediatrics of Permanente Medical Group in San Francisco for many years and has been effective in helping pediatricians to treat, with more insight and comfort, emotional problems of children and their families and physical disorders which are an expression of emotional distress.

Using a broader perspective than the focus on the clinical pathology, one can wonder what social, economic or cultural factors are related to choice of symptoms, attitudes toward being "sick" (mentally or physically), attitudes toward and expectations of the doctor, traditions of family illness, superstitions relating to bodily damage, child raising practices, etc. How often is the understanding of such factors of crucial importance for effective and efficient treatment for the patient? Of special interest in general medical practice and overlooked almost routinely by physicians (and by many in the psychological field) are the "anniversary reactions" in which symptoms appear at an age at which a relative had similar symptoms and/or died.

Health Plan statistics indicate an increase in medical utilization with increasing age in adults. This is consistent with the relatively flat curve seen in the "medical utilization" of the control sample over the six year period and is in marked contrast to that of the experimental sample. There is the implication in this that some of the increasing symptoms and disability of advancing years are psychogenic and that psychotherapeutic intervention may in some cases function as preventive medical care for the problems associated with aging as well as preventive medicine in children.

A certain percentage of the long-term psychotherapy group seems to continue without diminution of number of visits to the psychiatric clinic; these patients appear from the data to be interminable or lifelong psychiatric utilizers just as they had been consistently high utilizers of nonpsychiatric medical care before. They seem merely to substitute psychiatric visits for some of their medical clinic visits. A further breakdown of the long-term group into three parts, e.g., less than 50, 50 to 150, and more than 150 visits, would probably help to sort this population's utilization into several patterns. More precise data on these groups would suggest modifications in classifications and methods of therapy or might suggest alternatives to either traditional medical or traditional psychiatric treatment in favor of some at-

tempt to promote beneficial social changes in the environments of these chronically disturbed people.

Sources of Criticism

(1) One problem in providing a control group comparable to an experimental group in this kind of study is that, although undoubtedly having emotional distress, and in a similar "quantity" according to our yardstick, the control group did *not* get to the psychiatric clinic by either self- or physician referral. The fact that the control patients had not sought psychiatric help may reflect a more profound difference between this group and the experimental group than is superficially apparent. One cannot assume that the medical utilization of this control group would change if they were seen in the Psychiatry Clinic. (This objection will be minimized in the "prospective" part of this study, which will be reported in another paper). Although the average inpatient utilization for the three combined psychotherapy groups is the same as that of the control group in the year before (1959), the inpatient utilization of the long-term psychotherapy group is two and a half times that of the control group. If the study were extended to several years before, rather than just one year, it would become evident whether this was just a year of crisis for the long-term group or whether this had been a longer pattern of high inpatient utilization.

(2) Patients who visit the psychiatric clinic may, for one reason or another, seek medical help from a physician not associated with the Medical Group so that his medical utilization is not recorded in the clinic record, the source of information about utilization. In the long-term-therapy group the therapist is usually aware if his patient is visiting an outside physician, and although it is an almost negligible factor in that group, there can be no information in this regard for the one-session-only and brief-therapy groups without follow-up investigation.

(3) There is no justification in assuming that decreased utilization means better medical care, necessarily. Criteria of improvement would have to be developed and applied to a significantly large sample to try to answer this important question.

(4) Patients may substitute for physical or emotional symptoms behavioral disturbances which do not bring them to a doctor but may be just as distressing to them or to other people.

(5) The "unit" of utilization cannot be used as a guide in estimating costs, standing as it does for such diverse items. In itself the units are not an exact indicator of severity of illness nor of costs. A person with a minor problem may visit the clinic many times, while a much more severely ill person may visit the clinic infrequently. Even more striking is the variation in the cost of a unit, varying from about a dollar for certain laboratory procedures to well over a hundred dollars for certain hospital days (with admissions procedures, laboratory tests, x-rays, consultations, etc.) each worth one "unit." To arrive at an approximation of costs, the units have to be retabulated in cost-weighted form.

Suggested Further Studies

(1) The question of treatment of patients by non-medical professional clinicians has been argued for more than a half century. It is generally recognized that there are not enough psychiatrists now and that there will not be enough in the foreseeable future to treat all those persons who have disabling emotional disorders. In the late President Kennedy's program for Mental Health this lack was recognized; the recommendation for professional staff for community Mental Health Centers included clinical psychologists, psychiatric social workers and other trained personnel. Having little distinction in our psychiatric clinic between the various disciplines as far as their functions are concerned, it would be feasible and interesting to compare therapeutic results of the disciplines as well as individuals with various types of patients and various types of psychotherapy.

(2) Is length of treatment correlated with diagnostic category, original prog-

nosis by therapist, socio-economic level of patient, discipline and orientation of therapist, or "severity of pathology"?

(3) What happens to the spouse, parents, and children of the patients who are seen in psychiatry?

(4) Are there distinguishing patterns of complaints in the three psychotherapy groups?

(5) How do blue-collar patients differ from white-collar or professional patients in number of interviews, diagnostic label, use of medication, recommendation of hospitalization, and type of complaints?

(6) What is the nature of the illness that resulted in hospitalization before the patient came to psychiatry—and after? How often was this a diagnostic work-up because the internist could not find "anything wrong" in the clinic?

Summary

The outpatient and inpatient medical utilization for the year prior to the initial interview in the Department of Psychiatry as well as for the five years following were studied for three groups of psychotherapy patients (one interview only, brief therapy with a mean of 6.2 interviews, and long-term therapy with a mean of 33.9 interviews) and a control group of matched patients demonstrating similar criteria of distress but not, in the six years under study, seen in psychotherapy. The three psychotherapy groups as well as the control (non-psychotherapy) group were high utilizers of medical facilities, with an average utilization significantly higher than that of the Health Plan average. Results of the study indicated significant declines in medical utilization in the psychotherapy groups when compared to the control group. Those inpatient and outpatient utilization rates remained relatively constant throughout the six years. The most significant decline occurred in the second year following the initial interview, and the one-interview-only and brief-therapy groups did not require additional psychotherapy to maintain the lower utilization level for five years. On the other hand, after two years the long-term-psychotherapy group attained a level of psychiatric utilization which remained constant through the remaining three years of study.

The combined psychiatric and medical utilization of the long-term-therapy group indicated that for this small group there was no over-all decline in outpatient utilization inasmuch as psychotherapy visits seemed to supplant medical visits. On the other hand, there was a significant decline in inpatient utilization, especially in the long-term-therapy group from an initial utilization of several times that of the Health Plan average, to a level comparable to that of the general adult Health Plan population. This decline in hospitalization rate tended to occur within the first year after the initial interview and remained generally comparable to the Health Plan average for the five years.

References

1. Avnet, Helen H.: Psychiatric Insurance: Financing Short Term Ambulatory Treatment. New York, Group Health Insurance, Inc., 1962.

2. Balint, Michael.: The Doctor, His Patient and the Illness. New York, International Universities Press, 1957.

3. Balint, Michael, and Balint, Enid: Psychotherapeutic Techniques in Medicine. London, Tavistock Publications Limited, 1961.

4. Collen, M. F., Rubin, L., Neyman, J., Dantzig, G. B., Baer, R. M., and Siegelaub, A. B.: Automated multiphasic screening and diagnosis. *Am. J. Pub. Health* 54, 1964.

5. Cummings, N. A., Kahn, B. L., and Sparkman, B.: Psychotherapy and Medical Utilization. As cited in Greenfield, Margaret: Providing for Mental Illness. Berkeley, Calif., Berkeley Institute of Governmental Studies, University of California, 1964.

6. Follette, W. T., and Cummings, N. A.: Psychiatry and Medical Utilization. An unpublished pilot project, 1962.

7. Forsham, Peter H.: Lecture before the Permanente Medical Group. San Francisco, 1959.

MEDICAL CARE
September-October 1970, Vol. VIII, No. 5

Effect of a Short-term Outpatient Psychiatric Therapy Benefit on the Utilization of Medical Services in a Prepaid Group Practice Medical Program

IRVING D. GOLDBERG, M.P.H.,* GOLDIE KRANTZ, M.A.,† AND BEN Z. LOCKE, M.S.‡

A pilot study was conducted to measure the effect of a short-term outpatient psychiatric therapy benefit on the utilization of general medical services at Group Health Association of Washington, D. C. (GHA), a prepaid group practice medical program. The study group consisted of 256 patients who were referred for such outpatient therapy and who were GHA members for a full 12-month period both before and after the psychiatric referral. Study patients experienced a marked reduction during the year after referral as compared with the prior year in the utilization of GHA nonpsychiatric physician services and laboratory or x-ray procedures. The reduction in number of patients seen was 13.6 per cent for nonpsychiatric physician services, and 15.7 per cent for laboratory or x-ray procedures. In terms of visits made, reduction was approximately 30 per cent for each of these services. Basic finding of reduced utilization was still obtained when factors of age, race, sex, psychiatric diagnosis, and number of therapy sessions attended under benefit were taken into account. Results support findings of reduced utilization in other studies and suggest more efficient utilization of appropriate medical services as a result of short-term outpatient mental health benefit in prepaid health plan settings.

ONLY IN THE PAST decade have significant increases in mental health benefits been included in the rapid growth in health insurance protection through private voluntary insuring organizations. Since 1963, the National Institute of Mental Health (NIMH) has actively stimulated this development by encouraging the expansion of private voluntary health insurance coverage for mental health.[5] In a collaborative effort with the NIMH, the United States Civil Service Commission, which administers the Federal Employees Health Benefits program,‖ requested insurance carriers and health plans participating in that program to incorporate new or improved mental health benefits, particularly coverage for outpatient services, into their existing benefit structures.

A total of some four million people are enrolled in community prepaid group practice health plans which are essentially comprehensive in their health coverage.[6] Prior to 1960, when the federal employees program went into effect, these plans in the main were without prepaid mental health benefits. However, all federal employees enrolled in these plans now have some mental health coverage, including outpatient benefits; and similar coverage is also available to other members and contractor groups in these plans.

* Chief, Evaluation Studies Section, Biometry Branch, National Institute of Mental Health, Chevy Chase, Maryland.

† Program Analyst, Group Health Association, Inc., Washington, D.C.

‡ Assistant Chief, Center for Epidemiologic Studies, National Institute of Mental Health, Chevy Chase, Maryland.

‖ The Federal Employees Health Benefits program, which became effective in 1960 under an Act of Congress, is the largest employer-sponsored contributing health insurance program in the world covering more than seven million persons, including employees, annuitants, and dependents.

With the adoption of mental health benefits in prepaid group practice plans, it has become possible to evaluate to some extent the effects that these benefits might have on patient utilization of nonpsychiatric medical services covered by the plans.[1,2] Group Health Association of Washington, D.C. (GHA) cooperated with the Biometry Branch of the NIMH in conducting a small pilot study directed towards this question. This paper reports on the results of that study which is based on the first year's experience with a mental health benefit at GHA before benefits were expanded and before the total population of GHA was included.

Setting and Nature of Short-Term Mental Health Benefit

The Group Health Association of Washington, D. C. is a comprehensive prepaid group practice program whose participating population resides almost entirely in the metropolitan Washington, D. C. area and is comprised of three groups: federal government employees, D. C. transit workers, and general members. In November 1964, GHA included a limited outpatient mental health benefit in its structure of benefits for its government employee group who then comprised 66 per cent of the GHA participant population of approximately 54,000. In January 1965, this benefit was extended to the general members who accounted for 18 per cent of the participant population. Thus, 84 per cent of the GHA population had some coverage for short-term outpatient psychiatric care at the inception of the partially prepaid benefit. Acute short-term hospital care had previously been part of the benefit structure.

At its initiation, the GHA mental health benefit offered under prepayment was essentially as follows: GHA paid up to 15 dollars for each of 10 therapy sessions in a membership-year for outpatient treatment of acute mental illness and emotional disorders subject to significant improvement through short-term outpatient therapy.* A GHA screening psychiatrist determined eligibility for referral on benefits. When the patient was referred by a GHA nonpsychiatric physician to the GHA screening psychiatrist for evaluation purposes as to eligibility for benefits, there was no charge to the patient for that visit or visits. During the study period, a patient could also self-refer to the screening psychiatrist. An evaluation of the patient's psychiatric condition was made by the screening psychiatrist and, on the basis of his diagnostic impression, he recommended appropriate psychiatric care where indicated, and he determined whether GHA coverage for benefits could be approved. If short-term therapy was authorized under the benefit, the patient was referred to psychiatrists or other mental health disciplines. If the condition was chronic, and hence not covered by the benefit, referral could still be made to another agency or psychiatrist, but no payment would be made by GHA for such care.

Study Design

The basic study plan was to compare, for the case group under study, the utilization of GHA medical services before and after each patient was referred on benefits for short-term outpatient psychiatric therapy. The "before" period was the 12-month interval immediately preceding the date of referral by the screening psychiatrist. It was considered likely that virtually all of the patients undergoing therapy would have completed such care during the first three months immediately following referral. Since such therapy was apt

* The limit of 10 therapy sessions was a renewable benefit each membership-year (i.e., year beginning with each anniversary date of joining the plan). Thus, if therapy was initiated towards the end of one membership-year and carried into the next, the patient could actually have as many as 19 sessions for the same referral.

to affect the utilization of GHA services during this period, and to allow sufficient time for completion of the therapy on benefits, the "after" period of 12 months' duration was taken to begin three months following the referral date. Thus, the records for each study patient were reviewed for a 27-month exposure period, although the three-month "psychiatric therapy interval" was not to be included in the "before-after" analysis of medical services utilization.

For purposes of the study, it was desirable that the study group be confined to persons who were covered by the same mental health benefit. It was, therefore, decided to limit the study group to all patients enrolled under the "high option" or "premium" plan who were referred on benefits for psychiatric therapy during the first year the benefit structure was in effect.* Thus, as a by-product, the results of the study could provide a baseline for any future studies based on a revised benefit structure. (After the first year, the GHA mental health benefit was substantially increased and broadened.)[7]

Since the GHA mental health benefit during the study period applied only to the federal employee and general member groups (including covered family members), they comprised the study population. The GHA medical records for these enrollees were reviewed by GHA staff to identify all patients who were referred to, and seen by, the screening psychiatrist during the period November 1, 1964 through October 31, 1965, the first full year in which the psychiatric benefit was in effect. To protect the confidentiality of the patient, individuals were not identified by name to the study staff. Also, it should be noted that the confidential psychiatric notes are not part of the medical record and were not made accessible for this study.

A total of 726 patients (excluding GHA staff and dependents) were referred to the screening psychiatrist. Of this total, 409 patients were excluded from the study because they were judged ineligible for coverage under this benefit or because they overtly refused psychiatric care. Specifically, 161 were judged not to be in need and hence not referred for outpatient psychiatric care; 197 were referred for psychiatric care but not on benefits; referral was deferred for 45 patients; and 6 patients who would have been referred on benefits overtly refused to accept such care.

The records for the remaining 317 patients seen by the screening psychiatrist were reviewed for the 27-month period referred to earlier. From this total, 61 were eliminated from the study as follows: 57 cases were not available for the full 27-month period (35 began membership less than one year prior to the date seen by the screening psychiatrist, and 22 terminated their membership within the 15-month period following that date); for four patients the files were not available. This left 256 patients who comprised the study group. Of the final study group, 197 were enrolled in the federal employee program and 59 were general members—approximately in the same ratio to one another that these two groups comprised in the total GHA population.

As a point of interest, the age distributions were examined for the 409 patients ineligible for benefits and the 61 eligibles who did not otherwise meet the study criteria. The age distribution for the former group was found to be very similar to that of the 256 study patients; however, the latter group of 61 patients had a somewhat younger age distribution than the final study group.

Data extracted from the medical records were counts of all visits to GHA physicians

---

* Under the "low option" or "standard" plan, GHA paid up to 10 dollars (as compared with 15 dollars under "high option") per therapy session. Only about 10 per cent of the GHA members are enrolled in the "low option" plan.

for medical care, all visits for x-ray and laboratory procedures, as well as the number of visits made for psychiatric therapy under the mental health benefit. Other data abstracted for each patient, where available, were age, race, sex, and psychiatric diagnostic impression. Information on psychiatric and nonpsychiatric hospitalizations recorded in the medical record was also extracted. However, study data on hospitalizations were incomplete because such information was not generally recorded on patients who were hospitalized outside of GHA auspices. Also, during the period of study, the GHA hospitalization information was not consistently available in the progress notes which formed the primary source of data for this pilot study.

Results

The distribution of the study population by age, sex, and race is shown in Table 1. Approximately 70 per cent of the study group were from 25 to 64 years of age at time of referral on psychiatric benefits. In contrast, only 50 per cent of the total GHA participant population (in the federal employee and general groups) were in this age group during the study period.[3] About 60 per cent of the study group were female, which was slightly higher than the proportion of females in the total GHA membership. With respect to race, about 83 per cent of the study group were Caucasian. Although no precise data on race are available for the total GHA membership, the proportion of Caucasians in the total membership is estimated to have been appreciably less than that in the study group. Specific psychiatric diagnosis for each patient was not uniformly recorded in the medical records. However, from information which was recorded, based on the evaluation of the screening psychiatrist or the psychiatrist providing therapy, it was possible to classify the psychiatric diagnostic

TABLE 1. Distribution of Study Group by Age, Race, Sex, and Psychiatric Diagnostic Impression

Patient characteristics	Number	Per cent*
Total study group	256	100.0
Age group (years)		
0 - 14	22	8.6
15 - 24	49	19.1
25 - 44	97	37.9
45 - 64	82	32.0
65 +	6	2.4
Race		
Caucasian	210	82.7
Other	44	17.3
Unknown	2	
Sex		
Male	100	39.1
Female	156	60.9
Psychiatric impression		
Psychosis	40	20.7
Psychoneurosis	106	54.9
Personality disorder	21	10.9
Transient situational personality disorder	22	11.4
Other	4	2.1
Unknown	63	

* Based on total patients for whom characteristics were known.

TABLE 2. Comparison of Number of Patients Seen and Visits Made During Year Before and Year After Psychiatric Referral by Type of Service

Type of Service (nonpsychiatric)	Patients Seen (N = 256)			Visits Made*		
	Year before referral	Year after referral	Per cent change	Year before referral	Year after referral	Per cent change
Physician services	243	210	−13.6	1264	876	−30.7
Laboratory or x-ray	210	177	−15.7	795	558	−29.8

* Each visit for laboratory or x-ray services was counted only once regardless of the number of procedures performed at each visit.

impression into broad categories for three fourths of the study group. Among those for whom the diagnostic impression was determined, 21 per cent were classified psychotic, 55 per cent psychoneurotic, 11 per cent with personality disorders, 11 per cent as having a transient situational personality disorder, and 2 per cent were considered to have some other psychiatric problem.

Initially, the data were analyzed separately according to the specific medical department or ancillary service in which the patients were seen (i.e., internal medicine, other nonpsychiatric medical department, laboratory, x-ray). Almost 95 per cent of the visits by the study patients for physician services were made to the department of internal medicine. However, since the study findings for visits to internal medicine were similar to those for other nonpsychiatric medical departments, the data for all medical departments were combined in the analysis presented here. Similarly, with respect to ancillary services, the findings on visits for laboratory procedures were essentially the same as those for x-ray visits, so the data for laboratory and x-ray services were also combined.

Study findings presented below compare separately the physician and ancillary (laboratory or x-ray) services received by the study group during the 12-month periods before and after referral on psychiatric benefits, by age, race, sex, diagnosis, and number of psychiatric therapy sessions attended on benefits. It was not possible to conduct a "before-after" analysis with respect to utilization of psychiatric services. Although some psychiatric counseling was provided on a fee-for-service basis prior to the initation of the mental health benefit, there was no psychiatry department as such at GHA at that time and, therefore, no comparable or meaningful basis for comparison. Thus, the "before-after" analysis was limited to utilization of nonpsychiatric medical services.

Table 2 shows the number of study patients who received care from the various GHA departments, except psychiatry, and the number of visits made to these departments during the "before" and "after" periods. Also shown is the per cent decrease from the "before" period to the "after" period with respect to number of patients seen and number of visits made. Each visit for laboratory or x-ray services was counted only once regardless of the number of procedures performed at each visit.

It is clearly evident from these data, in terms of persons seen and visits made, that medical and ancillary services were each provided to more of these patients and more frequently before psychiatric referral than after. Thus, the reduction in the number of patients seen by the nonpsychiatric medical departments was 13.6 per cent, and for laboratory or x-ray procedures, 15.7 per

TABLE 3. Per cent Decrease During Year After Referral as Compared with Prior Year in Utilization of Nonpsychiatric Physician Services and Laboratory or X-ray Procedures, According to Patient Characteristics and Psychiatric Therapy on Benefits

Patient characteristics and therapy received	Number in study	Per cent decrease after referral*			
		Patients seen		Visits made	
		Physician services	Lab or X-ray	Physician services	Lab or X-ray
Total Study Group	256	13.6	15.7	30.7	29.8
Age (years):					
0 - 14	22	4.5	21.1	23.8	35.6
15 - 24	49	17.4	15.8	36.1	33.0
25 - 44	97	16.5	17.9	29.7	27.4
45 - 64	82	11.5	13.0	31.7	30.8
65 & over	6			20.6	20.0
Race:					
Caucasian	210	13.1	15.9	26.1	30.5
Other	44	14.0	14.7	49.0	25.6
Unknown	2				
Sex:					
Male	100	16.1	23.5	37.8	47.6
Female	156	12.0	10.9	26.0	18.0
Psychiatric impression:					
Psychosis	40	25.0	28.6	35.0	29.0
Psychoneurosis	106	10.0	6.7	23.4	23.3
Other	47	4.4	12.2	46.9	32.2
Unknown	63	19.0	26.7	24.7	41.5
Psychiatric therapy sessions:					
None	70	16.9	24.1	39.2	22.6
1 - 9	75	12.7	18.5	30.4	23.8
10 or more	104	11.0	6.0	23.3	35.3
Unknown	7			50.0	44.4

*Per cent not shown in any cell where base (number before referral) was less than 10.

cent. Similarly, in terms of number of visits made, the reduction was approximately 30 per cent both for physician services and for laboratory or x-ray procedures.

Viewing the reduction in utilization another way, the average (mean) number of visits made by the 256 study patients, during the "before" and "after" periods, respectively, were 4.94 and 3.42 for physician services, and 3.11 and 2.18 for laboratory or x-ray procedures.

Overall, the study group experienced a total reduction of some 30 per cent in the number of visits made for physician and ancillary services. The difference between the periods before and after referral with respect to the number of patients seen was statistically significant ($P<.001$)* for physician services as well as for laboratory or x-ray procedures. Similarly, for each of these services, the reduction in the mean number of visits was also statistically significant ($P<.001$).†

The study data were analyzed further to determine whether the observed decreases after psychiatric referral held for various subgroups of the study population. Thus,

* McNemar's chi-square test for correlated samples was used.

† The two-tailed t-test of paired (before-after) differences was used.

TABLE 4. Number and Per cent of Persons with Fewer, Same, or More Visits in Year After Referral Compared with Year Preceding Referral, by Type of Service

Visits before and after referral	Physician Services		Laboratory or X-ray	
	Number	Per cent	Number	Per cent
Total study group	256	100	256	100
Fewer visits in year after referral	152	59.4	134	52.3
Same number of visits both years	42	16.4	50	19.5
More visits in year after referral	62	24.2	72	28.1

for both physician services and ancillary services, the "before" and "after" periods were compared with respect to the per cent change in number of persons served and total visits made according to age, race, sex, psychiatric diagnostic impressions and number of psychiatric therapy sessions attended under benefit.

The findings presented in Table 3 clearly show the overall consistency of reduction in utilization of the physician and ancillary services by the study group. Although some variation existed in the extent of decrease (partly due to small numbers in some cells), the pattern of reduced utilization of these services held throughout each of the distributions.* There was particularly little variation in the per cent change by age. It is also of interest to note that patients who did not avail themselves of the short-term outpatient therapy benefit generally showed as great a relative reduction in utilization of medical services as did those who received the full benefit of at least 10 sessions.

Another indication of the consistency of reduced utilization of physician and ancillary services after psychiatric referral is evident in the data in Table 4. Here, a determination was made as to whether each patient made fewer, more, or the same number of visits during the 12-month period after psychiatric referral as he or she made during the prior year for physician services or for laboratory or x-ray procedures. Only about one fourth of the study patients made more visits for physician services after referral than before in contrast with the almost 60 per cent who made fewer visits after referral. Similarly, only 28 per cent of the patients made more visits for laboratory or x-ray procedures after referral than before, while 52 per cent made fewer such visits. Both of these differences were statistically significant ($P<.001$).* When the patients were grouped according to the actual number of visits made in the year preceding referral, this pattern of fewer

* For both of the service categories, statistical tests of significance were performed comparing the various age groups, Caucasians with those of other races, males with females, the various diagnostic categories, and those who had no psychiatric therapy sessions under benefit with those who had 10 or more sessions. With respect to persons seen, each patient was classified as to whether or not he showed a "before-after" reduction in number of visits made, and a chi-square test was used to compare the dichotomous distributions for the various comparison groups. None of these comparisons was significant at the .05 level. With respect to visits made, either an analysis of variance or a two-tailed t-test was made of the difference between the comparison groups in the mean "before-after" reduction in number of visits. In only one instance (the greater reduction observed among males than females in average number of laboratory or x-ray visits, $P<.02$) was the observed difference statistically significant at the .05 level.

* The chi-square test was employed to test the equality of the number of patients showing a decrease in number of visits with those showing an increase.

visits held for virtually all groups of patients who had at least two visits in the prior year for physician or ancillary services. The greatest relative reductions occurred among those who made the most visits during the prior year. Thus, of the 81 patients who made more than five visits for physician services during the year preceding referral, 64 (79 per cent) made fewer visits in the post-referral year than they did in the prior year.

Discussion

The consistent results of this pilot study clearly indicate that the short-term outpatient psychiatric benefit at GHA was associated with a decrease in the utilization of physician and ancillary services under the plan. Not only was there a decreased utilization following psychiatric referral for the study group as a whole, both with respect to the number of persons seen and the number of visits made, but this decreased utilization held—to a greater or lesser degree—for all subsegments of the population studied.

Of some interest in this regard is the relationship between utilization of physician and ancillary services at GHA and the number of therapy sessions attended under the short-term psychiatric benefit. Note has been made of the fact that the study patients who did not attend any outpatient therapy sessions under benefits (although referred by the screening psychiatrist for such care) showed as great a relative reduction of medical services utilization as did those who received all or part of their authorized therapy. This finding would seem to imply that the visit to the screening psychiatrist alone may have had a beneficial effect on the patient, at least to the extent that the patient apparently had reduced need or desire for physician or ancillary services following the screening. However, it should be noted that some patients referred on benefits may have elected to obtain their psychiatric therapy outside the GHA benefit structure at their own expense. Unfortunately, the GHA records do not ordinarily reflect such outside care. In any event, it is clear that whether or not the referred patients as a group actually availed themselves of the benefit provisions, they showed a reduced subsequent utilization of general medical services provided by the group practice plan.

It is reasonable to assume that the observed reduction in utilization of physician and ancillary services at GHA to a large extent reflects a reduced need or desire for such services, rather than a shift by the patients to other sources for their medical attention at additional cost to themselves (although, undoubtedly, some such shifting did occur). This assumption is based upon the fact that these patients continued to maintain their GHA membership throughout the 27-month study period, and that the very great majority did return to GHA for at least some medical attention during the "after" period.

When viewed in terms of the effect on the provider of services, the reduction in use of physician and ancillary services at GHA would seem to imply a reduction in cost which would otherwise occur in the provision of such services and, theoretically, a more efficient utilization of appropriate services. There was no attempt to do any cost-benefit analysis in this study, the primary purpose of which was directed at utilization without regard to costs. However, an inference could be made that the cost savings due to reduced utilization would be reflected in the entire benefit structure without setting forth dollar amounts.

Comment should be made about the possible effect of hospitalization on the study findings, since a question might be raised as to whether or not there was appreciably more hospitalization in the period after psychiatric referral than in the prior-referral year. As mentioned previously, during the

period of study, the GHA hospital records were not totally coordinated with the medical record, which was the principal data source for this study. Therefore, the effect of episodes of hospitalization on the study findings could not be evaluated. With respect to psychiatric hospitalization, however, since the study group excluded all patients whom the screening psychiatrist considered to have a chronic condition requiring inpatient or long-term outpatient psychiatric care, it is very unlikely that more than a handful of study patients would have required such hospitalization. In any event, the study findings were of such magnitude and consistency that they are unlikely to be materially affected by the factor of hospitalization.

Another consideration relates to the study design whereby each patient was used as his own control in the "before-after" comparison. The absence of a suitable control group in this pilot study, against whom the "before-after" findings of the case group could be compared, limits the conclusions which can be drawn at this time; however, efforts are underway in a broader study to obtain similar data for such a comparison group. The question which arises here is whether the study patients, having already received medical attention one year, would be likely to require more or less care in the following year. If need for less care were to be expected, this might account, at least in part, for the reduction in utilization observed among the study group. However, the GHA experience in the past indicates that patients using the plan, with its emphasis on preventive services and early detection of chronic disease, tend to use the services increasingly in subsequent years. This is supported by the following data for the total GHA experience around the study period, which show a level or rising per capita utilization in contrast to the observed finding of markedly reduced utilization by the study group.[3, 4]

Year ending September 30	GHA Per Capita Utilization		
	Office Consultations	Laboratory	Radiology
1963	3.65	3.88	1.08
1964	3.77	4.43	1.08
1965	3.77	5.06	1.14
1966	3.71	5.25	1.12

Follette and Cummings[2] also studied medical utilization before and after psychiatric therapy in a prepaid health plan setting, namely the Kaiser Foundation Health Plan in the Northern California Region. Their case group consisted of persons who received psychotherapy defined as any contact with the plan's department of psychiatry. The medical utilization for the year prior to the initial contact with that department was compared with the utilization for each of five subsequent years, both for the case group and a matched control group who did not receive psychotherapy. The outpatient medical services in that study included visits to outpatient medical (nonpsychiatric) clinics and contacts for outpatient laboratory and x-ray procedures; however, these three types of service were lumped together in the analysis. Despite differences in the setting, benefit structure, mental health disciplines utilized, and study design from those of the GHA study, Follette and Cummings also found a significant decline in utilization of medical services following psychotherapy.

A further, although limited, indication of reduced utilization of general medical services following outpatient psychotherapy is contained in an unpublished report of another study. In 1965, the Health Insurance Plan of Greater New York (H.I.P.) instituted, as a demonstration project, a mental health service which, upon referral by a group physician, provided an outpatient psychiatric treatment benefit in one of its medical groups. One section of the final report of that project[1] submitted by H.I.P. to

the National Institute of Mental Health, which partly supported the demonstration project, contains an analysis of the relationship between psychiatric treatment and the use of medical services including family physician office visits, specialist office visits, and x-ray and laboratory services. Due to sample size limitations and other considerations, the results of this analysis were viewed in the report as exploratory only. The "treatment" group (those seen in the mental health service for consultation or treatment) and three comparison groups were employed in a "before-after" analysis of medical utilization for periods covering one year before the appropriate "study" or "consultation" date and each of two years after. Although the report notes that the analysis did not demonstrate a consistent pattern across all comparison groups, it also states that the analysis indicated ". . . some tendencies pointing to lower medical utilization in the group to whom psychotherapy was available."

The supporting evidence of the Kaiser, H.I.P., and GHA studies strengthens the hypothesis of reduced utilization of medical services, and more efficient utilization of appropriate services, as a result of short-term outpatient mental health benefit in prepaid health plan settings.

On the basis of the findings of the GHA study presented in this paper, the authors are now initiating a broader study which will include a "before-after" evaluation of the utilization of GHA medical and hospital services by all family members of patients referred on psychiatric benefit and will also employ one or more comparison groups.

Acknowledgments

The authors wish to thank Mrs. Josephine Tate (GHA) for her assistance in abstracting the study data; Mr. Robert F. Woolson and Mrs. Warnilla Cook (both of the Biometry Branch, NIMH) for their assistance in the analysis; and Mrs. Mildred Arrill (Division of Mental Health Service Programs, NIMH) for her consultation.

References

1. Department of Research and Statistics, Health Insurance Plan of Greater New York. Psychiatric Treatment and Patterns of Medical Care. Unpublished final report to the National Institute of Mental Health, Project MH 02321, July 1969.

2. Follette, W., and Cummings, N. A.: Psychiatric services and medical utilization in a prepaid health plan setting. *Medical Care* 5:25, 1967.

3. Group Health Association. GHA News — Annual Report Issue, vol. 28, no. 1, March 1965.

4. Group Health Association. GHA News — Annual Report Issue, vol. 30, no. 2, March 1967.

5. Public Information Section, National Institute of Mental Health. Improving Mental Health Insurance Coverage. Washington, D.C., U.S. Department of Health, Education, and Welfare. PHS Publication No. 1253, August 1965.

6. Reed, L.-S.: Private health insurance, 1968: Enrollment, coverage, and financial experience. U.S. Department of Health, Education, and Welfare, Social Security Bulletin 32:19, No. 12, December 1969.

7. United States Civil Service Commission. Summary of Benefits — Group Health Association, BRI 41-41, January 1966.

[Whereupon, at 12:30 p.m., the subcommittee adjourned.]

○