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HOSPITAL COST CONTAINMENT ACT OF 1977

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

OF THE

COMMITTEE ON HUMAN RESOURCES

UNITED STATES SENATE

NINETY-FIFTH CONGRESS

FIRST SESSION

ON

S. 1391

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

Part 1

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HOSPITAL COST CONTAINMENT ACT OF 1977

TUESDAY, MAY 24, 1977

U.S. SENATE,
SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
OF THE COMMITTEE ON HUMAN RESOURCES,
Washington, D.C.

The subcommittee met, pursuant to call, in the Gorman Auditorium of Georgetown University Hospital, Washington, D.C., at 9:28 a.m., Senator Edward M. Kennedy (chairman of the subcommittee) presiding.

Present: Senators Kennedy, Hathaway, Schweiker, and Chafee.

Committee staff present: Stuart Shapiro and Robert Wenger, professional staff members; David Winston and David Main, minority.

Senator KENNEDY. We will come to order. I first of all want to express my very warm appreciation to Georgetown University and the medical school and the hospital for their kindness and their hospitality in extending to the Senate Health Subcommittee the forum for this particular meeting today.

I think all of us were impressed in reading this morning about the new directions that are being developed here at the Georgetown Medical School in trying to help the country meet its challenges in terms of the primary care function.

This topic has been a matter of great interest to the Senate Health Committee and to the Congress as a whole, and to have one of the really outstanding medical schools and universities sensitive to this issue, and working with us, and responding to a national need, I think is a great achievement.

I think those who are involved in the administration, those who are involved in university decisions, deserve a great deal of commendation.

In thanking the university, I want to recognize that we are dealing with a problem which is complex, which is involved, which is controversial, which, I imagine in some instances, will put us across the table from the administration of the Georgetown Hospital. I think it is to their credit that they are willing to examine these issues with us in an open forum, and to discuss these matters in a constructive and positive way.

I think that is in the highest tradition of a great educational center.

Finally, just in a personal way, I could not be back at this hospital without recognizing the close association that the hospital has had with my own family. There have been numerous members of my family who have benefited from the skill of its physicians and the care which is really among the finest in this country.

From a personal point of view, I have seen from my own vantage point the excellence, and the skill, and the compassion which is so much a part of this medical center.

We are under a time constraint this morning, but I want to just say a brief word on the subject matter which brings us here today.

Clearly understood among the American people is the absolute explosion in terms of hospital costs in our country in recent times. Hospital rooms that 25 years ago cost $15 per day are over $176 today. There has been an explosion in terms of the hospital bills which the average American family has to pay, either out of their pocket or through some kind of an insurance program.

Whether they realize it or not, they are working longer and longer every year in order to receive their health-care coverage. And the average worker now who is covered with some form of hospitalization is working anywhere from 4 to 5 weeks annually to be able to receive coverage.

We are under strict budgetary restrictions in the Congress of the United States, and as we see some figure established in terms of meeting our health-care needs, we are seeing other important priorities neglected such as preventive health care, health education, nutrition, and nutrition counseling, and immunization programs, in which Secretary Califano and President Carter have been so constructive in offering solutions. It is an attempt to try and reach, perhaps in a preliminary way, prior to the passage of health insurance, some cost controls that the administration has advanced in their particular proposal. And I introduced their proposal in the U.S. Senate.

Now, we on this subcommittee understand, as the Secretary has mentioned that there are troublesome aspects of that particular proposal.

But if we were to see it implemented, the best estimate is that by the time we got to 1981, 1982, we would be talking about saving approximately $40 billion in terms of health expenditures, which is an incredible amount of money to be able to save, particularly when we are facing scarce resources.

But we want to examine in some detail this particular proposal. It is a matter of great importance, and of great consequence, and it is a matter of great interest to the hospitals and the hospital administrators of this country.

[The text of S. 1391 follows:]

95TH CONGRESS
1ST SESSION

S. 1391

IN THE SENATE OF THE UNITED STATES

APRIL 26 (legislative day, FEBRUARY 21), 1977

Mr. KENNEDY (for himself, Mr. ANDERSON, and Mr. HATHAWAY) introduced the following bill; which was read twice and referred to the Committees on Finance and Human Resources jointly by unanimous consent

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 pro-

grams, 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 Health Maintenance Organization 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 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.

(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 compli-

ance 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 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 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 INCREASED 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 "gross national product deflator") for the twelve-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 gross national product 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 gross national product deflator with respect to such period is expected to exceed by more than one percentage point the gross national product 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 gross national product 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 ad-

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missions 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 four thousand 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 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 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 (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 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 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 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) (i) 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 establish 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 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 Secretar 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 ten 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 pubic use, the information it recevies 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 sys-

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tems 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.

"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 STANDARDS FOR OCCUPANCY OF HOSPITAL BEDS

"SEC. 1504. (a) (1) Before the beginning of the fiscal year beginning October 1, 1977, and at least sixty 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 eighteen 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

per centum; 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 expenditures 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 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 Socal 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 thirty 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 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 (A) of the preceding sentence, the cost of the studies, surveys, design, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, 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 section 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 ceil-

ing 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.

Senator KENNEDY. I will ask Senator Schweiker if he has a comment to make, then Senator Hathaway, and then we will introduce our first witness.

Senator SCHWEIKER. Thank you, Mr. Chairman.

First, I too want to thank Georgetown University Hospital for their courtesy and hospitality in having us here as their guests this morning.

I look forward to this opportunity to examine more closely the administration's proposed cap on hospital costs. As the ranking minority member of this subcommittee, I am greatly concerned about how much damage skyrocketing hospital bills can do to all American families, to the poor and the elderly, and to our entire health care delivery system. Comprehensive reform is long overdue.

Of course, President Carter's proposals are not set forth as comprehensive reforms. Instead, they are called a first step toward comprehensive reform. Further proposals by the administration are probably a year away.

Our job is to decide if the administration's temporary adjustment is a better approach than any number of long-range overhauls already pending before the Congress.

I must admit that after 3 days of hearings in the House of Representatives, and a personal study of this plan, I still have some basic questions about the wisdom and practicality of this approach.

For example, under the administration's bill, a hospital's revenue limit would be calculated by adding the implicit GNP deflator to the last 2 years' average hospital cost increase, divided by 3; then making a 50-percent adjustment for changing admissions, if they increase more than 2 or decrease more than 6 percent; then adjusting the base for their accounting year, passing through increases in nonsupervisory wages, and making other adjustments for major changes in character, or capacity, or exceptional situations.

How can the administration tell a nation already swamped by government paperwork that this bill will be "simple and easy to administer"?

HEW also says the plan is merely transitional. But transitional to what? We have heard nothing about the national health insurance plans for the future, or any other long-range plans. Should we really enact a transitional plan without knowing where it leads?

Finally, it is stated that hospitals can save money by cutting out the fat. But what in this bill would make sure they cut the fat before the lean? So far, I have not heard a convincing answer to the most common question people ask me about this plan: Won't it result in a lower standard of hospital care for the American people?

I hope our witnesses today will address themselves to these basic questions during the course of these hearings, and I look forward to them as an educational experience in the quickening debate on the very important issue of health care in America.

Thank you, Mr. Chairman.

Senator KENNEDY. Thank you very much.

Senator Hathaway?

Senator HATHAWAY. Mr. Chairman, thank you very much.

I am happy to be a cosponsor along with you of the bill that the administration introduced to put a curb or a ceiling on hospital costs. There is no question that the American public is in no bargaining

position, no control really over the cost of the hospitals and the other medical services imposed upon them. And it is necessary that the Government do something about it.

There is no question that fees for services can be limited, that reimbursement procedures could be looked into and thoroughly examined, and effect cost savings; that building costs can be curbed. There is no question there is duplicative equipment that could be cut out. There is no question that there are management economies that could be effected.

And I think that all of those would go a long way toward curbing costs.

But I hope, at the same time, that we do not impose the burden of the cost savings on the nurses, on the paramedicals, on other lower paid employees who are, in my opinion, already underpaid, and——

[Applause.]

Senator HATHAWAY. I brought my own audience. [Laughter.]

They should be allowed to get the amount of money that they so richly deserve.

Thank you. [Applause.]

Senator KENNEDY. That is the first applause he has heard in a long time. [Laughter.]

He does not get it up in Maine.

Senator Chafee, we would welcome any comments that you would like to make.

Senator CHAFEE. Thank you very much, Mr. Chairman.

Mr. Secretary, delighted to see you.

I think I will listen to the testimony and we might as well get on with it; the meat and potatoes of the program.

Thank you.

Senator KENNEDY. Fine.

We look forward to your testimony, Secretary Califano.

I think Senator Schweiker, in his comments, raised some of the real issues that we hope to be able to examine in terms of administration, in terms of quality, in terms of equity; some of these issues I know you have been asked about before. We look forward to your testimony.

STATEMENT OF HON. JOSEPH A. CALIFANO, JR., SECRETARY OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY KAREN DAVIS, DEPUTY ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, HEALTH

Secretary CALIFANO. Mr. Chairman and members of the subcommittee, I would like to submit my entire statement for the record. I will just read some excerpts from it, and ad lib a little bit.

I would also like to join the subcommittee in thanking Georgetown University. It is a hospital that has also been very good in terms of treating myself and my own family. I recognize what a superb hospital it is.

In that connection, I also would like to join with the chairman of the subcommittee in commending the medical school and the university for the steps reported in the Washington Post this morning. As we have said repeatedly, we do not need to increase the number of doctors in this country, we need to increase their focus on primary

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care and family care. And what Georgetown University Hospital and Medical School is doing is excellent in this area.

Mr. Chairman, you individually and as chairman of the subcommittee, and this subcommittee are among the most sophisticated and thoughtful students of health care and health care costs in this country, and we deeply appreciate the opportunity to present our case for this legislation.

One of the most pressing problems vexing our country today is the rocketing increase in health care expenditures, especially hospital costs.

They are now reflected in a merciless rate of inflation; a rate 2½ times the national rate, a rate that has been at this level for the last few years.

In a remarkable outflow of editorial comment and letters that we are receiving, it is clear to us that our citizens have come to realize that hospital inflation and inflation in the health care industry seriously jeopardizes some of the other programs, some of the benefits that workers ordinarily would receive, or would hope to receive in take-home pay.

If we do nothing about the present situation, total health expenditures will double in this country between now and 1982; hospital costs paid by medicare and medicaid will double even sooner; private insurance premiums for hospital care will more than double during that 5-year period; and hospital spending, if unchecked, will reach $220 billion by 1986. It was about $55 billion in 1976.

We recognize fully that Government and the private sector have helped create this problem of rapidly escalating hospital costs by giving too little attention to the relationship between the methods of paying for hospital care and the inflation in hospital costs.

We have created, if you will, financing and reimbursement methods that shield consumers from the actual costs of the care they receive.

I might note that the hospital industry is peculiarly outside the rest of our entire free enterprise system. Ninety percent of the costs are not paid by the individual who is buying the service, if you will, but paid by third-party carriers.

Second, the individual is not choosing that service, a doctor is telling him what he needs or what his children need or what his parents need.

Third, he is not picking the place where he goes to get that service, he is being told where to go to get that service.

These are typical indicia, in traditional economic terms, of giving the person who is setting the service no incentive to hold the price, and total power over the price.

And let me just quote the words of a hospital comptroller in Massachusetts:

> I am a fiscal person, not a moral person. If insurance is going to pay my costs, what do I care how much they are going to run up? Or if you look at it in another way, what is in it for me to keep my expenses down? Nothing.

I close the quote, not to judge that individual, but it is his own recognition of the fact that there are no incentives built into this system to hold their costs down.

Mr. Chairman, we believe we must start now and boldly to reshape the health care system. The Hospital Cost Containment Act that the President proposes is the first step in that direction.

We do not believe that we can tolerate a rate of inflation over another 2, 3, or 4 years that will add almost another dollar to hospital costs for every dollar we now spend. It would, in my judgment, be irresponsible to continue to waste the taxpayers' money while we develop longer-run, more permanent solutions and a national health insurance system.

The proposed legislation is designed to stem the rate of hospital cost increase on a transitional basis for the next several years.

It contains the following basic provisions:

One, increases in total hospital revenues would be limited to an annual rate of about 9 percent, beginning in October 1977.

I would like to note in that connection that last year in Canada, in Quebec, under a similar plan, they limited the hospital revenue rate of increase to 3 percent, and this year the revenue rate increase is being limited to 0.7 percent. So we have left plenty of room, at least compared to our closest neighbor.

The President's program would cover the inpatient revenues of about 6,000 acute-care and specialty hospitals. It would exclude long-term and chronic care and new hospitals, those less than 2 years old as well as those obtaining at least 75 percent of their revenues from federally defined health maintenance organizations.

Federal hospitals would not be covered directly in the legislation, but the President has pledged to apply rigorous cost containment to Federal hospitals as part of his budgetary review; and, indeed, the VA hospital system will only go up about 7 percent this year over last year.

Senator KENNEDY. Are you planning to close any Public Health Service hospitals?

Secretary CALIFANO. No; we are not planning to close any Public Health Service hospitals now, but the administration is, in a variety of connections, looking at our Federal hospital system. I mentioned the VA hospital system. And in the building and reconstruction that is going on there, we are actually reducing the number of VA hospitals built, in the projection for the fiscal 1978 budget.

For example, we are replacing two hospitals in Vancouver, Wash. and Portland, Oreg., with another hospital reducing the beds from, 903 to 770. We are looking at the Federal health care hospital system carefully.

The basic limit under S. 1391 is set by a formula reflecting general price trends in the economy, with an increment for increases in services. The system would include adjustments for major changes in the patient load, with exceptions for unusual changes in service or facilities.

And, I might add, with an exception explicitly permitting a pass-through of increases in wages for nonsupervisory personnel, Senator Hathaway; we are sensitive to the fact that nonsupervisory hospital workers average 15 percent below the hourly wage rate of the average nonagricultural worker in this country. We believe they should have an opportunity to catch up, and we have a passthrough for them in this legislation.

Senator KENNEDY. The fact of the matter is that they have been below even the inflationary rate in recent years, and over the period of the last 30 years, of course, notably below it.

Secretary CALIFANO. That is correct, Mr. Chairman. Over the last 6 years, the nonsupervisory personnel in hospitals have, on the average, had their hourly wages increased by only 7.2 percent annually.

Senator KENNEDY. I have heard that mentioned many times as being the significant or principal factor in terms of the inflationary push, but I think the record is very clear on that, that that has not been the case.

Secretary CALIFANO. That is correct, Mr. Chairman.

Each cost-based third-party payer would apply the limits, our 9-percent limit, to his payments and would monitor the hospitals for compliance with respect to their own subscribers. The medicare intermediaries would monitor total charges. Thus, medicare, medicaid and Blue Cross would be working with the hospitals throughout the year to minimize the need to recover overpayments after the year's end.

We would also put a national limit on new capital expenditures by acute-care hospitals. We set it at $2.5 billion. I would note in that connection that in Canada, in Quebec again, they had a moratorium on all hospital construction for the last 5 years. They just lifted it this spring. And we propose the $2.5 billion limit. These limits would initially be allocated to the States on a population basis; after 18 months of experience we might allocate them in another way.

Senator KENNEDY. That saves you about a billion dollars, is that correct?

Secretary CALIFANO. Yes; it does.

Senator KENNEDY. Yes. OK.

Secretary CALIFANO. No; it saves—it is—I am sorry.

Senator KENNEDY. The first year.

Secretary CALIFANO. Yes. But it is about half of what we would project would otherwise occur about 18 months out, if you will. We think we would be saving about $2.5 billion by the second year with that limit.

Senator KENNEDY. Just on the construction?

Secretary CALIFANO. Just on the construction.

Senator KENNEDY. OK.

Senator HATHAWAY. Mr. Secretary, let me interrupt a minute. You have already passed the point about the nonsupervisory personnel but who are considered nonsupervisory? Does that include nurses?

Secretary CALIFANO. That does include most hospital workers. It does include the nurses, Senator; yes.

Senator HATHAWAY. But a supervisory nurse would not be included, is that what you are saying?

Secretary CALIFANO. That's right.

Senator HATHAWAY. I had trouble in the beginning, when I was asked to cosponsor the bill, getting a clear answer as to who was included; and I understood that nurses were not included. And that is one of the reasons I made the statement at the outset of these hearings. That it just included cafeteria employees and so forth.

Secretary CALIFANO. Well, cafeteria employees, all the employees that work in the hospital in a nonsupervisory capacity, all nurses except the head nurse in the hospital would be included.

Senator HATHAWAY. Why should she not be included?

Secretary CALIFANO. We moved her into the supervisory category, if you will.

Senator HATHAWAY. It is just that it does not necessarily mean that she is getting enough money.

[Laughter.]

Senator HATHAWAY. Why would you not just include all personnel?

Secretary CALIFANO. Because——

Senator HATHAWAY. If they are all underpaid, then why would they all not be included?

Secretary CALIFANO. Well, because we think that the doctors, administrators, and others are not underpaid people.

Senator HATHAWAY. Well, all but doctors; I will go with that.

[Laughter.]

Secretary CALIFANO. We estimate that the number—I mean, we are covering about 86 percent of the work force in the hospital. I think the people that are not covered are essentially doctors, residents, engineers, the top nurse in the hospital, and the top administrators in the hospital.

Senator HATHAWAY. All right. I think we probably should specify a little bit more before we finally report a bill out, that is all.

And I would appreciate it if you, Mr. Secretary, or somebody in your office could supply us with just who is covered and who is not.

Secretary CALIFANO. We will, Senator.

Senator HATHAWAY. Thank you.

[The information referred to follows:]

(1)

Exemptions of Nonsupervisory Personnel Wage Increases from Revenue Limit, Hospital Cost Containment Act of 1977

Section 124(a) of the Hospital Cost Containment Act of 1977 modifies the inpatient hospital revenue increase limit to enable acute and community hospitals to pass through "the average amount of any increases in regular wages granted to employees who do not meet the definition of 'supervisor' as that term is used for purposes of the National Labor Relations Act." The modified limits are derived by combining the average percentage increase in regular wages granted to non-supervisors multiplied by the percentage of the total inpatient cost attributed to them plus the adjusted inpatient hospital revenue increase limit attributable to all other expenses. The question posed for analysis within a hospital is, who is supervisory and who is not?

The definition of a supervisor under the Labor Management Relations Act as amended, Title 1, Section 2, Part II, defines the term supervisor:

> "Any individual having authority in the interest of the employer, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or responsibility to direct them, or to adjust their grievances, or effectively to recommend such action, if in connection with the foregoing the exercise of such authority is not of a merely routine or clerical nature, but requires the use of independent judgment."

The National Labor Relations Board has begun recently to further develop on a case by case basis the dimensions of the supervisor definition. Considerable controversy surrounds the supervisory issue with the amount of employee discretion in hiring and firing very important. Obvious inclusions are:

1. All directors of professional care divisions and lower level supervisors, including staff physicians, dentists, pharmacists, residents and interns.

2. Director and Assistant Director of Nursing Services, Supervisor of Nursing Services, Head Nurses, and Ward Service Managers.

3. All directors of administrative and management departments including employment managers, purchasing agents, stock supervisors, and financial managers.

4. All directors and foremen and managers of plant operations and maintenance divisions including engineering, housekeeping, and laundry.

5. Instructors when engaged in training duties.

A more precise specification of supervisory positions could be found in job descriptions in Job Descriptions and Organizational Analyses For Hospitals and Related Health facilities, 1970. By using the job title and skill clusters one could get some more exact idea of the proportion of supervisors although available estimates for supervisors in the hospital labor force range from 10 to 20 percent and up to 25 percent of labor costs. A list identify supervisory positions is attached. All other positions would be exempted by this provision.

Secretary CALIFANO. As I indicated, this bill includes provisions to assure that hospitals continue to carry their charity patient load, and it does provide for the disclosure of information necessary to allow for informed choices by consumers and other interested parties.

We also recognize in the legislation the importance of efforts in certain States that have undertaken cost containment initiatives.

Senator KENNEDY. Before we leave this issue, how are you going to insure that the hospitals are going to carry their charity loads and not dump the patients in order to cut back on the services?

Secretary CALIFANO. We have a provision for using the health systems agencies, the local health systems agencies to permit to any hospital in a community that feels its fellow hospitals are not carrying their load, to go to the health systems agency; if the health systems agency determines that that is so, we would ask them to either pick up their charity load, or else we would start not meeting their medicare and medicaid payments.

Senator KENNEDY. Part of the problem with that Mr. Secretary, is that there is a general feeling that those agencies are underfunded, and that they have neither the resources, nor the personnel, to really do that kind of job. And that is tied into another question in terms of budgetary allocation. I do not know whether that is your information, but we have received a good deal of information that they are underfunded at the present time.

Well, will you work with us on it to insure that there is going to be adequate funding if we give them additional jobs?

Secretary CALIFANO. I think it is imperative to make sure that they have adequate funding and adequate resources, because it will be the local health systems agencies that will be the critical factor in the purchase of new equipment or the capitalization limitation of $2.5 billion.

Senator SCHWEIKER. One other point on this subject, Mr. Secretary. Why do we exempt Federal hospitals?

Secretary CALIFANO. Because we can control them ourselves, that is why we exempt them. And because as far as the VA hospitals are presently operating at a 7-percent increase per year, from 1977 to 1978, it will be about a 7-percent increase. And we can control the Public Health Service hospitals. That is why we exempt them.

Senator SCHWEIKER. One of the problems I see with this provision is that every time we pass a law we manage to exempt the Federal establishment, setting up a double standard; and I think the people back home resent the fact that we apply tougher standards to the private sector than to ourselves.

It seems we are building up that grist, that we have a double standard. If the bill is good enough for the people back home, why is it not good enough for the Feds?

Secretary CALIFANO. There is no problem in putting the 9-percent limit in the statute for Federal hospitals. We just thought it was completely unnecessary. But we have no problem if you want to put it in.

Senator SCHWEIKER. One gripe we'll get right away is that the private hospitals will not be able to obtain the latest technology and equipment. They will say, "If we were a Federal hospital we would be allowed to have it."

Secretary CALIFANO. Well, that will not happen.

But, I mean, if you want to put it in, we would be delighted to have them covered in the legislation.

Senator CHAFEE. Mr. Secretary, I want to ask a question on another subject, but when you are talking about VA hospitals, of course you are talking about an entirely different type of patient load, so I do not think that when the Federal Government says there is only a 7-percent increase in the VA hospital, it should be a cause for celebration and "are we not doing great?" attitude. I think their situation, as I think you will agree, is entirely different than a private hospital, in that they are dealing with long-term patients and do not have the turnover or the type of patient that an acute-care private hospital has.

But, in connection with capital expenditures, the $2.5 billion that you are going to allocate by population, it seems to me that that is a strange way of doing it because some States have sort of a zero population growth, and that getting the per capita would be very good for them because they have plenty of beds and maybe even a declining hospital population, as compared to some of the Western States that are growing rapidly.

How are you going to take care of them?

Secretary CALIFANO. We have a provision that would, in addition to that limit, limit increases in hospital beds in areas already well in excess of bed needs. Any area which had more than 4 beds per 1,000 of population, or less than 80 percent occupancy, would not be able to increase the number of beds.

The reason we distributed this on the basis of population nationally was because it is a temporary allocation method for the first 18 months. Once we had more experience, we would consider other factors.

I recognize the kind of question you raise, I also recognize the kind of question that can be raised in the situation where you have a national hospital, if you will.

Senator KENNEDY. If the secretary would yield—why four beds? Why not three? That is what the HMO's use now. Why not use 3 beds per 1,000?

Secretary CALIFANO. We wanted to bend over backwards, as I think the 9-percent lid indicates, in giving hospitals as much flexibility as possible. We think this is a generous bill to the hospital industry.

Senator KENNEDY. Well, I think, as I understand it, the HMO's use the 3 beds per 1,000.

And of course, then, you have the 80 percent of occupancy rather than the 85. Those are significant factors in terms of that rate. I would think that you would have drawn the conclusion that if you do 3 beds per 1,000 and do the 85 percent, you would have an even more dramatic impact. That is why I raise that question.

But perhaps you can give us some idea of how you reached those figures? Could you, at a later time?

Secretary CALIFANO. Yes, I can, Senator.

Senator KENNEDY. Thank you.

[The following information was subsequently supplied for the record:]

Ratio of Hospital Beds Availability Per Thousand Population

The joint standards of 4.0 beds per thousand population and 80% average occupancy rate are proposed by the Department because they represent an important yet realistic improvement in the efficiency of the nation's hospital system.

In 1975 the nation had more than 4.5 beds per thousand and an average occupancy rate of 75%. As the attached tables indicate, the hospital systems in only 10 of 205 health systems areas met both standards in that year. Over 100,000 beds would have to be closed for all areas to meet these standards. Attainment in the near future of the 4.0 and 80% standards would thus represent a significant achievement for the nation's hospital system.

The more strigent standards of 3.0 beds per thousand and 85% average occupancy rate, while representing a more efficient system, would be more difficult to achieve. Only one health system area --Montgomery, County, Maryland with 2.2 beds and an 86% occupancy rate but adjacent to the District of Columbia with 6.9 beds and a 79% occupancy rate-- currently meets this standard. More than 300,000 beds would have to be closed to bring all areas in the nation to these standards.

It is important to note that the bed and occupancy standards are applied jointly under the Administration's proposal. Areas must meet both criteria to be permitted to build freely. Areas with fewer than 4.0 beds but with many empty beds may not build since additional admissions may be absorbed by existing capacity; areas with a high occupancy rate and many beds may not build since the resulting high utilization rate indicates that space for additional admissions may be made available by more rigorous utilization review. Applied jointly the 4.0 beds per thousand and the 80% average occupancy rate are a significant yet reasonable goal for hospitals systems to attain in the near future.

Table C. COMMUNITY HOSPITAL BEDS PER 1,000 POPULATION BY HEALTH SERVICE AREA, UNITED STATES, 1975

STATE	Health Service Area														
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Alabama	5.2	3.7	6.1	4.5	4.3	4.5	4.4								
Alaska	1.8														
Arizona	4.0	4.1	2.5		2.7										
Arkansas	5.4	3.6	5.7	4.2											
California	4.4	3.2	3.8	5.0	3.4	3.9	3.0	4.0	3.5	3.9	4.5	4.0	3.9	3.2	
Colorado	4.3	4.5	4.3												
Connecticut	3.5	3.9	2.7	3.6	2.9										
Delaware	3.5														
District of Columbia	6.9														
Florida	4.1	4.7	4.6	4.7	5.0	5.4	3.9	5.4	5.8						
Georgia	4.7	3.8	4.3	4.1	4.4	4.7	5.0								
Hawaii	3.1														
Idaho	3.9														
Illinois	3.9	5.6	6.0	4.8	3.5		3.0	4.2	3.4	5.1	5.6				
Indiana	4.1	4.6	4.6												
Iowa	6.1	7.1	5.1												
Kansas	7.9	4.4	6.4	5.1											
Kentucky	4.6	4.2	4.3												
Louisiana	4.6	4.3	5.0												
Maine	4.7														
Maryland	4.0	2.2	1.2	4.1	3.5										
Massachusetts	4.7	4.9	3.9	6.4	3.2										
Michigan	4.4	3.4	4.6	3.9	4.9	4.2	5.9	5.1							
Minnesota	6.7	7.8	5.5	4.8	5.5	5.7	7.7								
Mississippi	4.9														
Missouri	5.1	5.2	5.6	4.9	4.6										
Montana	5.3														
Nebraska	5.3	5.5	7.1	6.1											
Nevada	5.1	3.8													
New Hampshire	4.1														
New Jersey	3.9	5.0	4.1	3.4	3.6										
New Mexico	3.4														
New York	5.1	4.0	4.1	4.8	4.6	4.0	5.6	3.2							
North Carolina	4.3	3.9	4.2	4.9	3.7	3.3									
North Dakota	7.5	6.7	5.5												
Ohio	4.3	3.8	4.2	4.8	4.6	4.7	4.4	4.1	5.0	4.8					
Oklahoma	4.6														
Oregon	4.6	3.0	4.7												
Pennsylvania	4.7	4.0	4.8	4.0	4.9	5.0	5.5	4.8	5.6						
Rhode Island	3.7														
South Carolina	4.2	4.0	3.9	3.5	4.1										
South Dakota	5.5														
Tennessee	4.9	5.4	4.7	5.1	5.0	6.3									
Texas	5.5	5.6	4.5	5.6	4.5	3.8	5.0	3.8	4.0	4.9	5.5	4.5			
Utah	3.2														
Vermont	4.9														
Virginia	4.6	2.6	4.6	5.0	3.6	4.9									
Washington	3.2	2.9	3.7	4.6											
West Virginia	5.8														
Wisconsin	5.3	4.6	5.1	5.2	6.6	5.4	7.8								
Wyoming	4.7														

Note: Data base of Health Service Areas as used here differs somewhat from officially designated Areas due to data constraints. Community hospitals are defined as non-federal, short-term general and other special hospitals, excluding hospital units of institutions.

Source: Unpublished data from Area Resource File, Bureau of Health Manpower

Table I. COMMUNITY HOSPITAL OCCUPANCY RATES (%) BY HEALTH SERVICE AREAS, UNITED STATES, 1975

STATE	Health Service Areas														
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Alabama	66	81	76	71	69	76	67								
Alaska	64														
Arizona	74	75	59		70										
Arkansas	71	69	72	69											
California	60	68	65	70	69	66	69	67	64	61	66	66	60	67	
Colorado	69	71	65												
Connecticut	80	81	77	78	66										
Delaware	81														
District of Columbia	79														
Florida	68	62	70	73	68	70	72	67	74						
Georgia	72	67	68	73	67	63	73								
Hawaii	68														
Idaho	68														
Illinois	66	68	71	71	65		80	72	78	73	81				
Indiana	78	76	74												
Iowa	67	71	73												
Kansas	64	70	70	78											
Kentucky	79	73	85												
Louisiana	75	65	66												
Maine	71														
Maryland	76	86	72	80	80										
Massachusetts	75	75	80	82	79										
Michigan	82	69	77	75	80	77	76	70							
Minnesota	65	74	69	72	72	62	74								
Mississippi	71														
Missouri	78	69	81	73	73										
Montana	61														
Nebraska	60	65	71	67											
Nevada	65	70													
New Hampshire	71														
New Jersey	83	79	83	81	81										
New Mexico	65														
New York	84	84	82	81	84	81	85	86							
North Carolina	75	79	78	78	78	75									
North Dakota	69	65	69												
Ohio	85	84	75	78	80	76	76	84	81	79					
Oklahoma	69														
Oregon	69	68	59												
Pennsylvania	81	82	73	76	70	78	72	81	71						
Rhode Island	82														
South Carolina	77	73	72	74	73										
South Dakota	64														
Tennessee	75	74	72	76	64	78									
Texas	65	64	67	63	71	64	70	70	70	67	72	61			
Utah	74														
Vermont	71														
Virginia	75	75	79	78	78	75									
Washington	70	63	64	67											
West Virginia	75														
Wisconsin	70	74	71	69	68	72	74								
Wyoming	56														

Note: Data base of Health Service Areas as used here differs somewhat from officially designated Areas due to data constraints. Community hospitals are defined as non-federal, short-term general and other special hospitals, excluding hospital units of institutions.

Source: Unpublished data from Area Resource File, Bureau of Health Manpower

Secretary CALIFANO. Just on VA hospitals, Senator Chafee, I would like to note that they are bringing their hospital stays down on a consistent basis, and we are beginning to infuse better management into those hospitals.

In terms of the point that you raised, Senator Schweiker, the program will not require a single new reporting form, above those already coming in to third-party carriers and to medicare and medicaid. The only time you will need a new reporting form is if you apply for the exception. It was deliberately designed to have the third-party payor. So that we have tried to be attentive to the problem of additional paperwork.

Only if a hospital asks for a special exemption or exception would a new form or data be required.

Senator KENNEDY. I think this is a key point that would have been raised, and perhaps it is the time now to talk just about that administration and its simplicity. That is one of the points which the AHA was going to raise, in terms of how feasible it is to administer, what kind of new burden, what kind of new personnel, how many more Federal employees. What do you estimate will be needed in terms of additional employees in hospital administration? Could you briefly touch on that, because it is a significant factor in terms of the issue itself.

Secretary CALIFANO. Well, as I indicated, there will be no new forms that will have to be filed. Independent of this legislation and as part of combining medicare and medicaid in a single health care financing agency, we would also hope to come up with one form that will cover medicare and medicaid and work that through with the third-party payor, so we are down to one form for everybody.

It is the same kind of thing we are trying to do in the student area.

Unless they apply for an exception, this legislation requires no new paperwork by the hospitals.

Our best estimate in terms of people required to administer the program is about 50 to 70 people in the Health Care Financing Administration; we do not think we need more people. We spent a lot of time with the insurance industry, Mr. Chairman, not only with Blue Cross and Blue Shield, but with Health Insurance Association of America and many others, in trying to work out the simplest way to administer this program. And that is why we came up with so few people.

We also try and make as much of it as we can work automatically, and so that is our best estimate there.

We believe that this legislation will work, and in that connection I would like to note that, first of all, several States in this country, including your State of Massachusetts, have in effect rate commissions, or caps of one kind or another which are working. Maryland is one here close by; Massachusetts and Rhode Island and Connecticut are also putting in place caps like this.

Second, more than one-fifth of the hospitals in this country have operated at an increase of 9 percent or less according to the latest available data, and those hospitals were teaching hospitals, small hospitals, rural hospitals, urban hospitals, from all over this country.

So that we believe that that demonstrates that this can work.

Lastly in this connection, and going to, in part one of Senator Schweiker's points, we are leaving with the hospital administrator the

flexibility to determine where he makes the changes necessary to reach the 9 percent. We believe the calculations that he needs to make, to go from 1 year to the next, can be made in a matter of 10 or 15 minutes.

Senator KENNEDY. Now let me just give you a bit on the other side. If the States have various laws, I understand that unless they are stricter than your procedure, that they will not be recognized. You do not permit the passthrough for the labor increases among your States, as I understand it.

The question I want to raise is this: there are some who believe that your regulations might be an incentive for some States to even repeal some of their stronger laws and come back to the Federal one, and that is obviously not your intention.

Secretary CALIFANO. No, it is not our intention.

Senator KENNEDY. It should not be, and you will work with the committee in assuring that the States necessarily have stricter requirements than you have in your legislation?

Secretary CALIFANO. Absolutely, it is not.

Senator KENNEDY. So if that point is raised, then you will work with us in insuring that this will not occur.

Secretary CALIFANO. Yes, we will, Mr. Chairman. I note that this is an area in which we in Washington have learned from the States. The States, like Massachusetts and Maryland, are ahead of the Federal Government in this area, and a lot of what is in our legislation is modeled on or adapted from provisions that are in existing State laws.

Senator KENNEDY. Now, the other point. You talk about the 22 percent of hospitals that are below the 9 percent. How do you answer the question, that they are the ones that are trying to do a job, they are trying to be more efficient, and you are slapping a lid on them, while the others that have been abusive in terms of raising their rates have got a built-in floor, or at least a plateau to build more on. You are effectively rewarding those that have been inefficient and inefficiently administered over the period of recent years. At the same time the fellow who has really tightened down in terms of it, he is going to be limited to the 9 percent and have more restrictions on him. How do you respond to that?

Secretary CALIFANO. Mr. Chairman, in this legislation if the hospital is able to reduce its increase in revenues below 9 percent in any particular year, we let it carry that over for the next year, so that they will have that as an incentive to come in below the 9 percent for those hospitals that are in below 9.

If the admissions of the hospital are reduced down through 6 percent below the prior year, we still let them maintain, in effect, their 100-percent base plus the 9 percent, as an incentive for some of the fatter hospitals, if you will, to watch their weight.

So that we have that kind of incentive built in.

What this bill does not do, and what I think, what you are directing your comment at, is the hospital that is charging $400 a day for a private room that should really be charging about $250 a day for a private room; and the fact is that we do not have the kind of data necessary to compare one hospital with another in a fair way. We do not have a comparable wage data, we do not have enough detail on patient loads yet, in order to move on that hospital.

But even though that one hospital continues at its high state of obesity, we still will save $40 billion by the time we are 5 years out. And that is critical.

We save, just in the health insurance trust fund, over the next 5 years, we will reduce the payments out of that trust fund by $10 billion. Without this legislation, there will have to be additional taxes levied on the American taxpayers to pick up about $7 billion of that $10 billion over the next 5 years for the hospital insurance trust fund, in connection with our social security proposals.

So this reverberates, as you indicated in your opening statement, this reverberates throughout our society.

Senator KENNEDY. You are not saying that this is really the final answer; as I understand and as you made very clear, this is really a temporary measure that is designed to be a simple one, that is administratively simplified, but it is really basically a transitional process, until you come up with a comprehensive health insurance.

Secretary CALIFANO. That is correct, Mr. Chairman.

Senator KENNEDY. Do you want to tell us when that is going to be? [Laughter.]

Secretary CALIFANO. Well, as I read your speech at the UAW and President Carter's, I gather it will be early next year. [Laughter.]

Our national health insurance advisory committee had its first meetings this weekend, and we will be making proposals early next year. But, as we all know, that plan will not go into effect immediately.

What we are faced with now is 9 cents of every dollar the Federal Government spends goes to the hospital industry. If we do not do something about that, within 5 years Federal dollars that will go to the hospital industry will double.

Now, that is a staggering amount of money.

Senator KENNEDY. That is the total Federal dollar you are talking about?

Secretary CALIFANO. That is the Federal dollar that is spent, 9 cents of every Federal dollar spent goes to the hospital industry.

Senator KENNEDY. In national defense, we are not spending that amount in terms of the Federal dollar. We will be spending more just in terms of hospitals, then?

Secretary CALIFANO. If we do not have this legislation, within 5 years we will be spending far more to the hospital——

Senator KENNEDY. Just to the hospitals?

Secretary CALIFANO [continuing]. Just to the hospital industry than we are for the defense of the country. That is correct, Mr. Chairman.

Senator CHAFEE. Mr. Chairman, could I ask just one question?

Getting back to the question Senator Kennedy asked about the hospital that has done a good job and you said that they will be able to carry forward whatever they have done better than 9 percent.

Secretary CALIFANO. That is correct.

Senator CHAFEE. But I take it this is not retroactive, that you are starting as of now to compute what they do in the future. In other words, if they do better—if they do 8 percent in 12 months, in the 12 months starting from the passage of the act, then they can carry that 1 percent forward.

But what about the hospital that, say, in 1975, really started strapping down? Is the base going to be figured as of what year?

Secretary CALIFANO. The base will be figured, assuming this legislation passed in 1977, on the fiscal year ending in 1976.

Senator CHAFEE. So that if they did something dramatic in cutting back in 1974, they would not get any credit for that?

Secretary CALIFANO. A hospital is entitled to claim a minimum average adjustment of 6 percent for those 2 years, even if it held its cost increases lower.

Senator CHAFEE. Yes.

Senator KENNEDY. Before leaving the percent of the Federal dollar that is in hospitals, what percent of the Federal dollar is in the preventive health care area?

Secretary CALIFANO. I cannot answer that, Mr. Chairman.

Senator KENNEDY. But I mean just in general.

Secretary CALIFANO. Twelve cents of every Federal dollar is in health care. And 9 cents goes to the hospital industry.

Senator KENNEDY. But would it not be safe to say it is certainly less than 1 percent? I would think that you are much closer to even less than one-half of 1.

Secretary CALIFANO. Probably.

Senator KENNEDY. With all the implications that that has in terms of improving the health of the American people I am sure this is something that both you and the President are concerned about.

Secretary CALIFANO. Absolutely.

Senator KENNEDY. OK.

Senator HATHAWAY. Mr. Secretary, let me ask you a question. Do you think that the PSRO's are going to effect the mechanism to control the hospital stays? When lots of times they are occasioned by the physicians themselves.

Secretary CALIFANO. They are getting more effective. I met with them last week, with the national council, and we are looking at them now to make them even more effective.

We believe in those organizations. We think that kind of review is important, but we think we have got to strengthen them. It varies widely from community to community.

Senator HATHAWAY. Yes. Is the mechanism effective, or do you think that depends on the personnel, or some other factor?

Secretary CALIFANO. We think the basic mechanism is effective. We think there may be some things we want to do to give them a little more teeth, and we are looking at it now.

Senator HATHAWAY. Should we provide for some consulting services in the bill? For hospitals that need to have data and information as to how they could be more cost effective. I mean, there are many in rural areas, in particular, which are not that cost conscious and many times do not operate with the efficiency of larger hospitals. They could use some consulting services if they could be provided by HEW.

Secretary CALIFANO. Yes. We would be happy to provide those, Senator.

I would note that when I mentioned that 22.2 percent of the hospitals are at 9 percent or less, that 28.3 percent of the hospitals with fewer than 4,000 admissions—and most of those would be rural hospitals——

Senator HATHAWAY. Right.

Secretary CALIFANO [ccntinuing]. Are at 9 percent or less.

Senator HATHAWAY. Or less, yes.

Senator KENNEDY. Did you finish?

Senator HATHAWAY. Yes.

Senator KENNEDY. You mentioned that the PSRO's are beginning to work more efficiently, how about extending them beyond the medicare, medicaid?

Secretary CALIFANO. We are looking at that, Mr. Chairman. We have faith in that, in the PSRO's, and, as I said, I met with them personally—with the council personally last week, and we are looking at whether they should be extended, whether they should be given more teeth, and how we can make it more effective.

Senator KENNEDY. Will you let us know what your conclusions are?

Secretary CALIFANO. Yes, sir.

[Laughter.]

Secretary CALIFANO. There is not much we can do about it without consulting you.

[Laughter.]

Secretary CALIFANO. Action now on hospital cost containment is essential. We estimate that our plan will reduce hospital costs from an annual 15-percent increase to a 9-percent increase. Thus saving $1.9 billion in the first year. We have identified a fat list of those items that can be cut by hospitals which will have no effect on health care quality.

First on our fat list, according to the American Hospital Association's own data, community hospitals accumulated $1 billion in profits that were put into hospital reserves in 1976. That is up from $500 million in 1971. So the profits of community hospitals have doubled in this nonprofit industry over the last 5 years.

Second, there are today about 240,000 empty beds in community hospitals; 100,000 of those beds have been determined to be excess by local health systems agencies. It costs between $10,000 and $20,000 per year per bed, which means that we are paying $1 to $2 billion.

Yet in 1976, the hospital industry built 27,000 additional beds at a construction cost of $2 billion.

Our proposal would prohibit additional hospital beds, as I indicated, in areas that have more than 4 beds per 1,000 population.

Third, there are now 700,000 people in the Nation's acute-care hospitals. As many as 100,000 of them, almost 15 percent, do not need to be hospitalized and would be better cared for at home, in skilled nursing facilities, or on an outpatient basis. These patients generate excess charges of $7 million per day or $2.6 billion per year.

Fourth, the Institute of Medicine released a study 3 weeks ago that strongly urged careful controls on the purchase and use of "CAT" scanners, a sophisticated X-ray and computer diagnostic tool, costing at least $500,000 or more.

Currently, there are about 500 CAT scanners in the United States, with a total operating cost of $150 million to $250 million annually.

At the rate that scanners are being adopted and purchased, the bill for scanning will quadruple in just the next 3 years, with little noticeable change in the care for the average American citizen.

Fifth, hospitals have not carefully examined their use of energy. A recent HEW study found that hospitals could save $332 million this year by simple energy conservation proposals, simple insulation,

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being careful about turning off lights the way people are in their homes, and the like, and save a $500 million per year by 1980.

Sixth, the use of expensive and often unnecessary therapies has increased rapidly in recent years.

I noticed in the paper last week that in this area, the Blue Cross-Blue Shield people are not going to pay for about 20 or 30 tests that are routinely given in hospitals, unless the doctors can prove that those tests are absolutely necessary.

We note that individual hospitals report that as many as 25 to 35 percent of their patients receive inhalation therapy services. Estimated costs are $500 million annually. Yet there is limited and divided professional evidence to support the widespread use of that therapy.

Finally, hospital costs could be cut substantially by not admitting patients several days before treatment, as is often done now. Either the diagnostic tests should be done on Saturdays and Sundays, or hospital patients should not be put in the hospital on Friday, to sit over the weekend.

As we cited in our testimony before the House, there is a hospital in Las Vegas, Nev., that offers a chance on a Mediterranean cruise for those patients who are admitted in the hospital on Friday or Saturday, and if that patient does not fare well in the hospital, the chance passes on to his estate.

[Laughter.]

Secretary CALIFANO. I have indicated, Mr. Chairman, that this is a transitional measure; it deals with a problem of desperate inflation, and I would like to underscore the fact that we believe that we are dealing with fat. We believe that we are dealing with the obese part of the hospital industry. We believe that we are simply saying, instead of having five pieces of chocolate cream pie for dessert, try and hold it to one—and even two in some areas.

We have left flexibility for the administrator to bring it within the 9-percent cap, and we think we have made it as administratively simple as possible.

We have learned a lot from what States have done in this area. We went through 12 weeks of consultation with your staff, with the staffs in the House, with the hospital industry, with the insurance industry; and we believe that this plan will work, and will save the American taxpayers a tremendous amount of money over the next 5 years.

Thank you, Mr. Chairman.

Senator KENNEDY. Thank you, Mr. Secretary.

What do you intend to do with the savings? Are you going to reallocate it to other areas of social purpose, or are we going to continue to focus the resources in needed areas of health policy; in preventive health, in primary care, and the health delivery system, and getting good quality health out to the American people, meeting the inequities which exist in our current system?

Secretary CALIFANO. I indicated in my statement that the large part of these savings should go to other parts of the health care system, and that there are lots of parts of it in need—a large part of these savings will help to ease the way for national health insurance. A large part of these savings can go to the preventive area, in which the payoff is enormous; not just with children but in providing much better health education for all American citizens—much better education about the fact that cigarette smoking kills people, much

education about the dangers of obesity. There are a whole host of areas in which this can be used.

Also, much better health care in rural areas, better incentives, if we can discover them, to attract doctors to those areas, like your National Health Service Corps legislation.

These are the kinds of things, these areas where hospital cost savings can be used.

Senator KENNEDY. One of the matters which is raised by the Hospital Association is the charge that implementation of the administration's program is going to have a deleterious impact on the quality of health care that is going to be practiced in the hospitals of this country. This is a serious charge that has to be a matter of concern to American people. How do you react to that?

Secretary CALIFANO. Mr. Chairman, my response is in that fat list I went through. I listed about $5 or $6 billion that are available for savings. That is three times the $1.9 billion we save in the first year.

And not one of those items I listed has anything to do with the quality of health care. Take the excess beds. If you go to Houston, Tex., where the hospital system has been planned carefully for years—some of the most modern hospitals in the world—it is $85 per day for a private room.

If you go to Miami, Fla., where we are terrifically overbedded, it is more than twice that. It is up around $190 per day per room.

And the reason there, the largest single reason for that, is excess beds. And it does not have anything to do with the quality of health care in Miami as distinguished from Houston.

And there are a host of other examples, which I gave in my testimony.

I think there is plenty of fat. I think the quality of health care will be better if we reduce this excess capacity. Long ago we should have started watching the way that the hospital industry in this country was going.

Senator KENNEDY. How does your program really deal with getting doctors to cut back on the unnecessary services, the tests, the procedures, all of the other range of activities which are enormously costly?

Secretary CALIFANO. We tried to build up the hospital administrator, in some areas, as a negotiator. There are many hospitals in this country today where the radiologists, the pathologists, and the anesthesiologists get a percentage of the gross. And that is like Robert Redford in a movie. That is not like doctors in a health care system.

And we think that the hospital administrators, faced with a 9-percent cap, will start negotiating with the big stars of the hospital business in a much better way than they have in the past.

Second, we think that by having the local health service agencies be involved in the decisions about capitalization, with the hospital administrator, doctors will be more inclined to look on the efficiency of equipment. A television show indicated the other night that two hospitals in Chicago, one literally across the street from the other are both acquiring CT scanners.

Under our plan we think they will be more careful about ordering that kind of equipment. We do not touch the doctors' pay or the doctors' bills, if you will, except for those that are under contract with the hospital, in this legislation.

Senator SCHWEIKER. Mr. Secretary, on that same point, you said earlier that you wanted to reduce the expense of unnecessary services that a hospital provides. But is it not a fact of life that it is the doctor who orders those services? He orders the X-ray, he orders the data. And yet you say we are not going to place any limitations on the doctors.

So I am confused as to how we are going to cut down expenses if we do not in some way limit the doctor's ability to order that service.

Secretary CALIFANO. Senator, the big ticket items that I mention here, the big ticket items do not involve the doctor ordering an individual test. We encourage and are delighted by Blue Cross and Blue Shield coming in and saying, here in this area for example, that in the future we will not have an automatic set of 40 or 50 tests. There are 21 or 22 of those tests that we want doctors to prove are necessary before we will reimburse for them.

Senator SCHWEIKER. By the big ticket item, you mean the CT scanner?

Secretary CALIFANO. Well, the CT scanner is one, ——

Senator SCHWEIKER. Yes, well, the doctor says, "I need my patient scanned," "and if your hospital does not have a scanner I will send him to one that does." How can the bill control that? So if one hospital has it and the other does not, and the doctor orders it, where are we?

Secretary CALIFANO. There are hospitals in more and more parts of this country that are combining their resources. I think the appetite of doctors for every piece of sophisticated equipment in every single hospital they go to has got to be curbed, just like the appetite of the hospital has got to be curbed. And by having the administrator sit there and say: We have to pick and choose. We have to make some decisions here that will not affect the quality of health care for any individual patient.

We can have an impact. We do not need a CT scanner in every hospital in this country. And I hope that this legislation will bring that into some sense of balance.

Every child does not need a Rolls Royce; every teenager does not need a Cadillac; every hospital does not need a CT scanner.

Senator SCHWEIKER. But will not the hospitals privileged to have that kind of equipment be the ones that live, and won't the others die? A doctor is going to say: "My patient needs that CT scanner." And he will send him to the hospital that has it.

Secretary CALIFANO. No; I do not think so, Senator. I think——

Senator SCHWEIKER. You put a cap on their livelihood and on their future.

Secretary CALIFANO. We are not saying that. That is the judgment that has to be made by the hospital administrator. I think what you are suggesting is that every hospital in the country have every expensive gadget—I do not think the American taxpayer can afford that any longer. I think if you suggest that, those hospitals—those who suggest that have got to come in to the Congress and to the American people and say: These are the taxes I will add to your burden, Mr. Worker: Instead of working 2 weeks a year to pay your hospital bills—which is what the average worker now does—I want you to work 3 weeks a year.

We have reached a point in this country where we have to say: Enough.

Now, I think our legislation gives plenty of flexibility to hospital administrators, with a 9-percent increase—lower, as I indicated, in Canada—with the 80-percent bed load, which could be 85 percent occupancy, as Senator Kennedy indicated, with the four beds per thousand, which could be three beds per thousand as the HMO's have them. We are beginning to learn that we can do this.

And 22 percent of the hospitals in this country do not have a problem staying under 9 percent, and they are all over this country, and they are the most sophisticated in the world.

Johns Hopkins Hospital in Baltimore has all the sophisticated equipment of any hospital in this country. It has driven its rate of increase down to 9 percent.

Senator SCHWEIKER. But we are confusing two different things. I agree with you that we should have some constraints, and some limits. That is why we passed the Planning Act, so that the regional groups would make those decisions. Supposedly, if we give them the chance, they may well do so.

You are saying, in addition to regional agencies making the decision, that we must have an absolute cap and that whether you need it or not, if your arithmetic does not come out right. You cannot get it.

And as far as us having the most modern equipment, countries from all over the world fly patients here because we do have that kind of technology. It raises the cost on the one hand, but we also have to recognize that patients are flown here because we have the latest equipment and the latest technology available.

Now, is that not a plus we have to weigh in the health planning process?

Secretary CALIFANO. With all due respect, Senator, it seems to me that patients do come in from all over the world to this country for medical treatment, and we should be very proud of that. But they do not come to every hospital in this country for medical treatment.

Senator SCHWEIKER. But it is because of our technology as a nation—the very thing we must not stifle—that is the reason they are coming here. That is why people finance trips from India through service clubs—to get some poor boy for special surgery, because we have the medical capability to do it. We must be sure the bill does not endanger that national resource.

Secretary CALIFANO. Senator, I think a little sharing by hospitals of some of this very expensive equipment will go a long way, and that sharing is going on in 20 to 25 percent of the hospitals in this country, and they include superb hospitals.

We obviously do not want to stifle technological advancement, but we do not want expensive equipment to run riot when it does not involve any significant improvement in the health care of the American citizens. And that is what is happening in this country.

The report of the Institute of Medicine on the CT scanner, which I would like to submit as part of the record of these proceedings, and commend to you, will indicate how we have moved in this area of technology.

[The material referred to follows:]

INSTITUTE OF MEDICINE

A POLICY STATEMENT

Computed Tomographic Scanning

APRIL 1977

NATIONAL ACADEMY OF SCIENCES WASHINGTON, D.C.

NATIONAL ACADEMY OF SCIENCES
2101 CONSTITUTION AVENUE
WASHINGTON, D. C. 20418

INSTITUTE OF MEDICINE
OFFICE OF THE PRESIDENT

April 29, 1977

Mr. Walter J. McNerney
President
Blue Cross Association
840 North Lake Shore Drive
Chicago, Illinois 60611

Dear Mr. McNerney:

It is my pleasure to transmit to you the report on computed tomographic scanning, undertaken by the Institute of Medicine at the request of the Blue Cross Association.

In responding to your request for a rapid report on this important and complex subject, the Institute committee, chaired by Dr. Charles Sanders of the Massachusetts General Hospital, addressed the issues of efficacy, planning policy, utilization, costs and charges, and information and evaluation needs. As you requested, the report provides specific recommendations for action as well as a review of the current status of this significant new technology.

The swift spread of CT scanning as a diagnostic technique may well make it a watershed for policy decisions about appropriate distribution and use of costly medical technologies. We are pleased that your request afforded us the opportunity to address this important issue, and we trust that the Institute's report will

help your association and its member plans develop reimbursement policies. We hope the report will also provide guidance for other agencies and institutions, public and private, which are attempting to develop plans for the effective and efficient use of CT scanning.

Sincerely,

David Hamburg

David A. Hamburg, M.D.
President

INSTITUTE OF MEDICINE

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INTRODUCTION

Computed tomographic (CT) scanning is a recently developed technique which combines radiographic and computer techniques to produce cross-sectional images of the head and body.[1] Whereas conventional x-ray films show internal structures superimposed upon each other and, therefore, are best suited to high contrast structures such as bone, the CT scanner can produce high quality images of soft tissue structures.

The technology of CT scanning was developed for clinical use in England in the early 1970s; the first units provided images only of the head. By 1974 scanners were available for producing transverse section images anywhere in the body.

The first two CT scanning units in the United States were installed in mid-1973. Slightly less than four years after that introduction, it was estimated that at least 760 CT scanners were in operation or had been ordered by American hospitals, clinics, and physicians, [2] posing a ratio of one machine for every 281,000 people in the nation.[3]

Such swift and widespread adoption of this new medical technology has attracted the attention of planners, insurers, and investigators of health services.[4] Their questions concern efficacy and expense. The long-term effects of CT scanning on medical care and its costs are not yet discernible, although there is little doubt that the technique represents a major improvement in diagnostic imaging. Head scanning became an accepted diagnostic tool before coordinated studies of its impact on diagnosis could be completed,[5] and there are as yet few reports to indicate what the information from CT scanning of the head has meant for patient treatment methods or outcomes.[6]

Now, as CT is extended to other areas of the body, the same concerns apply.

As for medical care expenditures, scanners range in price from $300,000 to $700,000 each, the newer systems being the more expensive.[7] Operating costs for a unit are estimated to range from $259,000[8] to $371,000[9] per year. The real costs of CT scanning will depend not only on the number of units purchased and the number of scans performed, but also on the extent to which CT scanning replaces other diagnostic procedures and reduces hospitalization. There is not enough evidence now to enable measurement of these effects.[10]

The rapid acceptance of CT scanning has also heightened concerns about other diagnostic technologies and even medical technology in general. Evidence is accumulating that the present organization of medical care and methods of financing and regulating that care in the United States have encouraged investment in beds and equipment beyond a socially efficient level.[11] Competition among hospitals for medical staff, prestige, or revenues is often cited as a reason for overinvestment in capital equipment.[12] The risk of losses from overinvestment has been reduced or eliminated by the retrospective, cost-based reimbursement systems that predominate today.[13] Regulation designed to control large capital expenditures may have had a perverse effect itself; state certificate of need (CON) laws requiring institutions to obtain approval for purchasing expensive equipment like the CT scanner may have stimulated hospitals to adopt new technologies quickly--before the planning agency has sufficient facts to approve or deny the purchase.[14] The fact that most CON laws do not cover capital expenditures in freestanding ambulatory care settings, combined with the high fees currently charged for CT scans, has further encouraged the purchase of CT equipment by private physicians.

Concurrent with the proliferation of equipment has been an increasing rate of use of diagnostic tests, including x-rays.[15] Such increases have been attributed to several factors. Changes in medical education have placed increasing emphasis on objective tests and precise measurement when less technologically advanced methods might still be adequate for diagnosis.[16] Fear of malpractice litigation encourages "defensive" medical practice, usually expressed as over-utilization of services,

particularly diagnostic tests.[17] The growing share of personal health care expenditures covered by third-party reimbursement has reduced the incentives to control use, because the physician's decision to use services is separated from the patient's immediate expenses.[18]

Concerns about the proliferation and overuse of new medical technologies have called attention to the fact that information about their efficacy is inadequate. Well designed studies of the efficacy of procedures are necessary to evaluate any technology, but the completion of such studies prior to the introduction of new technologies is very unusual. The application of new diagnostic or treatment techniques has typically been based on observational studies with inherent problems of observer bias, rather than on rigorous evidence that can only be gathered through well-designed clinical trials or the statistical analysis of large numbers of observations. Often an assessment of the broader implications of introducing new technologies is also needed.[19] At present, such studies are not required or coordinated by any organization, public or private, and no system exists to identify areas for evaluation of emerging technologies at an early stage. The Office of Technology Assessment of the United States Congress is developing guidelines for measuring the efficacy of medical technologies.[20]

Until better data are available, all attempts to recommend and implement policies on the use of new technologies must be viewed as tentative because of the inadequacies of our traditional approaches to acquisition and evaluation of clinical information. These inadequacies must permeate the committee's recommendations, or any recommendations based on current knowledge.

SCOPE OF THE INSTITUTE OF MEDICINE STUDY

The problem of CT scanning is important both in itself and as representative of other medical technologies.* The

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*The Institute of Medicine is cooperating in a year-long, National Academy of Sciences study of the relation between technology and the efficiency and effectiveness of the health care system. That study, focusing on costly,

committee recognizes that the eventual solution to many of the policy problems created by CT scanning, as well as other medical care technologies, depend on availability of data that meets much higher standards of evidence than are presently required and on structural changes in the way that health services are delivered and financed. However, health planning agencies and third-party payers must make decisions now about reimbursement for CT scanning. In order to meet these immediate needs of planning agencies and third-party payers, and within the time constraints imposed by these needs, the committee has made recommendations on the assumption that certain aspects of the medical care system will remain constant. In particular, the committee has assumed that the general structure of the health care delivery and financing system remains as it is today; that no major changes occur in the medical compensation system; that present emphases in medical education remain the same; and that the health planning system as structured under the National Health Planning and Resources Development Act of 1974 remains in existence.

The inadequacies of existing data raised a more fundamental problem for the committee. Obviously, all recommendations concerning the distribution, use, and financing of CT scanning capabilities must be based on a prior finding of efficacy, defined in some manner. But many different standards of evidence can be used in establishing that efficacy. The standards which have guided most changes in clinical practice have been criticized as inadequate.* The committee recognizes that to require higher standards for CT scanning than for other diagnostic or treatment techniques is to advocate either a dual standard of evidence or a fundamental change in the standards by which the practice of clinical medicine is determined. The former course raises issues of fairness; the latter raises issues of practicality in the context of this report. Yet, the issue cannot be ignored. Therefore, in addition to calling for better clinical data (see the last section of

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capital-intensive technologies, will explore the major obstacles to the appropriate use of such technology and will suggest policies to correct deficiencies.[21]

*A. L. Cochrane, Effectiveness and Efficiency: Random Reflections on Health Services (London: The Nuffield Provincial Trust, 1972).

this report for details), the committee has presented two approaches to the evidence about efficacy, one based on past and current standards in clinical medicine and the other based on a requirement for higher standards of evidence that meet more rigorous criteria of experimental design. These options are presented in the chapter on efficacy.

With these study constraints, the committee examined the following matters.

> Efficacy At the current stage of technological development, for what uses is CT scanning safe and efficacious and, therefore, indicated?
>
> Cost and Level of Reimbursement How should the level of reimbursement for the technical and professional components of CT services be determined?
>
> Placement How should the need for and placement of CT scanners be determined?
>
> Implementation What policy instruments--of reimbursement, planning, and quality control--are required to promote appropriate utilization, costs, and placement of CT scanners? How and by whom should these policies be implemented? How can flexibility to accommodate new developments be incorporated into these policies?

The Institute of Medicine convened a committee to review what is currently known about these matters and to develop a policy statement that would offer recommendations for immediate implementation by third-party payers and health planners. This study was sponsored by the Blue Cross Association, but the Institute of Medicine did not limit the study to policies affecting only Blue Cross. The committee considered short-run policy options open to both public and private organizations. It used several policy studies as background material for its deliberations, including the draft report on CT scanning of the Office of Technology Assessment[22] and a technical report by the American Hospital Association.[23] In addition, the committee invited speakers from several

organizations representing a wide variety of interests and perspectives to participate in a discussion of these issues (Appendix).

SUMMARY OF RECOMMENDATIONS

This committee urges careful consideration of two possible approaches to reimbursement and policy for CT scanning procedures.

The first option would require of CT scanning only the traditional and incomplete evidence of efficacy that builds up in the clinical research literature as experience accumulates.

The second option would require that the efficacy of CT scanning be established by clinical trials that meet high standards of experimental design and statistical significance. Policy recommendations arising from choice of the second option would include reimbursing only for CT scans conducted as part of a clinical trial designed to provide more definitive evidence of efficacy, and approving wider reimbursement only when that definitive evidence is available.

Although the committee does not endorse this second option as the preferred path for body scans in the immediate future, the final section of this report contains recommendations which would begin to correct existing deficiences in information about the effects of CT scanning. A basic shift to new standards of evidence as the basis for decisions requires a careful analysis of its full implications for public and private policies concerning all medical care, including techniques for policy implementation. The scope and time constraints of this report precluded such a major re-examination of the base of evidence for all clinical practice, although the first steps in providing improved information are recommended at this time.

The following policy recommendations are founded on the first option, but also contain the initial steps to generate the improved information required by the second option.

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Reimbursement for CT Scanning

- CT scanning of both the head and body when appropriately used for specified indications should be a covered diagnostic service under third-party reimbursement plans, accepting as criteria of efficacy the usual standards of clinical practice.

- Third-party payers should reimburse only for services provided by CT installations approved under a certificate of need program.

- Third-party payers should reimburse only for examinations approved under a utilization review program satisfactory to the payers.

- Third-party payers should continue to work toward elimination of differences in coverage for ancillary services between inpatients and outpatients.

- A uniform cost-based method for determining the technical component of charges for all CT scanning should be established to eliminate excessive surplus or profit. This method should include amortization of equipment and remodeling costs over a minimum of five years and should be based on a minimum annual volume of 2,500 patient examinations and on actual use above that volume.

- Professional fees for the interpretation of all CT scans should be at a rate which eliminates excessive profits. A rate of $35 per patient examination is recommended at this time, unless special local conditions can justify a lower or higher rate. This charge may be subject to a modest adjustment for examinations involving the use of contrast material.

Planning for CT Scanning

- Congress should amend the National Health Planning and Resources Development Act of 1974 to include the review of proposals for large capital equipment expenditures in freestanding ambulatory care settings.

- Certificate-of-need laws in each state should require the review and approval of the acquisition of major capital equipment whether by an individual, group, or institution.

- Health systems plans and state health plans should include specific provisions for CT scanning services.

- CT scanners should be placed in freestanding ambulatory care settings only when placement in full-service hospitals is not practical.

- New units should not be approved until there is full and appropriate use of existing scanners.

Utilization of CT Services

- Each request for a CT examination should be reviewed by a physician with responsibility to control access to determine whether the scan is appropriate. No facility should be operated in such a way that scans are performed without such prior review.

- An advisory panel should be established by third-party payers to develop criteria for use of CT services.

Information Needs

- The federal government, perhaps in cooperation with national professional and third-party organizations, should develop and implement a comprehensive research protocol to provide definitive evaluation of CT scanning.

- The federal government should sponsor the development of a common data collection protocol to be followed by all providers of CT scanning services.

- Willingness to collect uniform data by owners of CT equipment should be a condition of CON approval and reimbursement by third-party payers.

- A procedure should be developed at the federal level to identify and evaluate costly technological innovations before their widespread introduction into the medical marketplace.

ASSESSMENT OF EFFICACY

Computed tomographic scanning should provide information that contributes to the formulation of a diagnosis. To examine the value of the information from the CT scan, the committee adopted a hierarchy of five levels of efficacy based largely on the work by Fineberg, Bauman, and Sosman.[24] In this, the determination of efficacy on any level is a necessary but not sufficient condition for a finding of efficacy at subsequent levels. The levels are:

1. Technical capability--accurate representation of the area scanned.

2. Diagnostic accuracy--provision of information that contributes to the formulation of a correct diagnosis.

3. Diagnostic impact--the extent to which CT scan information replaces other diagnostic procedures, including diagnostic imaging, surgical exploration, and biopsy.

4. Therapeutic impact--change in disease management that would not have taken place without the information from the scan.

5. Patient outcome--the effect of CT scan information on patient morbidity or mortality.

Diagnostic procedures should be evaluated not only on their own merits but also in comparison with competing procedures and combinations of procedures. It may be, for example, that efficacy is increased when CT

scanning is used in conjunction with other modalities such as diagnostic ultrasound, conventional x-ray, or radioisotope scans. The results of such comparative efficacy studies should be useful in defining diagnostic protocols.

Little is known about the efficacy of most diagnostic procedures above the level of diagnostic impact. Only the absolute and comparative efficacy of CT scanning at levels of technical capability and diagnostic impact can be assessed at this time. However, when unequivocal improvements in diagnostic impact occur, improvements at higher levels of efficacy can follow.

The efficacy of any diagnostic procedure must be evaluated against its costs and risk to the patient. The risk of ionizing radiation and the risks associated with other diagnostic imaging modalities, such as ultrasound, radioisotope scans, and conventional x-ray procedures are not fully known and should continue to be explored. The risks of CT scanning result from the possibility of allergic reactions to the contrast material injected intravenously in 40 to 60 percent of the scanning procedures[25] and from the effects of ionizing radiation. The committee finds that the risk associated with ionizing radiation in properly designed and calibrated scanners is equivalent to conventional x-ray procedures and substantially less than most invasive x-ray procedures. Exposure to x-rays should be kept to the minimum level that provides adequate information from the scan; manufacturers of CT equipment are urged to continue to incorporate this principle into machine design.

EVIDENCE FOR ESTABLISHING EFFICACY

As the committee indicated in its introductory remarks, a finding of efficacy at the level of diagnostic impact, or any of the higher levels of efficacy, depends upon the type of evidence that is found acceptable. The traditions of clinical medicine have accepted evidence based on observation and informed judgment. Agreement on that evidence by leaders in the field has usually been accepted as the guide to clinical practice and to reimbursement by third-party payers. Sometimes, a large-scale cooperative clinical trial is conducted after a technique has been introduced to general use, although ethical issues can

then be raised about the use of double-blind experimental designs. But well-designed clinical trials have not been a requirement for widespread utilization or reimbursement. Only in the case of drugs have we had a legal requirement for a finding of efficacy based on clinical trials.

An additional problem about evidence is raised by a technique like CT scanning that is evolving so rapidly and where the diagnostic accuracy for many applications, especially in the body, is so dependent upon the speed of the scan. The new generations of scanners have much more rapid scan times, now below five seconds in some cases, and the results from these rapid scanners show definite differences in findings in the body. The rapid changes in the capability of new equipment means that the usual lag before studies are published in the literature may make rapidly obsolete any judgments based on published studies. Since the lag in this field is only several months, however, a wait until studies are published seems reasonable before reaching conclusions about efficacy and reimbursement. This stance is consistent with the traditional principles of scientific evidence that call for evidence to be submitted to peer scrutiny with opportunties for reproduction of results or critiques of methodology.

In making specific recommendations about efficacy, the committee has based its judgments on the published literature. That literature shows the remarkable promise of CT scanning, both in its applications to the head and more recently, as scan times have been reduced, to a number of indications in the body. However, this evidence is not based on carefully designed, large-scale clinical trials. Therefore, the committee can reach two different sets of conclusions about efficacy at the level of diagnostic impact. The first would be based on existing standards of clinical evidence evaluated by the expert judgment of leaders in the field. Many significant advances in diagnosis and treatment have been introduced into practice on the basis of this type of evidence, and the results over time, when evaluated, have shown very positive value. The second type of evidence would require clinical trials meeting high standards of experimental design and statistical significance. The evidence for CT scanning, even in the head, does not yet meet this second standard.

The policy recommendations can be very different, depending on which standard of evidence is chosen. The first standard would call for a finding of diagnostic efficacy for CT scanning in the head and for a number of indications in the body. The second standard would find the results still inconclusive. The logical policy conclusion based on the first standard would be to recommend reimbursement for those uses found efficacious. The conclusion based on the second standard would be that the procedures are still experimental and should be supported only in settings that are part of a clinical trial leading to more definitive evidence. Only when that more definitive evidence is available would reimbursement in all approved treatment settings be available.

Because the focus of this study is on the near term, the committee has based the specific recommendations in this report on the first standard, which is the standard currently used in most decisions about the use of new techniques. The committee recognizes that recommendations based on the second standard would be substantially different. Because CT scans of the head are so widely used, the more rigorous evaluation of these applications must be considered retrospective, rather than prospective studies completed before a decision about reimbursement. However, CT scans of the body are such a recent use of this technology that delaying decisions about efficacy and reimbursement until prospective clinical trials are completed is still a feasible option. Implementing this option might call for the design of a cooperative large-scale clinical trial, with payment for CT scans of the body being limited to those institutions participating, or elgible to participate, in the trial, as determined by a national committee. The committee would also determine which indications were being examined in the trial. The trial design would involve not only absolute determinations of diagnostic efficacy but also comparative determinations involving other diagnostic techniques. Only when the trial was complete for a particular indication would a recommendation for general use in clinical practice be made and reimbursement provided for scans performed in other institutions. At that time, all other recommendations made by this committee concerning the location, financing, and evaluation of CT scanning would apply.

Although the committee does not endorse this second option as the preferred path for decisions about body scans in

the immediate future, the final section of this report contains recommendations which would begin to correct existing deficiencies in information about the effects of CT scanning. A basic shift to new standards of evidence as the basis for decisions requires a careful analysis of its full implications for public and private policies concerning all medical care, including techniques for implementation. The scope and time constraints of this report precluded such a major re-examination of the base of evidence for all clinical practice, although the first steps in providing improved information are recommended at this time in the final section.

EFFICACY OF CT HEAD SCANNING

Using current standards for evaluating clinical evidence, the committee finds CT scanning of the head to be efficacious at the level of diagnostic impact when used to diagnose and determine the effect of treatment on mass and structural lesions in or about the brain, including the meninges and orbit. CT scanning holds promise in demonstrating other lesions, including those resulting from demyelinization and cerebritis. Indications for a scan should include sufficient clinical information for determining the area of the head to be scanned and whether contrast should be used. CT scanning of the head is not an appropriate diagnostic procedure in the absence of strong clinical indications and supporting signs and symptoms.

CT scanning of the head is usually efficacious in comparison with other diagnostic procedures.[26] Cerebral angiography, radionuclide scans, pneumoencephalography, echoencephalography, and skull x-rays will continue to have diagnostic utility, but CT is likely to replace them to some extent, to judge from comparisons of the information and risk associated with each method. The committee supports the decision of most third-party payers to reimburse for CT head scanning when competent judgment finds it clinically indicated.

EFFICACY OF BODY SCANNING

Although many possible uses of CT scanning in the body are presently under research, recent studies have presented substantial evidence meeting current standards that CT

scanning is diagnostically accurate in certain applications.[27] The committee has considered the most recent results obtained by clinical researchers and has applied its best judgment in evaluating these results. On this basis, the committee finds that CT scanning of the body is efficacious at the level of diagnostic impact when used for specific indications, limited largely but not entirely to diagnosis and managing treatment of cancers at certain sites. The areas of the body for which CT scanning is or is not indicated at this time are listed below.

Neck - CT scanning is not indicated at this time.

Chest -

- Pleura
  -- Detection of pleural metastases and other chest wall lesions.

- Lung
  -- Detection of multiple tumor nodules where one or more have been found by conventional x-ray techniques. If there is clearcut evidence of bilateral involvement, CT is not appropriate.

  -- Search for a primary tumor when a positive sputum for malignant cells has been obtained, but no evidence has been found through conventional x-ray techniques.

  -- Determination of extent of spread of tumor to adjacent lobes in patients with impaired pulmonary functions.

  -- Differentiation of solid, cystic, fatty, inflammatory, and vascular masses.

  --CT is not indicated for detection of pulmonary emboli at this time.

- Mediastinum
  --Detection and evaluation of masses.

  -- Differentiation of solid, cystic, fatty, inflammatory, and vascular masses.

-- Determination of extent of primary or secondary tumor.

- Heart
  -- Studies of the heart are not indicated at this time.

Great Vessels (including abdominal aorta) -

-- CT scanning is not indicated in the aorta and great vessels except in the few post-operative patients in whom aortic graft abscesses are suspected.

Spine and Contents -

- Spinal Cord
  -- CT is not indicated in the spinal cord at this time.

- Spinal Column
  -- Determination of content and extent of meningoceles and meningomyeloceles.

  -- CT biopsies.

  -- Otherwise, CT scanning of the spinal column is indicated only where other procedures, including conventional tomography, radionuclide scanning, and myelography have failed to detect primary tumors, metastases, and inflammatory diseases in the presence of persistent symptoms.

Abdomen -

- Retroperitoneal Area
  -- Diagnosis and staging of nodal and extranodal extension of lymphomas, determination of extent of retroperitoneal involvement with lymphomas, and extent of other types of retroperitoneal metastases from various primary sites.

  -- Detection of primary malignancies such as those of mesenchymal, neural, lymphatic, embryonic rest origin, melanomas, and benign conditions such as cysts which may mimic malignancies.

- Peritoneum
  -- Detection and aspiration of abscesses and cysts.

- Liver
  -- Search for primary and secondary tumors and some life-threatening benign lesions such as liver cell adenomas and cavernous hemangiomas and abscesses.

  -- Determination of extent of tumor and differentiation of solid, cystic, inflammatory, vascular, and fatty lesions.

  -- CT biopsies.

- Spleen
  -- CT is not indicated at this time.

- Pancreas
  -- Search for primary and secondary tumor.

  -- Determination of extent of tumor.

  -- Differentiation of solid, cystic, inflammatory, vascular, and fatty lesions.

  -- CT biopsies

- Kidney
  CT scanning of the kidney is indicated only when preceded by a conventional IVP study, and then for:
  -- Search for primary and secondary tumor.

  -- Determination of extent of tumor.

  -- Differentiation of solid, cystic, inflammatory, vascular, or fatty lesions.

  -- CT biopsies or aspiration.

- Gall Bladder
  -- CT is not indicated at this time.

- Biliary Tree
  -- Differentiation of obstructive from non-obstructive jaundice.

- Gastrointestinal Tract
  -- CT is not indicated at present except for determination of extent of tumor spread to other organs (see other indications).

- Adrenal Glands
  -- Search for primary and secondary tumor.

  -- Determination of extent of tumor.

  -- Differentiation of solid, cystic, inflammatory, vascular, or fatty lesions.

  -- CT biopsies.

Pelvis

- Uterus and Ovaries
  CT scanning is indicated after detection of a mass by clinical examination or after positive biopsy for:
  -- Evaluation of primary tumor and its extent of spread; and evaluation of secondary tumor.

  -- Differentiation of solid, cystic, inflammatory, vascular, or fatty masses.

  -- CT biopsies.

- Bladder, Ureters, and Prostate
  -- Evaluation of primary and secondary tumor, including extent of tumor.

  -- Differentiation of solid, cystic, inflammatory, vascular, or fatty tumors.

  -- CT biopsies.

- Flat Bones
  -- Evaluation of bone lesions.

  -- CT biopsies.

Extremities -

-- CT is indicated for determining the local extent of a tumor and presence of regional metastases.

Therapy Planning & Follow-up -

-- CT is indicated for collection of information on cross-sectional anatomy and attenuation coefficients of bone and soft tissue in tumor-bearing areas for planning surgery and radiation therapy.

-- Follow-up evaluation of effectiveness of radiotherapy, surgery, or chemotherapy in cancer patients at primary or metastatic tumor sites when part of an established and acceptable follow-up protocol or when signs and symptoms suggest progression, recurrence, or failure of therapy.

Foreign Body Localization in the Chest and Abdomen.

Conditions for which CT scanning is more hazardous than or diagnostically inferior to other procedures were not included in the list of indications. For some indications listed, other tests may be more appropriate in particular patients. If other diagnostic tests have permitted a definitive diagnosis to be made, CT scanning is justified only for planning treatment. Conversely, if a CT scan establishes a definitive diagnosis, additional diagnostic tests are unjustified. Sometimes, tests may complement each other either by providing different information or when one test succeeds after the first has failed to yield useful information. Recent studies comparing CT scanning with ultrasonic imaging of the abdomen suggests the two methods are complementary.[28]

Based on current evidence, CT is not superior in all applications. For dynamic studies of the circulatory and digestive systems and for high-resolution radiography in which structural details below a millimeter must be discerned, CT cannot compete with conventional radiographic techniques. In mammography, for example, xeroradiography provides definitive diagnostic information at a lower cost, although at a higher radiation level. Ultrasonic imaging is safer and, therefore, diagnostically superior to CT scanning in obstetrics and gynecology. In cardiology, TM mode and real-time ultrasonic imaging provide more valuable data than do currently available CT scanners. CT scanning cannot replace those nuclear

medical techniques that provide unique information about body functions and body chemistry, as in the case of thyroid scans.

Because CT scanning of the body is an efficacious diagnostic tool for the conditions listed above on the basis of current standards of evidence, the committee recommends that CT scanning of the body when used for appropriate indications be recognized as a covered service under third-party reimbursement plans until and unless a decision is made to require more demanding standards of evidence for these decisions. However, experience with body scanning is evolving rapidly and the list of indicators for which coverage is warranted should be reviewed at least every six months. Therefore, the committee recommends that:

- CT scanning of both the head and body, when appropriately used for specified indications, should be a covered diagnostic service under third-party reimbursement plans, accepting as criteria of efficacy the usual standards of clinical practice.

The committee considers it essential, however, that controls be placed on the location and use of and charges for CT services. The controls are discussed in the succeeding chapters of this report.

HEALTH PLANNING POLICY FOR CT SCANNING

A fundamental problem with CT scanning and, indeed, with all diagnostic services is the seeming inability of the health care system to assure that only medically necessary and appropriate use occurs. The lack of control over use provides financial support for socially undesirable proliferation of facilities capable of rendering such services. In the absence of a complete restructuring of providers' economic incentives, two regulatory approaches to this dilemma are possible; control over the number and location of scanners; or control over the utilization of CT services. The first approach assumes that providers of health care can and will develop systems for appropriately rationing the use of such services. The committee believes that control over the placement of CT scanners is necessary but not sufficient; effective control over the utilization of CT services is also required. Providers of CT services cannot be expected to effectively ration access to CT scanning capability without such controls. This section discusses policy issues involving planning and regulation of CT scanner placement. The following chapter will consider policies for controlling the utilization of such services.

CERTIFICATE OF NEED

The major regulatory tools currently available to control the number and location of CT scanners are state certificate of need (CON) laws. CON legislation requires approval by a planning agency for major capital investments in health care resources. Twenty-nine states and the District of Columbia have CON requirements, and PL 93-641

mandates CON legislation in each state by 1980. However, laws in only three states require CON approval for capital investments made by private physicians. In the others physicians wishing to purchase CT equipment are legally exempt from review and approval, although administrative policy may encourage voluntary submission.

The Congressional Office of Technology Assessment reports that 15 percent of identified CT installations are owned by physicians and located in private offices or clinics; 6 percent are owned by physicians but located in hospitals.[29] There is every indication that a similar proportion of CT equipment will be owned by physicians in the future. Some physicians wishing to purchase CT equipment have voluntarily submitted applications for CON; others have been encouraged or required to apply for CON by legal, administrative, or reimbursement policies. However, some physicians appear to have deliberately circumvented the intent of CON requirements by purchasing CT equipment for use in private offices.

The exclusion of physicians' offices from planning agency review and approval under the CON program undermines the program as it applies to CT scanning. Although CON may not be an ideal mechanism for controlling the allocation of capital investment in medical care technologies, it is the only mechanism currently available. Planning agency decisions about the appropriate number and location of CT installations in a health service area will be ineffective as long as this loophole exists. Further, other prospective institutional purchasers may be denied CON approval because the quota for an area has been met or exceeded as a result of private ownership. The committee, therefore, recommends that:

- Certificate of need laws in each state should require the review and approval of the acquisition of major capital equipment whether by an individual, group, or institution.

Federal action is also recommended. There has been considerable debate since the passage of PL 93-641 about the congressional intent regarding noninstitutional providers of health care services. The administration has interpreted the law to exclude freestanding ambulatory care facilities. PL 93-641 expires in mid-1977, providing

a timely opportunity for Congress to clarify its position. Therefore, the committee recommends that:

- Congress should amend the National Health Planning and Resources Development Act of 1974 to include the review of proposals for large capital equipment expenditures in freestanding ambulatory care settings.

In making these recommendations, the committee is aware of the further burden that would be placed on health planning agencies which are considered by many to be developing and, therefore, fragile.[30] At the same time, the committee recognizes the importance of effective health planning and is anxious to assure that planning agencies have the power to develop and implement policies at the state and local level. To enhance the effectiveness of certificate of need programs, the committee recommends that:

- Third-party payers should reimburse only for services provided by CT installations approved under a certificate of need program.

In making this recommendation, the committee recognizes that some existing CT installations were not required to obtain a CON in the past. These installations should not be denied reimbursement for this reason.

In some states, CON laws do not exist or are ineffectively administered at present. Although the National Health Planning and Resources Development Act mandates the establishment of CON laws meeting certain specifications in all states, the network of capability to administer such laws has not been uniformly established. But the need for control over the placement of CT scanning capability is immediate. Consequently, third-party payers must evaluate the extent to which state legislation can be relied upon now to perform this function. Where such capability does not presently reside in existing agencies, third-party payers are urged to establish mechanisms to determine the elgibility of CT scanning installations for reimbursement using criteria consistent with sound health planning principles.

PLAN DEVELOPMENT

PL 93-641 requires that HSAs develop a health systems plan containing long-range goals and objectives. State Health Planning and Development Agencies also must assist the State Health Coordination Council in the Development of a state health plan. These plans play an essential role in describing the desired future state of the health care system in all health service areas. The committee recommends that:

- Health systems plans and state health plans should include specific provisions for CT scanning services.

If this recommendation is followed, the process of CON review and approval can then be used to implement these priorities.

In developing objectives for CT scanning services, health planning agencies should consider the desirable attributes of facilities which might offer CT services to area residents. These attributes should include:

Responsibility for training and medical education Physicians in all specialities should be familiar with the appropriate use of CT services, and those specializing in diagnostic imaging should acquire expertise in the use and interpretation of CT scans. Technicians must also have the opportunity to be trained in CT.

A full range of diagnostic modalities CT Services, particularly body scanning, sometimes complement other diagnostic modalities such as ultrasound, radionuclide scanning, and conventional x-ray. CT is better placed in facilities which have the full range of these services so that inpatients need not be moved nor outpatients inconvenienced by the need to visit several facilities. Clustering complementary modalities also has the advantage that providers become conversant with each modality. The administrative burden is likely to be reduced since the patient receives services from one facility only. Since this policy would concentrate complex diagnostic services in fewer places, regional transportation systems become particularly important.

Capability of treating many of the conditions diagnosed by CT procedures CT scanning of both the head and body is capable of diagnosing many conditions which require highly complex treatment modalities. Therefore, CT equipment should be located in institutions which have the facilities for treating many of the conditions likely to be diagnosed by imaging with CT.

Services to both inpatients and outpatients CT equipment can be used most efficiently in facilities which have an outpatient department as well as inpatient beds. Such a policy suggests that most ambulatory care facilities and physicians' offices are less well suited for CT services.

Radiation physicist on staff or as a consultant A staff or consultant physicist with expertise in the technical aspects of CT scanning is desirable to assure the quality and safety of CT equipment. Consideration should also be given to facilities which include biomedical engineers and computer experts on their staffs.

Acceptance of referral from all area physicians Patients should not be denied access to CT services because of restrictive referral policies or on the basis of physician status. CT services should be considered a community resource.

Emergency facilities and services CT services may be indicated for certain emergency conditions. Priority should be assigned, therefore, to the installation of at least one CT unit in an appropriately defined geographic area to be available for use on a 24-hour, 7-day-a-week basis. The number of emergency cases in most communities, however, is unlikely to justify the cost of constant availability of more than one CT installation.

Because full-service hospitals have most of these attributes, the committee recommends that:

- CT scanners should be placed in freestanding ambulatory care settings only when placement in full-service hospitals is not practical.

ASSESSING THE NEED FOR CT SERVICES

Each health planning agency must determine the number of scanners which should be placed in its region if priorities for placement are to have any meaning. Yet, generally accepted methods for determining need have not been developed. Health planning agencies have used four general bases for calculating the need for scanners:

Population to be served Indiana suggests that there should be one scanner in each service area with more than 100,000 population.[31] Idaho guidelines state that a service area should have at least 250,000 population.[32]

Area to be served Massachusetts [33] and New Jersey[34] guidelines state that each HSA area should have one scanner, and Ohio suggests one for every major medical center area.[35]

Incidence of diseases among the population Kentucky has developed a complicated formula based on the incidence of cancer and the incidence and prevalence of neurological diseases.[36]

Number of other diagnostic procedures currently being performed The South Central Pennsylvania Health Planning Council uses a formula for determining the number of cranial CT scans based on the number of radionuclide scans, cerebral arteriograms, and pneumoencephalograms per year.[37]

Most agencies recognize that there are insufficient data available on which to base estimates of need and that the estimates adopted are crude. The uncertainty in these estimates is illustrated in a staff paper from the Massachusetts Department of Public Health which applied formulas from eleven different sources to data from Massachusetts and found estimates of "need" ranging from 5 to 52 scanners for the state.[38] The federal government has distributed two technical assistance memorandums which offer general guidance to health planning agencies, but they do not suggest a particular need assessment method.[39]

One suggested solution to the problem of inadequate information is to impose immediately a national moratorium on acquisition of all new scanners until firm guidelines can be developed based on studies of efficacy.[40] Such a

moratorium could be implemented either by health systems agencies if they have the power to conduct CON reviews for CT scanners in all settings, or by third-party payers if they have the authority to refuse payment for examinations performed on new scanning units. The committee believes, however, that such action is not warranted by the present situation. However, approvals in areas with existing CT units should be granted prudently. The committee recommends that:

- New units should not be approved until there is full and appropriate use of existing scanners.

If effective utilization review programs are established, congestion measured by long waiting lines for scans or near-capacity volumes of existing units will serve as good indicators of additional needs.

In the absence of effective controls on use, aggregate formulas for determining the number of scanners which should exist in an area must serve as a guide for health systems plans. The committee had neither sufficient time nor access to epidemiological data to evaluate alternative guidelines for the number of scanners which should exist in any defined region; moreover, these guidelines would soon become obsolete as new information on the efficacy of body scanning is generated. The problems facing health planning agencies in developing guidelines will not be solved until better information for policymaking is collected.

UTILIZATION REVIEW OF CT SERVICES

The tendency toward overuse of diagnostic tests in general and x-ray tests in particular has been discussed earlier in this report. CT scanning is no exception. Effective utilization review (UR) programs for CT examinations of the head and body as well as other diagnostic procedures are essential both to control costs and to assure adherence to standards of medical practice.

Formal programs of UR involving independent review of the use of CT services by parties outside of individual clinical decisions are necessary. Such UR programs can occur at various points in the process of delivering CT services. Prospective review involves an independent assessment of the appropriateness of or medical necessity for the procedure before its performance. Retrospective review involves a similar assessment sometime after the service has been rendered. Formal UR programs do not necessarily imply review of all CT examinations. A periodic analysis of patterns of care can isolate particular procedures, diagnoses, physicians, or institutions whose unusual features merit case-by-case review for some period of time.

Regardless of its configuration, a UR program must carry with it real sanctions and incentives to alter unsound patterns of use. Therefore, UR should be tied to payment for services. The committee recommends that:

- Third-party payers should reimburse only for examinations approved under a utilization review program satisfactory to the payers.

Third-party payers presently reimbursing for CT scans of the head or body should institute CT utilization review programs if they do not exist already. Third-party payers may wish to contract with qualified professional groups such as Professional Standards Review Organizations or foundations for medical care to conduct such programs.

The value of any UR program depends both upon its effectiveness in deterring inappropriate examinations and its cost. A program that works well in one environment may be ineffective or too costly in another. The committee considered various approaches to the review of CT scanning services. Prospective review of all or selected examinations by a physician with competence to judge the appropriateness of the use was suggested as the most effective control over unnecessary scans; however, the costs of such a program and the difficulty of finding competent reviewing physicians in some areas were considered by a majority of the committee to be major disadvantages. Retrospective utilization review programs as part of the claims review process were considered to be more feasible in most situations. However, many claim forms provide little information about the case. Claims review requires that all claims meet an initial set of screening criteria which identify cases for additional review. Often claim forms do not include information on ancillary services sufficient to identify cases of inappropriate use. The Medicare claim form for inpatient care, for example, does not require the identification of a CT scan independent of other x-ray procedures. Third-party payers and intermediaries should work to correct such deficiencies.

Any UR program must be based on criteria for appropriate use. Because the indications for CT body scanning are limited at present, this is a particularly appropriate time for third-party payers to develop such criteria. Third-party payers, perhaps in cooperation with each other, should establish an ongoing advisory group on CT scanning composed of radiologists, neurologists, neurosurgeons, oncologists, nuclear medicine specialists, ultrasonographers, clinical researchers, statistians, computer experts, and consumer representatives. This body should develop criteria for use of CT scanning and should meet periodically to revise

those criteria as new information develops. Therefore, the committee recommends that:

- An advisory panel should be established by third-party payers to develop criteria for use of CT services.

The criteria for use developed by the advisory panel should address the following considerations:

-- suspected diagnoses or therapeutic uses for which CT scanning is indicated;

-- presenting signs and symptoms;

-- place of CT scanning in the sequence of diagnostic procedures (including neurological consultations, where indicated and available).

-- appropriateness of contrast-enhanced scans; and

-- number of, and time elapsed between, repeat CT scans.

The advisory panel should also consider the need for information to develop profiles of use and to conduct studies of patterns of care. The panel should consider and recommend characteristics of CT facilities that can be used for these purposes, such as proportion of examinations that are contrast-enhanced, percent of examinations that are positive, and percent of scans used before or after other tests were conducted.

The committee recognizes that utilization review can be expensive and that it has met with mixed success.[41] In the absence of a complete restructuring of the economic incentives to which health care providers react, the committee believes UR is a necessary tool that should be initiated immediately to influence the use of CT services. UR should also be developed for other diagnostic services.

The imposition of formal utilization review programs does not relieve the referring physician and the CT provider from the responsibility of using the service

appropriately. Requests for CT scans should be required to contain the results of a clinical examination or assessment, to include suspected diagnoses and information sufficient for accurate localization of the scan and determination of the need for constrast enhancement. In the case of head scanning, this requirement ordinarily entails a neurological examination by the referring physician. Therefore, the committee recommends that:

- Each request for a CT examination should be reviewed by a physician with responsibility to control access to determine whether the scan is appropriate. No facility should be operated in such a way that scans are performed without such prior review.

COSTS AND CHARGES OF CT SERVICES

The variation in charges for CT services and the relation of costs to charges, in the light of actual costs, raises several questions for policymakers. It is apparent that there is a potential for individuals and organizations to charge significantly more than cost for both the technical and professional aspects of CT. Cross-subsidization and excessive profits can and have resulted from the installation of a CT unit.

CT charges include a professional component, which covers the physician's services, and a technical component, which covers all other expenses. In many cases, a single charge covers both components, as in hospitals where radiologists are salaried or when the scan is performed in the physician's office. To analyze the reasonableness of the total charge, however, it is necssary to review them separately.

TECHNICAL COSTS AND CHARGES

Charges for the technical component of CT examinations vary from $100 to $440, with an average of $240;[42] the charge for a study with contrast media--used for image enhancement in 40 to 60 percent of scans[43]--averages $67. About 10 percent of institutions charge a standard fee for CT scanning, regardless of whether the scan is unenhanced, enhanced, or both. The others make separate charges for enhanced and unenhanced scans and may have a third rate when both unenhanced and enhanced scans are ordered at the same time.

The real costs of providing scans vary in different settings because of differences in methods for allocating indirect costs. It is generally believed that overhead and administrative costs are lower in physicians' offices than in hospitals; but, unlike hospitals, physicians are rarely required to report costs or use cost-finding methods to establish or justify their charges. If charges for scans in physicians' offices mirror those in hospitals, then it is safe to say that when hospital charges are too high relative to costs, the same is true of physicians.

The reported costs of CT installations are summarized below:

- Annual operating costs range for $259,000[44] to $371,000.[45] One study reported an average of $285,000.[46]
- Purchase price and installation range from $300,000 to $700,000.[47]
- Maintenance contracts average $25,000 per year after a first year's warranty on most parts.[48]
- Updating costs per installation range from $12,000 to $220,00, with an average of almost $74,000.[49]
- Remodeling costs average $19,903, with a reported range of $15,055 to $34,000.[50]
- Technical staff costs approximate $36,000 annually for two technicians and a secretary-receptionist.[51]
- Insurance costs average $1,000 per year.[52]
- Contrast materials average $7.70 per use.[53]
- The cost of other supplies has a mean value of $10 per patient.[54]
- Overhead rates vary from 10 percent to 60 percent of direct costs.[55]

In reviewing the relation between technical costs and charges for CT services, the committee concluded that present charges do not represent the true resource costs

of CT scanning and do not promote efficient use of existing equipment. Charges are affected by the period of amortization, the volume of procedures, and methods for calculating indirect costs.

Amortization Period

CT scanning equipment for both the head and whole body has reached a state of development where present equipment will not become clinically obsolete before it wears out. Equipment may be made more efficient and convenient, but it is not expected that a major breakthrough in design will render present CT systems inadequate in terms of clinical information and diagnostic capability. In addition, it has been possible to update existing systems as new features are developed, although there is always an additional expense.

Amortization periods of five years or longer are considered to be realistic at this time. This finding should be reexamined at least once a year to take account of further experience with the life span of CT scanning equipment. The actual life span of CT equipment depends on the number of scans performed and will, therefore, vary with use.

Number of Procedures

The high fixed costs of operating a scanner argue for as high a volume of use as the equipment allows without jeopardizing the quality of care. Charges based on low volumes of examinations do not encourage efficient use of existing equipment.

The number of scans performed with a CT scanner depends largely on demand and the number of hours equipment is available for use. Each patient examination takes up to an hour. Estimates of full use vary from a low of 1,800 scans a year (based on one per hour, 40 hours a week, and excluding downtime[56], to approximately 4,000, based on 16 patients a day.[57] In their survey, Evens and Jost found an average of 228 patients per month;[58] the AHA reported a daily range of 6 to 25 with an average of 13 patients.[59]

The committee acknowledges that a few types of existing machines are slower than others and urges manufacturers to design CT equipment capable of handling more patients in less time. The committee also recognizes the limits

placed on some institutions by labor agreements which discourage or prohibit working hours beyond one shift.

The committee recommends a minimum volume of 2,500 patient examinations per year as a conservative basis on which to establish charges after a start-up period of up to one year. To avoid inappropriate use for the purpose of generating revenue, it is recommended that, above a minimum of 2,500 patient examinations, charges should be based on actual volume. The relatively low variable cost should lead to a decrease in charges at higher volumes. The period over which actual volume would be calculated should be determined by third-party payers. For example, it might be decided that volume over one six-month period should be used to calculate the charge made for CT examinations over the following six months.

Indirect Costs

Providers use different methods for allocating indirect (administrative and overhead) costs to various services and procedures for purposes of reimbursement. These variations can be used to justify large differences in scanning charges. One Blue Cross/Blue Shield plan estimated that indirect costs have ranged from 10 percent to 60 percent of direct costs.[60] This difference would justify a 45 percent difference in charges if direct costs were the same for all providers. The committee suggests that such differences in cost-finding methods be eliminated by third-party payers and that a uniform method for determining costs be adopted by third-party payers.

The committee, therefore, recommends the following:

- A uniform cost-based method for determining the technical component of charges for all CT scanning should be established to eliminate excessive surplus or profit. This method should include amortization of equipment and remodeling costs over a minimum of five years and should be based on a minimum annual volume of 2,500 patient examinations and on actual use above that volume.

For new installations a start-up period of up to one year should be granted. This recommendation applies to institutional and private settings. It implies that charges

for CT examinations would be the same for inpatients and outpatients and that the charge should be the same for enhanced or unenhanced examinations, singly and together.

The committee recognizes the biases in patterns of use that result from differences in coverage of benefits between inpatient and outpatient use of services. Therefore, the committee urges that:

- Third-party payers should continue to work toward elimination of differences in coverage for ancillary services between inpatients and outpatients.

PROFESSIONAL COSTS AND CHARGES

Fees charged by professionals for the supervision and interpretation of CT scanning examinations range from $25 to $75.[61] The average professional fee is estimated at $55.[62] Using an estimate of one full-time-equivalent radiologist required for 2,500 scans per year, this would generate annual gross earnings of $137,000. (Blue Cross/ Blue Shield of Michigan has estimated that 3,000 examinations a year would require a half-time radiologist.[63]) Using this and other information, the committee finds the average charge for CT to be excessive even when bad debts and other costs are considered and recommends:

- Professional fees for the interpretation of all CT scans should be at a rate which eliminates excessive profits. A rate of $35 per patient examination is recommended at this time, unless special local conditions can justify a lower or higher rate. This charge may be subject to a modest adjustment for examinations involving the use of contrast materials.

INFORMATION AND EVALUATION NEEDS

In addressing the many policy questions raised by the introduction of CT technology into the routine practice of medicine, the committee recognized the serious deficiences in information available for sound planning and policymaking. Data are needed so that the usefulness of the technology can be determined and decisions on the number and location of CT units can be made. The committees' recommendations, or any recommendations affecting distribution and utilization of CT scanning, will remain deficient until better data, based on soundly conceived and executed clinical trials, are available.

The evaluation of CT scanning must consider not only its diagnostic efficacy relative to other procedures, but also the impact of CT scanning on therapy and on patient outcomes. Carefully controlled studies of CT procedures should produce information that can be used to develop indications for use and diagnostic protocols related to signs and symptoms.

Studies are being conducted at several institutions; these studies should be coordinated and, where necessary, expanded to include information on the impact of CT on the use of other health care services. At present, a comprehensive plan for the evaluation of CT scanning does not exist, and no agency, public or private, is developing one. Therefore, the committee recommends that:

- The federal government, perhaps in cooperation with national professional and third-party payer organizations, should develop and implement a comprehensive research protocol to provide definitive evaluation of CT scanning.

Information necessary for planning for CT services requires the development of a comprehensive data base from a wide range of CT facilities on the patterns of use of these services. Data of the following kinds are required:

- Presenting signs and symptoms of recipients of CT examinations
- Demographic characteristics of recipients of CT examinations.
- Rate of positive diagnoses of different disease conditions by CT.
- Place of CT examinations in sequence with other diagnostic procedures.
- Sensitivity and specificity of CT examinations performed in different parts of the body.

Uniform data collected from many facilities would make it possible to establish the approximate population base for which a scanner is needed. The committee recommends that:

- Willingness to collect uniform data by owners of CT equipment should be a condition of CON approval and reimbursement by third-party payers.

Common data collection formats should be developed at the federal level. The committee recommends that:

- The federal government should sponsor the development of a common data collection protocol to be followed by all providers of CT scanning services.

The history of CT scanning has shown that manufacturers of medical equipment and providers of medical care are willing to make major financial commitments before the efficacy of a technology is proven. The lack of a coordinated policy for collecting data to provide that information before major new technologies are diffused has exacerbated problems of control. The committee

recommends that:

- A procedure be developed at the federal level to identify and evaluate costly innovations before their widespread introduction into the medical marketplace.

If manufacturers and providers could expect early dissemination of the results of evaluations, they might alter their investment patterns accordingly. As long as providers bear no risk for poor investment decisions, as is the case now with cost-based reimbursement, they will continue to adopt new technologies prematurely.

APPENDIX

The individuals and organizations listed below were invited to make a presentation to the Committee on CT Scanning Policy at its meetings on December 21, 1976, and January 3, 1977.

Blue Cross and Blue Shield of Greater New York
(Steven Sieverts)

Blue Cross of Michigan, Detroit (Louis F. Hayes, M.D.)

Division of Health Policy and Planning, Madison, Wisconsin
(Steven Grode)

Health Research Group, Washington, D.C.
(Sidney M. Wolfe, M.D.)

Health Systems Agency of Northern Virginia, Falls Church
(George Parker)

National Electrical Manufacturers Association
(Gene E. Lewis)

Office of Technology Assessment, United States Congress, Washington, D.C. (Carl A. Taylor)

Society of Nuclear Medicine, New York
(C. Douglas Maynard, M.D.)

Raymond Gize, M.D., Fort Wayne, Indiana

George L. Sheppard, M.D., Winchester, Virginia

The American Hospital Association was unable to send a representative to the meeting but presented written testimony. (Herbert K. Gatzke; written testimony)

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Senator SCHWEIKER. Yes; but that kind of proliferation is what the Planning Act and the HSA's were supposed to stop. You do not have to have a cap to do it; we can do it now through the HSA's. That is why we passed the Planning Act.

So why do we not give them a chance to work before coming up with another way?

Secretary CALIFANO. The health service agencies will be a significant part of this legislation. They do not have the power, as the legislation is now constructed, to impose this kind of a lid on the increase in capital expenditures. We would use the HSA's and the State agencies as the determining body, along with the hospital administrator, in terms of distributing the $2.5 billion in capital expenditures, in terms of monitoring the hospitals to make sure that their patient charity loads are maintained, and in terms of implementing other aspects of this legislation.

So we are using them and strenghtening them in our legislation.

Senator HATHAWAY. Now, in regard to the third-party payments, the only incentive for the third-party payors to bring down the cost, the 9-percent cap, is going to be the only one if there is no other provision?

Secretary CALIFANO. Under this legislation, third-party payors will only pay up to that 9 percent.

Senator HATHAWAY. Yes; so then the hospital can turn around and charge the patient.

Secretary CALIFANO. No payments by patients will be included in the hospital's revenues, Senator, and it is the revenues, from year to year, that will be limited and they cannot go up more than 9 percent. So the ability of the hospital to charge the patient more than the insurance company will not be more than a total of 9 percent.

Senator HATHAWAY. Yes; 9 percent will be the ceiling revenues.

Secretary CALIFANO. That will be the ceiling, that is correct.

Senator HATHAWAY. That is all.

Senator KENNEDY. We have been extremely interested in the area of technology. We are working with the Office of Technology Assessment, of which both Senator Schweiker and I are members to devise a system by which we are going to get the health implications of new technology, as well as the cost implications.

The explosion of new technologies appearing on the market is something for which we have to establish modalities to insure that we act responsibly in this area. For instance, how do we remove old technologies from the market and how do we regulate the proliferation of new ones? Not only is this going to be costly, it also deals with complex and ethical questions, ones which will not be solved here today. It is an issue which requires the help of HEW.

A couple of final areas.

One is on the question of the HSAs. We spent much time on that planning bill and we had strong opposition in terms of the vested kinds of interest on it. The bill does not have the kind of teeth in terms of HSAs to really accomplish the kind of job that you hope to do. That is going to be something for us to do in terms of the planning function for the new year and an issue on which we are going to need a lot of help and recommendations.

But the other thing is, as you know, that the HSAs must be more adequately funded and given more power if they are going to serve a useful function in our health care system.

We want to work with you to make sure that they are going to get the funding and the technical competency to really meet this challenge.

I would think that those of us on this committee would believe that this is not the case at the present time.

In the waiver provisions that you have, how are you going to make sure that a hospital is not going to have to go to the verge of bankruptcy in order to be able to get any kind of waiver? The process is going to have to reach the issues of merit; but how are we going to do it so that you are not sticking them right through the cellar before they are able to get serious consideration in terms of meritorious questions?

There have been all kinds of comments which we are going to have to deal with later. Questions about rural hospitals having to sell land in order to pay off, and other factors such as this which I know, in the fair reading of your provisions, are not included.

Would you talk on this issue for a few minutes.

Secretary CALIFANO. Let me, if I could, just make a couple of points.

One, hospitals will be able to apply well in advance, if they need a waiver, of the time at which they think they will need the waiver.

Second, if the Secretary of HEW does not act within 90 days, the waiver is automatically granted, so there cannot be the kind of extensive delays that normally plague this kind of procedure.

Senator KENNEDY. And they get reimbursed for it, too?

Secretary CALIFANO. And they will get reimbursed, So we have to act promptly.

And third, we set it at ratios which we believe, even by American Hospital Association figures, will not create these kinds of problems for the hospitals.

Senator KENNEDY. What about the plethora of Federal regulations that burden down hospital administrations. You have got fire regulations, you have got all kinds of regulations and codes, you are just burdening the hospitals down, and they cannot comply with it; what is your answer to that?

Secretary CALIFANO. Senator, my answer is that, first of all, this will not put in place a whole host of new Federal regulations. As I indicated, there will be no new forms that have to be filled out by a hospital unless they are seeking a waiver.

Second, we have begun a review within HEW, and I am also, at the President's direction, looking at regulations that apply to hospitals throughout the Federal Government, with a view towards easing their burden. We have a new post in HEW, a Deputy General Counsel for Regulatory Review, who is in the process, just beginning, to start this reviewing regulations to ease their impact.

And I think we can do it for hospitals, as we are doing it across the board; we eliminated the need for 2.5 million families to file student aid forms under the education grant programs. And I think we can do the same kinds of things for hospitals.

As I said, we are also trying to work toward a single medicare-medicaid third-party payor form.

Senator KENNEDY. I just have a final question. Will you get your HSA regs or standards out quickly?

Secretary CALIFANO. Yes, I will.

I just do not know where it stands right now.

Senator KENNEDY. Well, we need those out. Maybe you can let us know when you are going to put them out, what your time limit is. But it is very important that they get them out.

[The following information was received for the record.]

The Interim Final HSA Regulations, for State Health Planning and Development Agencies, were promulgated June 3, 1976. Final Regulations will be published in approximately 6 weeks, or mid-August.

Senator HATHAWAY. Mr. Secretary, what assurance is there that the hospitals will maintain the same quality of care? I know it is very difficult to measure, but they could just, lay off a few personnel and not have quite the same nursing and other services for the patient, and cut back on cost considerably that way, thus also lower the quality of care? That is a difficult thing to measure, is it not?

Secretary CALIFANO. It is, Senator. As I indicated, the 9 percent is 1½ times the rate of inflation; it gives them, we think, plenty of flexibility. Most hospital administrators in this country and most doctors and most people that are involved in hospitals, are going to make sure that they maintain the quality of care.

This is not the only mechanism in place, as you have indicated, we have the PSRO's in place, and you have the health systems agencies in place.

So I do not think we will have any problem there.

Senator HATHAWAY. Do you think that will be adequate?

Secretary CALIFANO. Yes, sir.

Senator HATHAWAY. And you are thinking of extending that concept to non-Federal paid cases?

Secretary CALIFANO. We are looking at—well, this cap applies to all sources of patient revenues.

Senator HATHAWAY. No, no, I mean the PSRO mechanisms.

Secretary CALIFANO. Yes; we are looking at this.

Senator KENNEDY. Senator Schweiker?

Senator SCHWEIKER. Thank you, Mr. Chairman.

Mr. Secretary, as I read the bill, it contains incentives mainly to cut back or reduce services. One of the principles of the planning approach is that in certain areas some services, because they are duplicative, would no longer be provided but they would be made up for by other servicing units in the area. That is, the other units would have to add services to their load. That is the theory of the Health Planning Act we passed, and the theory behind what I understood you to say here this morning.

My question is: If that is true, it seems to me we are not providing an incentive to shift services, because if you impose a penalty when a hospital picks up more than a 2-percent increase in patient load, where some other hospital has shut down or closing out, you are penalizing the hospital that has to pick up patients. So you really have only a negative incentive to cut services. Why is that?

Secretary CALIFANO. No; I do not think we have a negative incentive to cut services.

The same 9-percent cap applies to a hospital whether its patient load increases by 2 percent or decreases by 6 percent. Part of that is

a judgment made in scores of reports of this subcommittee and elsewhere, that there are too many people being admitted to hospitals that should not be admitted to hospitals.

Second, if the patient load increases from 2 percent to 6 percent, we will pay 50 percent of what would have been the full cost of a patient before. Because 50 percent is what appears to be the incremental cost of additional patients from 2 percent to 15 percent. So there is no penalty—from 2 to 15 percent we will pay the actual cost, nothing on top of the cost.

If the patient load increases above 15 percent, then the hospital can come in for an exception. I think it is going to be the most extraordinary circumstance in which any hospital that is more than 2 years old is going to have that kind of an increase in load. And if they do, they can come in for an exception and justify it.

New hospitals, with 2 years or less, which do not have that kind of experience, will not have these kinds of problems.

So I do not think that kind of incentive is built in. And if, in terms of giving better quality care and better services, there are incentives for the administrators to get—to take money they save from having patients in the hospitals that do not belong there, or other savings, and put them into better quality care, because they can keep it down to 6 percent below the 100.

Senator SCHWEIKER. But is not the incentive there to freeze the patient load? In other words, if a hospital knows it will make more money if his patient load does not vary any more than 2 percent on one side or 6 percent on the other, an administrator looking at profit and loss would then decide that he ought to stay within that range to insure maximum profitability. All of a sudden, profit becomes a prime motive as opposed to service.

Secretary CALIFANO. I hope that profit is not the prime motive. I think $1 billion—doubling profits over the last 5 years—is one of the areas of fat.

But the incentive——

Senator SCHWEIKER. But you make it a prime motive when you have a cap.

Secretary CALIFANO. I do not think so, Senator.

Senator SCHWEIKER. You force them to consider profit when you have a cap.

Secretary CALIFANO. Force them to consider their revenues. Just as the PSRO's are becoming more and more effective in terms of examining the patients, and as we see more and more reports about the number of patients that do not belong in acute-care hospitals, as I indicated we pay $7 million a day in this country, $2.6 billion per year for patients who do not belong in acute-care hospitals and could be in lesser facilities.

Now, I would hope that our legislation provides incentives for doctors to look at that, as their hospital administrators look at it and move those patients into the kinds of care situations they should be in, whether they are nursing care facilities or home care or what else.

But I think $2.6 billion is a lot of fat in that area alone, and we have got the whole 9 percent cap only involves $1.9 billion in this first year. And I think there is plenty of flexibility, and I hope, as best as we can construct them with a cap, the right kinds of incentives.

Senator SCHWEIKER. As I understand your proposal, life safety code expenditures are not exempt. And obviously, with a cap, something has to give.

Why should we not be exempt from life safety code expenditures? Since they are required by HEW, why are they included under the cap?

Secretary CALIFANO. Because, Senator, we think that the $2.5 billion capital expenditure cushion will be more than ample to take care of that.

Senator SCHWEIKER. But again, it gets back to the individual hospital having to decide whether it needs some lifesaving equipment—just meeting the minimum standard. It has to choose, because of the cap, which is the highest priority.

Secretary CALIFANO. I have given $5 billion that anyone in the world would agree was absolute fat. I think there is plenty of room. I do not think the 9 percent in any way, one and a half times the rate of inflation, one and a half times what every other big industry in this country has to live with, I think they can easily meet those requirements.

And I do not think that hospitals should be relieved of those life safety code requirements.

Senator SCHWEIKER. On quality of care, as soon as you put on a cap, administrators are going to have to worry about profit and loss; and will they not begin to look at patients with that in mind? And it seems to me that expensive patients whose care entails a great deal of extra expense are now going to become a red flag to a hospital administrator because, with a cap, he cannot make ends meet. Now, the focus is on saving lives. But with a penalty for increasing, a penalty for decreasing, there will be a disincentive to give them maximum service.

Secretary CALIFANO. Senator, if Johns Hopkins, the hospital that is one of the finest hospitals in the world, with the most sophisticated equipment in the world, and with some of the finest hospitals in the world in Massachusetts, with the most sophisticated equipment in the world and the most expensive and finest services, can operate at 9 percent, I think that the rest of the hospitals of this country can.

And those hospitals that I gave you, 14 percent of those hospitals—14 percent of the hospitals with more than 4,000 admissions, many of whom are hospitals with sophisticated, superb equipment, as expensive as even the most proliferate, obese hospital could want, are operating at a 9 percent or less, I am not concerned about that. I really think the way has been shown, as I said, by many States.

I see Governor Dukakis out there. We have learned a lot from what he has done in Massachusetts, and that is one of the finest medical center States in the world, the medical centers in the country in the world.

Senator SCHWEIKER. The issue of technology, I grant, is a very key area for cost savings. And I grant that there is too much duplication and overlap. I think we are dickering over how we achieve limiting that technology.

What concerned me about the formula is this. Suppose a hospital has splurged on technology, and has all the latest equipment—probably more than it needs, and suppose you have another hospital

that is a little more conservative and does not have that kind of equipment. When you put a cap on both hospitals, the one that has played it conservatively is handicapped.

So you are immediately penalizing the hospitals, as I read the formula, that have played it conservatively and you are rewarding the hospitals that have grabbed every technology advancement in sight: because they are both given the same cap, and because one would have to spend a lot more money to catch up to what the other is doing.

Secretary CALIFANO. Senator, I do not think we are penalizing any hospitals. I think, as I said, 1½ times the rate of inflation, $2.5 billion in capital expenditures, the leeway up 2, or down 6 percent—there is no penalty here.

There is, as you indicate and as Senator Kennedy indicated earlier, the hospital that is charging $400 a day, which should be charging only $250 a day, is not caught in this proposal. Ultimately we have to have proposals sophisticated enough to trim that bit of obesity out. But we do not have at present the kind of data we need to move on that hospital. We need caseload data, we need wage-area data, and, in our judgment, we do not know a fair way of moving on that hospital. If you have a proposal that you think is fair, that will capture that hospital and drive him down, for example, from $400 a day to $250 a day, we would be delighted to include it in this legislation.

Senator HATHAWAY. Mr. Secretary, should we not require that all of the doctor's fees be billed through the hospital? Because, otherwise, if they are not, then the doctors could bill separately. There is no ceiling on what they could charge. There is no ceiling on the third-party payments to them. So the consumer is going to have to pay more regardless of the cap that you have got in this bill.

Secretary CALIFANO. Well, we looked at the problem of doctor's fees early in February, and in all candor, Senator, there were proposals made to me and to President Carter about doctor's fees. We felt that we did not have enough information and enough data to do that in a fair way.

What we are capturing in this legislation is 40 percent of the health care costs, and we are capturing it in the most aggravatedly inflationary sector of health care, the hospital industry.

I am not sure that we are wise enough at this point to devise a way to put a lid on the doctor's fees right now as part of this legislation.

Senator HATHAWAY. I am not saying to put a lid on the fees, but just make sure that the fees are billed through the hospital, and then there would be some pressure on the hospital for the doctors to keep their fees down. It would not necessarily limit them, I do not favor putting out tables of how much should be charged for each procedure.

But if they had to be billed through the hospital, then the 9 percent cap applies to them, so there is going to be some pressure applied to keep their fees down.

Otherwise, there will not be.

Secretary CALIFANO. I think it——

Senator HATHAWAY. I imagine including physician fees would make up quite a chunk of the total individual's medical cost.

Secretary CALIFANO. I think there may be cumbersone administrative problems associated with that. At this point in time, I understand the objective, and the objective is certainly a worthy one.

Our hope is to enact this legislation as promptly as possible, so that we can stop something simply without any administrative burden on the hospitals that will bring under some semblance of control, at least at one and a half times the rate of inflation, this riot in the increase in costs in the health care industry.

Senator HATHAWAY. Well, I think, I will offer that amendment to the bill, to make sure that they are included at least for all of the hospital costs attributable to the doctor. I am not talking about his fees for private consultation in his own office, but certainly those fees that are billed to patients in the hospital should be included in the cap and be billed by the hospital.

Senator SCHWEIKER. Mr. Secretary, I was a little confused on the response you gave on paperwork. As I understand your proposal. if the patient load increases over 2 percent, it has to file for an exemption, if it decreases more than 6 percent, it has to file for an exemption. If it decreases more than 15 percent, there is no reimbursement at all and there is another form to file, and if it increases over 15 percent, the same thing happens.

If the character or capacity of the hospital substantially changes, you also file an exemption.

Now, why is this not a horrendous amount of paperwork?

Secretary CALIFANO. Well, Senator, let me just go back. Medicare already collects the data necessary to deal with the down to 6 percent and 2 to 15 percent, and that is going to capture an overwhelming percentage of the hospitals. I will give you the exact percentage, but it is well over 90 percent of the hospitals that are not going to vary up more than 15 percent or down below 6 percent from one year to the next.

[The material referred to follows:]

PERCENTAGE OF HOSPITALS FILING ADJUSTMENTS UNDER MEDICARE

Adjustments to allowable revenues for large hospitals that had changes in patient load of no more than 15 percent in either direction would be automatic. For small hospitals, all changes in patient load would be treated automatically. Thus, for about 97.3 percent of all hospitals, no new papers would be required, and the necessary calculations could be completed by the Medicare intermediaries based on information they already collect.

Secretary CALIFANO. And there is no need to file anything then. Medicare picks that information up right now.

When you go beyond that, when you have that much of an extraordinary move, we think, in fairness to the hospital, we ought to permit them to come in and file for an exception. If you are not beyond those extremes, you do not have to file a single piece of paper that is not being filed today.

I do not think it would be fair to the hospitals to have a piece of legislation that said to them: There is no circumstance under which you can come in here and apply for an exception; and I do not think it would be fair to the taxpayer and the public if we administer the program and just let them determine for themselves that everything above those extremes—I do not think there will be much; for 90 percent of the hospitals, they will not even notice this provision, except in more efficient, better service to their communities and their constituencies.

I would be pleased to submit for the record, further information on administration of the plan.

[The material referred to follows:]

The so-called "complexity of administration" of title I of the bill is a bogus issue. The calculations involved can be made by a reasonably adept elementary school student in minutes or in seconds on a $5.88 calculator. The percentage by which reimbursement or charges may exceed comparable 1976 revenues can be determined by anyone who can multiply and divide several figures already being reported by the hospital to the Medicare intermediary.

The percentage for the first affected year can be determined as follows:

Step (1): Divide the increase in inpatient cost per admission reported to Medicare for the hospital's accounting year ending in 1976 over the amount reported for the year ending in 1974 by 24.

Step (2): Multiply the result obtained under step (1)* by the number of months elapsing after the close of the hospital's 1976 accounting year and prior to the start of the cost containment program on October 1, 1977.

Step (3): Estimate the rate of change in admissions in the first accounting period ending after September 30,

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* But not less than 1/2 nor more than 1 1/4 percent.

1977 as compared to the accounting year ending in 1976 and select the appropriate adjusted limit from the attached table.

Step (4): The adjusted limit determined under step (3) is multiplied by the number of months elapsing from the start of the cost containment program to the end of the first accounting year ending after September 30, 1977.

Step (5): The result obtained under step (2) is added to the result obtained under step (4). This sum is the percentage by which reimbursement by any cost payer or charges by the hospital may exceed comparable 1976 revenues per admission.

Illustration

Accounting Year Ending	Number of Admissions	Total Inpatient Cost
6/30/74	5,000	$5,000,000
6/30/76	5,000	$6,200,000

Assume no increase in admissions in 1977-78 fiscal year.

Step (1): $\frac{\$1240 \text{ cost per admission}}{\$1000 \text{ cost per admission}} = 1.24$ or an increase of 24%

24% ÷ 24 = 1%

Step (2): Number of months between 6/30/76 and 10/1/77 or 15 x 1% = 15%.

Step (3): Since the number of admissions is unchanged, the factor selected from the table would be 3/4 of 1 percent on a monthly basis (same as 9% on a yearly basis).

Step (4): Number of months between start of cost containment with October 1, 1977 and the end of the first affected accounting year or June 30, 1978 or 9 x 3/4% = 6 3/4%.

Step (5): The 15% from step (2) is added to the 6 3/4% from step (4) to set a limit of 21 3/4 percent on increases in reimbursement and charges per admission in the accounting year ending in 1978 over the accounting year ending in 1976.

Of course, as the transitional cost containment provision goes into its second, and possibly, third year of operation, additional factors will need to be selected from the tables promulgated for those years and additional months will need to be counted up and multiplied by these factors. This will add minutes to the calculation (seconds on the $5.88 calculator). I should also point out that if the hospital requires a modification of limits to pass through wage increases of non-supervisory workers or is granted an exception it will have to furnish figures for the calculations that are not normally reported for Medicare purposes. However, once the new data is substituted, the calculations are as simple as those described above.

(I note in passing that what is involved is far simpler than most income tax calculations and child's play to the hospital and intermediary people who deal with the hospital cost reporting system itself.)

I will also freely admit that a hospital's ability to predict its revenue in advance will depend on its ability to predict the number of patients it will serve. We believe that sound estimates of admission loads are an essential element of sound hospital administration and that sound estimates of admissions can be made under normal operating circumstances. Where such estimates cannot be made, the administrator will be uncertain as to the revenue he will realize whether or not there is cost containment legislation.

The Medicare intermediary would calculate the allowable percentage increase as described above, using its best estimate of expected total admissions, and adjust the percentage periodically as actual experience developed.

This would be part of the present process by which the intermediary sets and adjusts interim payments to the hospital pending final settlement after the close of an accounting year.

The percentage figure used by the Medicare intermediary would be furnished to all other cost payers for their use and to the hospital for use in controlling charges per admission. Thus, from the hospital's standpoint, it would continue to receive interim payment from cost payers based on estimates and subject to final settlement after the close of the accounting year. The only new task for the hospital would be to divide its cumulative inpatient charges by cumulative inpatient admissions from time to time to assure that average charges per admission were not in excess of the limits. This simple procedure will alert the hospital whenever there is need to adjust charges or change utilization practices to bring them into compliance.

TABLE I - - LARGE HOSPITALS
(Hospitals with more than 4000 admissions)

Percent Change in Admissions From Base Year (accounting year ending in 1976)	Adjusted Inpatient Hospital Revenue Increase Limit (expressed on monthly basis)
Minus 16 percent	By exception only
" 15 "	1.8721
" 14 "	1.8062
" 13 "	1.7419
" 12 "	1.6790
" 11 "	1.6175
" 10 "	1.5574
" 9 "	1.4986
" 8 "	1.4411
" 7 "	1.3849
" 6 "	1.3298
" 5 "	1.2281
" 4 "	1.1285
" 3 "	1.0309
" 2 "	.9354
" 1 "	.8418
0	.7500

TABLE II - - SMALL HOSPITALS
(Hospitals with 4000 or less admissions)

Percent Change in Admissions From Base Year (accounting year ending in 1976)	Adjusted Inpatient Hospital Revenue Increase Limit (expressed on monthly basis)
Minus 16 percent	2.1558
" 15 "	2.0858
" 14 "	2.0174
" 13 "	1.9507
" 12 "	1.8854
" 11 "	1.8216
" 10 "	1.7593
" 9 "	1.6484
" 8 "	1.5399
" 7 "	1.4337
" 6 "	1.3298
" 5 "	1.2281
" 4 "	1.1285
" 3 "	1.0309
" 2 "	.9354
" 1 "	.8418
0	.7500

TABLE I - - LARGE HOSPITALS
(Hospitals with more than 4000 admissions)

Percent Change in Admissions From Base Year (accounting year ending in 1976)	Adjusted Inpatient Hospital Revenue Increase Limit (expressed on monthly basis)
Plus 1 percent	.6601
" 2 "	.5719
" 3 "	.5295
" 4 "	.4880
" 5 "	.4472
" 6 "	.4072
" 7 "	.3680
" 8 "	.3295
" 9 "	.2917
" 10 "	.2546
" 11 "	.2181
" 12 "	.1823
" 13 "	.1471
" 14 "	.1126
" 15 "	.0786
" 16 "	By exception only

TABLE II - - SMALL HOSPITALS
(Hospitals with 4000 or less admissions)

Percent Change in Admissions From Base Year (accounting year ending in 1976)	Adjusted Inpatient Hospital Revenue Increase Limit (expressed on monthly basis)
Plus 1 percent	.6601
" 2 "	.5719
" 3 "	.5295
" 4 "	.4880
" 5 "	.4472
" 6 "	.4072
" 7 "	.3680
" 8 "	.3295
" 9 "	.2917
" 10 "	.2546
" 11 "	.2181
" 12 "	.1823
" 13 "	.1471
" 14 "	.1126
" 15 "	.0786
" 16 "	.0005

Senator SCHWEIKER. As I listen to the points you are making this morning, Mr. Secretary, I gather the two areas of greatest cost increases are unnecessary hospital admissions and technology—whether it is duplicative or unnecessary.

My question is: Instead of using a cap, why not use a peer review system, based on how long people stay and whether it is unnecessary.

And, No. 2, why not put even more teeth into the HSA's, where the technology is allocated on a regional basis. That way, it seems to me, you are going after both factors which you are concerned about—rightly concerned about—but without the ceilings and inflexibility.

Secretary CALIFANO. I do not think it has much inflexibility here, because we are leaving it to the hospital administrator to be flexible in however he reaches his point.

I think part of what we are doing is putting more teeth in the HSA's by giving them some of the authorities they are going to get within this legislation, and I do not think the PSRO's are well enough developed and finely enough tuned at this point to bring this about.

And we are talking about going from $55 billion today to $100 billion 5 years from now, to $220 billion 10 years from now. And certainly in that brief period of the next several years, I think it would be irresponsible not to get some lid on hospital costs.

I do not want to be the Secretary of HEW who presides over the years in which workers started working 1 month a year and turning over one-twelfth of his work to the hospital industry, when now he is already turning over 2 weeks a year to the hospital industry.

I think we have got to put a lid on now. And I think that we are doing it in a fair and generous way, and a way that will work and a way that leaves as much flexibility as we can out there with the hospital administrator, to determine among the various choices, and with the HSA's.

Senator SCHWEIKER. Thank you, Mr. Secretary.

Senator KENNEDY. Just a final comment, Mr. Secretary.

We have talked about the technical aspects of it and we have talked about figures and utilization review and HSA's and other implications of this cost program; but I think you put it best when we tried to bring it back into the human aspects.

What we are talking about is that if we do not take these steps, I think we delude ourselves into thinking that there are not going to be significant additional taxes.

Second, in the Senate there is under the budget resolution a certain amount allocated to the health area, precision. And we have seen in recent years a cap on a variety of different preventive health programs and health education programs. You will see cutbacks in the areas of mental health, maternal and child health care, drug, and alcoholism programs and the neighborhood health centers program—all programs that reach out in terms of the community while we see an explosion in many of these other areas.

And I do not think that we can divorce these particular factors. We just have to come to grips with these particular kinds of tradeoffs. Otherwise, we are going to be, I think, ignoring a very essential and important aspect in terms of the health of the American people.

I think, as you mentioned earlier, this is a temporary measure, and we are going to have to deal with it in a comprehensive way. There are still, obviously, issues that trouble members of this committee, but it seems to me that we are really talking about the human aspects of the health care issue here, even though we have been wrestling around with the dollar-and-cents and the procedural aspects. We must never lose sight of that.

I know that is a matter of concern to you. We are looking forward to working with you on the issue.

I want to thank you very much, Mr. Secretary.

Secretary CALIFANO. Thank you, Mr. Chairman.

[The prepared statement of Mr. Califano follows:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

STATEMENT

BY

JOSEPH A. CALIFANO, JR.

SECRETARY OF HEALTH, EDUCATION, AND WELFARE

BEFORE THE

SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

COMMITTEE ON HUMAN RESOURCES

UNITED STATES SENATE

May 24, 1977

Mr. Chairman, the Health Subcommittee has long been a leader in identifying emerging problems in our health care system. I want first to pay tribute to that leadership role because this Administration is fortunate in being able to build on the foundations which you, and other committees in the Congress, have set in place.

I appear before you today to urge enactment of the first major health care initiative of the Carter Administration -- the Hospital Cost Containment Act of 1977.

This Subcommittee understands the complexity of this nation's health care problems well. Indeed, like the many-headed hydra, the health care industry seems capable of generating problems faster than they can be addressed. These problems are truly severe.

Millions of Americans have inadequate health insurance or none at all.

Millions of people have inadequate access to health care.

Our health resources are irrationally distributed.

As a nation, we place far too strong an emphasis on institutional care and far too little emphasis on primary and preventive care.

Inflation in the Health Care System

But today the most pressing problem vexing the health care system is our inability to control rapidly rising

expenditures, especially hospital costs. These skyrocketing costs are reflected in a merciless rate of inflation -- now more than two and a half times the national rate -- that has been at intolerably high levels for years.

Across the nation our citizens have come slowly to realize the threat such inflation poses to their security. Public opinion polls indicate that rising health care costs are among the top three domestic concerns of the American people -- even ranking ahead of rising energy costs.

I could recite a statistical litany to illustrate the point. But let me just summarize the problem by noting a few stark facts.

If we take no action now:

- Total health expenditures will double between 1975 and 1980.
- Hospital costs paid by Medicare and Medicaid will double even sooner.
- Private insurance premiums for hospital care will more than double between 1975 and 1980.
- If unchecked, total hospital spending could reach $220 billion by 1986.

We recognize fully that both government and the private sector have helped create the problem of rapidly escalating hospital costs by giving too little attention to the relationship between the methods of paying for hospital care and the inflation in hospital costs. We have created financing and reimbursement methods that shield consumers from the actual costs of the care they receive.

Indeed, more than 90 percent of hospital care today is paid for, in roughly equal shares, by government and private programs. Less than 10 percent is paid for directly by individual patients. Moreover, both the public and private programs reimburse on the basis of incurred costs or unquestioned charges and thus respond automatically to whatever the hospital does to increase its costs.

In essence, therefore, no one is in control of the costs generated by a hospital under present reimbursement systems.

The patient seeks care but has little control over the services he gets. The physician does direct the services given to patients but has little knowledge or control over the cost of those services he orders. Although the hospital administrator controls the unit costs of services, he has little control over the kind and amount of services rendered to patients. The third-party payors only assert control by raising premiums or taxes to meet ever-increasing costs.

Thus, in the hospital industry there are simply none of the normal financial incentives or constraints that other public and private endeavors must face -- including other life and death services like police and fire protection.

Listen to the words of a hospital comptroller:

> "I'm a fiscal person, not a moral person. If insurance is going to pay my costs, what do I care how much they're going to run up? Or if you look at it another way, what's in it for me to keep the expenses down? Nothing."

No clearer or more concise statement of the problem could be made.

Hospitals have thus been responding to an irrational system. If they perceive society as being willing to pay any price for whatever is labelled as improved health care, it matters not whether more care really means better care. If they perceive the American people as ready to load up the health care delivery system with every new gadget and procedure -- whether or not there is any solid evidence of its value -- it matters not that we starve programs designed to prevent illness in the first place.

Mr. Chairman, we must start now and we must start boldly to reshape the health care system. The Hospital Cost Containment Act of 1977 is the first step in that direction.

President Carter and this Administration are committed to the development, enactment and effective implementation of a sound national health insurance program. The President reiterated that pledge in his recent address to the United Auto Workers Convention.

But we are convinced that before national health insurance can be fully implemented, we will have to develop and put in place fundamental reforms in the health care delivery system, including reforms in the way in which hospitals and other providers of care are paid. We are now working in the Department on both fronts -- to develop a national health insurance program which can generate widespread support and to develop systems of reimbursing providers which will change the perverse incentives now at work.

We also have in place a number of provisions and programs that over time can help curb hospital costs -- utilization review and Professional Standards Review Organizations, health planning and certificate of need requirements. We also have initiatives in the areas of consumer information and education and community prevention. In addition, a number of State rate review experiments are underway as provided in Section 222 of the 1972 Social Security Amendments. And we intend to administer these laws more effectively and efficiently.

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Nonetheless, the combination of available instruments still leaves us with only a piecemeal, disjointed strategy, which is not directed at the fundamental cost and delivery problems in a comprehensive and coordinated manner.

Unfortunately, major changes in methods used to pay for health costs will take two to three years to implement fully. We presently lack both the necessary data to develop such plans in detail, and the necessary knowledge to guarantee effective and equitable implementation.

But this nation simply cannot tolerate a rate of inflation over those two or three years that will add almost another dollar of costs for each dollar we now spend. It would be irresponsible, in my judgment, to continue wasting the taxpayer's health care dollar while we develop longer range, permanent solutions to restrain and properly channel health care expenditures.

Hospital Cost Containment Act S. 1391

The proposed legislation is designed to stem the rate of increase in hospital costs on a transitional basis. It contains the following basic provisions:

- Increases in total hospital revenues would be limited to an annual rate of about 9 percent beginning October 1977.

- The program would cover the inpatient revenues of about 6,000 acute-care and specialty hospitals, but exclude long-term and chronic care and new (less than two years old) hospitals, as well as those obtaining at least 75 percent of their revenues from Federally defined Health Maintenance Organizations (HMOs). Federal hospitals would not be covered directly. However, the President has pledged to apply rigorous cost containment to Federal hospitals as a part of his budgetary review.
- The basic limit would be set by a formula reflecting general price trends in the economy, with an increment for increases in services. The system would include adjustments for major changes in patient load, with exceptions for unusual changes in services or facilities.
- Each cost-based third party payer would apply the limits in interim and final payments, and would monitor hospitals for compliance with respect to its own subscribers. The Medicare intermediaries would monitor total charges. Thus, Medicare, Medicaid and Blue Cross would be working with the hospitals throughout the year to minimize the need to recover overpayments after the year's end.

- There would also be a national limit on new capital expenditures by acute-care hospitals, set at $2.5 billion. This should be sufficient to support needed maintenance or conversion activities as opposed to construction of unneeded new beds, plus gradual expansion of hospital equipment. These limits would initially be allocated to the states on a population basis. The program also would limit net increases in hospital beds in areas already well in excess of hospital bed needs -- those with more than four beds per thousand population or less than 80 percent occupancy.

This bill includes provisions to assure that hospitals will continue to carry their charity patient load and will disclose the information necessary to allow for informed choices by consumers and other interested parties.

We also recognize the importance of efforts in certain states that have undertaken their own cost containment initiatives. Hospitals in states that have strict cost containment programs and that meet other specified conditions may be excluded from coverage under the Federal program.

In addition, the bill encourages communities to reorient their priorities for services and facilities. Financial

incentives are included to reward hospitals that reduce excess capacity or eliminate unnecessary services, as agreed upon by the health planning bodies. Hospitals also would carry forward any allowable revenues they did not spend in a given year, thus avoiding any incentive for the 9 percent ceiling to become a floor.

The program will be simple to administer and will require no new reporting forms, audits, or monitoring programs over and above those already established under existing third-party payment mechanisms. Only if a hospital asks for an exception would a new form or new data be required.

In addition to proposing the hospital cost containment program, I am taking a number of administrative actions which will supplement the legislation. At President Carter's direction, I have begun to examine closely all Federal regulations which hospitals say increase their costs. I will consult with the relevant Federal departments and agencies to weed out conflicting and unnecessary Federal regulations and to have all proposed regulations evaluated for their effects on hospital costs.

We will also be working to develop acceptance of a single reimbursement form which all third-party payers could use. This action alone would save $120 million according to the hospital industry.

We believe the hospital cost containment proposal would significantly improve our present health care system. We are convinced it is workable, is equitable to the hospital industry in this nation, will allow us to devote more adequate resources to other pressing health needs, and will be strongly endorsed by the American people.

Objections of the Health Care Industry

In developing the Hospital Cost Containment Act of 1977, we consulted closely with the Congress -- including this distinguished Subcommittee -- and with a wide range of provider, insurance, consumer and industry representatives.

We have taken great care that the legislation will treat hospitals fairly, without affecting patient care, and will build the foundation for a permanent hospital payment system. It will not give unnecessary bonuses to high-cost, inefficient hospitals, nor will it penalize those that have acted responsibly in the past. Those hospitals choosing to come to grips with long-run problems will, in the end, fare the best.

Our hospitals are varied -- large and small, teaching and non-teaching, urban and rural. Yet, despite this diversity, all types of hospitals have experienced similar rates of increase in hospital costs over the last few years. Slowing this rate of increase uniformly for all hospitals is the most equitable transitional, short-term approach.

We recognize, however, that there will be cases where hospitals have unique problems. That is why we propose an exceptions procedure to take care of special considerations and why we include several automatic adjustments to handle other problems that may affect some hospitals, such as changing patient loads and larger increases in the earnings of low paid hospital workers.

Despite claims to the contrary, the restraint we are requesting is modest. It can work.

Several states, including the State of Massachusetts, have been successful in slowing increases to the rate we are requesting. More than one-fifth of all hospitals have experienced cost increases of less than 9 percent according to the latest available data. These are hospitals of all types spread throughout the country. Thus the experience of the hospital industry itself convinces us that our goal is realistic and it is achievable.

Some charge that we are proposing a system that will be complex to administer. But a hospital administrator or third party payor could comply with this program by performing just a few calculations using data routinely reported to the Medicare program. The calculations should not take more than 10 minutes by hand. Using a

$5.88 pocket calculator, they take far less time. It simply will not be difficult for administrators to monitor their progress -- examining charges, revenues and admissions -- periodically throughout the year.

Some have argued that any slow-down in the rate of hospital cost inflation can only occur at the expense of quality health care. This objection is without basis in fact and should be seen for precisely what it is -- a baseless attempt to play unfairly on the American peoples' concern for decent health care and to continue interminably rising, unjustifiable increases in hospital costs.

We must all come to understand that in hospitalization "more" is not necessarily "better" but is, all too often, merely excessive and unnecessary. Many cost reductions can, if managed appropriately, actually increase the quality of care, and help the hospitals better serve the needs of their patients and the overall health care system.

The legislation we propose would slow the increase in hospital costs by $1.9 billion in the first year. In 1978 alone, there would be savings of $650 million in federal expenditures for Medicare and Medicaid. By 1980 these two programs would save $2 billion in federal dollars alone.

These are funds which can be better spent on child health, on preventive and primary health services for rural and

inner-city residents, and on improved benefits for our aged. Diverting expenditures from costly hospital care in order to tackle prevention and early treatment of conditions before they deteriorate to a point requiring hospitalization is essential to improving the quality of health care for all our people. Hospital cost containment is not just good health economics, it is a prescription for better health care for all Americans.

It should be emphasized that the Hospital Cost Containment Act of 1977 does not dictate to hospitals the specific ways in which they must live within this overall restraint on revenue growth, but instead allows each hospital complete flexibility in identifying those economies appropriate for its situation.

We have identified over $5.0 billion savings which could be achieved by hospitals without harming patient care:

First, according to the American Hospital Association's own data, community hospitals accummulated $1 billion in profits (or surplus revenues) that were put into hospital cash reserves in 1976. Nearly all of the reduced revenues which we are requesting could come from cutting out these surpluses for this largely nonprofit hospital industry.

Second, there are today about 240,000 empty beds in our community hospitals. At least 100,000 of these beds are absolutely unnecessary.

- At a maintenance cost of $10,000 to $20,000 per empty bed, the annual cost of 100,000 empty beds is $1 billion to $2 billion.
- Yet, in 1976, 27,000 additional beds were built in the United States at a construction cost of $2 billion.
- Our proposal would prohibit additional hospital beds in areas that already have more than 4.0 beds per 1,000 population -- the standard endorsed by the Institute of Medicine. As a positive incentive, a hospital closing beds with the approval of state and local planning bodies would be permitted to retain the allowable costs from those beds in its revenue base.

Third, there are now 700,000 people in the nation's acute-care hospitals. As many as 100,000 of them -- almost 15 percent -- do not need to be hospitalized and would be better cared for at home, in skilled nursing facilities, or on an out-patient basis. These patients are generating excess charges of $7 million per day just for operating costs, or $2.6 billion per year.

- Since our limit is on total revenues, a reduction in unnecessary admissions will automatically permit the hospital a higher

rate of increase in allowable revenues per patient. Thus hospitals would have an incentive to work with their medical staffs to reduce unnecessary hospital admissions.

- Changing these economic incentives to the hospital should help our existing utilization review and PSRO programs work more effectively.

Fourth, the Institute of Medicine released a study three weeks ago that strongly urged careful controls on the purchase and use of CT ("CAT") scanners, a sophisticated x-ray and computer diagnostic tool costing one-half million dollars or more. Currently, there are approximately 500 scanners in the United States with a total operating cost of $150 million to $250 million annually. At the rate that the scanners are being adopted, the bill for scanning could quadruple in just the next three years, with little noticeable change in the care of the American citizen.

- Our proposal would slow the purchase of redundant equipment by limiting new capital expenditures to about one-half the projected increases for new capital equipment and modernization.

Fifth, hospitals have not carefully examined their use of energy. A recent HEW study found that hospitals could reduce energy costs by up to 20 percent in the first year by reducing high water temperature, recycling air, improving

insulation, monitoring heating plant efficiency, and cutting use of nonessential equipment during peak hours. These measures would have saved $332 million if in place last year and could save nearly one-half billion dollars by 1980.

- Our proposal would give hospitals an economic incentive to institute energy-saving measures -- most of which can be achieved without major capital expenditures.

Sixth, use of expensive and often unnecessary therapies has increased rapidly in recent years. For example, individual hospitals report that as many as 25 to 30 percent of patients receive inhalation thereapy services. Estimated costs are $500 million annually. Yet there is limited professional evidence to support the widespread use of such procedures.

- Our proposal would encourage hospital administrators to work with their medical staffs to eliminate unnecessary services and tests. Allowable revenues from these services and tests would remain in the base. Since the limit is on increases in total revenues, hospitals would be permitted greater than 9 percent increases on other services to the extent that these tests are curtailed.

Finally, hospital costs would be cut substantially by not admitting patients several days before treatment, as is often

done now. Pre-admission diagnostic tests should be conducted on an outpatient basis. Friday and Saturday admissions should be eliminated if laboratory and operating facilities are closed on weekends.

- Our proposal would give hospitals an incentive to reduce lengths of hospital stay. Any reduction in stay results in an automatic increases in the allowable revenue increase on a per diem basis. Again, these changed economic incentives should strengthen our existing utilization review programs.

Toward Longer-Term Reform

As I have noted, the Hospital Cost Containment Act of 1977 is only the first, transitional step in developing a more rational strategy for controlling mushrooming health care costs. They very first section of S. 1391 would require the Secretary of HEW to submit to the Congress by March 1978 recommendations for more permanent reforms of the health care financing and delivery systems.

These recommendations will grow out of our national health insurance planning effort, already underway. They will address not only the need for changes in the economic incentives of hospitals, but recommendations for more fundamental reform of the entire health care system.

These reforms, and the overall cost containment strategy supporting them, must be developed around the following basic principles:

First, we must provide alternatives to costly institutional care -- whether in hospitals or nursing homes. Health maintenance organizations represent a major step in that direction, and we are pledged to assuring their viability.

Second, we must encourage the substitution of general primary care for more costly specialized care wherever that is possible without lowering quality standards, and we must make more efficient use of less expensive health care personnel. There is no valid reason why our most expensive service -- hospital care -- should continue to be the focal point of the entire health care system.

Finally, we must stress prevention and early treatment to avoid unnecessary illness, disability, and death.

But we simply cannot wait any longer to curb rising hospital costs. Unless strong action is taken now, hospitals will price the average American out of decent health care. Every day that we delay, hospital costs go up an astounding $20 million. The cost of national health insurance will be prohibitive, and there simply will be no funds available in the Federal budget to implement rational health insurance and other important health initiatives.

The Hospital Cost Containment Act of 1977 is the best alternative, under present circumstances, to the continued escalation of unnecessary hospital costs. I urge the Congress to pass this bill quickly as a first, and desperately needed step in the process of devising a permanent solution to the critical national problem of controlling health costs.

Thank you very much.

Senator KENNEDY. We are running into a real time problem this morning.

I want the record to show that Karen Davis was here this morning, as well. She has been very helpful to this committee in the past and has a great responsibility in this area, and we were very delighted to have her with the Secretary this morning.

We will welcome our next witness, the distinguished Governor of the Commonwealth of Massachusetts, who is here to speak in behalf of the Governors of this Nation.

Massachusetts has, as Secretary Califano discussed, one of the strictest cost control efforts in the 50 States; and, Governor, you must feel a great sense of pride in the fact that the Secretary mentioned specifically Massachusetts, and your leadership in terms of addressing this particular issue and how helpful it was in benefiting from the Massachusetts experience in fashioning the national program.

We welcome you here. We are interested in the experience of the Commonwealth, and we welcome you to make what comments you will, on whether this kind of program is feasible, whether you have seen it function and work, and whether it is going to be able to deal effectively with the problems of rising costs in the areas of hospitalization.

We are delighted to have you here.

STATEMENT OF HON. MICHAEL DUKAKIS, GOVERNOR OF THE COMMONWEALTH OF MASSACHUSETTS, ACCOMPANIED BY C. STEVE WEINER, CHAIRMAN, RATE SETTING COMMISSION

Governor DUKAKIS. Thank you, Mr. Chairman.

It is a great pleasure to be with you again this morning.

With me is Steve Weiner, who is the chairman of our rate setting commission, and is the guy in the Commonwealth of Massachusetts who is principally responsible for administering our hospital cost control program. And so if you or members of the committee desire additional technical information that I cannot provide, I would like to be able to turn to him from time to time and ask him to chime in, if that would be satisfactory with the committee.

I am delighted to be here today to testify on behalf of the National Governors Conference and the Commonwealth of Massachusetts on the rising cost of hospital care and on what we as a nation must do to get those costs under control.

You have before you an ambitious bill that has generated both controversy and skepticism. That should not worry you, for all important public policy initiatives are usually surrounded by controversy and skepticism. But the basic issues, Mr. Chairman, that this bill deals with have been swept under the rug long enough.

There are really two simple and very fundamental questions that must be answered here.

First, is the bill needed?

Second, can it work?

And if the experience of Massachusetts is at all instructive, then the answer to both of those questions is a clear and an unmistakable "yes."

First, is the bill needed? When I became Governor of Massachusetts in January of 1975, health-care costs, at least in my State, were skyrocketing out of sight. Our medicaid budget was increasing at a rate of 15 to 18 percent a year. Blue Cross and commercial health insurance premiums were increasing, at times by 40 percent per year; and Massachusetts experience in this regard, as I am sure the members of the committee know, was anything but unique among the States.

What was even worse, Mr. Chairman, however, was the thing that you mentioned at the close of Secretary Califano's testimony, and that is the serious and disturbing economic and social impact of these developments in hospital cost control. For, in order to keep up with the runaway cost of institutional care, we were forced in 1975 to slash other benefits to the poor and the elderly in our State and to severely reduce the scope of our medicaid program as well.

In the past, as the cost of health care for individuals grew, the financial burden was shifted. The expansion of Blue Cross and commercial health insurance, the introduction of medicare and medicaid, and the inclusion of health benefits as an employee fringe benefit were all designed to insulate the individual from the cost of care. But the problem we faced in 1975 in Massachusetts was that even the organizations who were asked to shoulder that burden—employers, government, union funds—could no longer tolerate the costs.

In short, we had to act, and we had to act quickly and decisively. For we could no longer tolerate a situation in which the major financing mechanisms—insurance, medicare and medicaid—simply accepted the existing patterns and agreed every year to ante up the higher costs.

And so we adopted what is generally considered to be the toughest hospital control program in the Nation.

That program involves three major elements:

First, a comprehensive hospital budget approval program.

Second, a stringent certificate of need process.

And third, a very comprehensive statewide health planning process established under Public Law 93–641, which is closely related and worked closely with our hospital budget control and certificate of need activities.

All three pieces of the Massachusetts program are reflected in the provision of the administration's hospital cost containment proposal: Title I's program for limiting revenue increases; title II's limitation on capital investment; and the allocation of capital resources based on planning process priorities.

Can such a program work? Can it restrain cost increases and begin to correct the resulting social and economic dislocations? Is it having any impact in Massachusetts, and is it likely to have any impact at the national level? Again, Mr. Chairman, the answer is an emphatic "Yes."

The Massachusetts budget approval program was enacted on an interim basis in 1975 and was made permanent in 1976. I can assure you that winning approval of that legislation was no picnic. In fact, politically it was one of the most controversial bills that I proposed during my 2½ years as Governor.

The hospitals fought us almost to the very end. But a coalition of business, of labor, of Blue Cross, and of insurance leadership, working

with legislative leadership and executive leadership, carried the day.

And in the end, even the hospitals themselves recognized the need to cooperate in establishing and implementing a reasonable cost-restraining program. For they acknowledged and understood finally that increasing public disaffection would inevitably lead to more dramatic and, from their perspective, even more disruptive cost control actions.

The Massachusetts program is similar in a number of respects to the bill before you. It establishes allowable annual increases in hospital revenues, and these increases are determined as a function of cost increases. The program allows a hospital to increase revenues if its costs have increased as a result of three factors.

The first is inflation in the economy generally, measured by a hospital composite price index which has, over the past few years, produced an inflation factor rather close to the consumer price index.

The second is a net increase in the volume of services provided by the hospital.

These two factors taken together produce rates of increase roughly equivalent to those allowed by the inpatient hospital revenue increase limit contained in title I of the administration's proposal.

There is also in our bill a provision for certain costs—such as those associated with insurance premium increases and new governmental requirements—by insurance premium increases, I mean insurance premium increases for the hospital, that is medical malpractice, that kind of insurance coverage—to be passed through in the form of allowable revenue increases.

The Massachusetts program, as currently administered, is somewhat more sophisticated and complex than the revenue containment proposed in the administration bill; but it is, in concept, quite similar. It proceeds from the basic assumption that effective public control over hospital costs cannot be acheived unless there is public review and approval of all sources of hospital patient-care revenue.

Senator KENNEDY. This is an important point, because, as I understand the principle of the legislative proposal, the Talmadge bill only covers the medicare and medicaid aspects of it; and in terms of reaching the expenditure of the hospital dollar, it is significant, but still it is only a percentage of the hospital dollar.

Governor DUKAKIS. That is correct, Mr. Chairman.

Senator KENNEDY. Your point is that if you are really going to deal with this, it ought to be comprehensive in those respects.

Governor DUKAKIS. Yes. With all due respect to Senator Talmadge, our experience in Massachusetts indicates that the other simply will not work. We had those kinds of controls, and we worked very hard to try to impose them and make them stick.

But, as you know, Senator, if a portion only of the industry's revenues and care is controlled, then it is very easy to simply cover those costs over——

Senator KENNEDY. They move it from the medicare and medicaid over to the private carriers.

Governor DUKAKIS [continuing]. To the private carriers, over to Blue Cross, other insurers and to private patients. And it just does not work, particularly when the problem is not simply medicare and medicaid, however much, those of us who are appropriating the funds for those purposes may be concerned about it, the problem is a health

cost bill to industry, which today, as you know, Senator, is costing General Motors more for its employees than the steel it is putting in its cars. And similar kinds of burdens on the economy generally, and on employers and employees, which go far beyond the burden that medicare and medicaid impose on the public treasury.

So, really, it is only by controlling total hospital patient-care revenue that the public can limit hospital expenditures and begin to slow down the inflationary spiral.

The program's implementation in Massachusetts was carried out smoothly and quickly. The Massachusetts Rate Setting Commission is required, under the law in our State, to take action on budget submissions of the hospitals within 60 days; and the commission has, I am happy to say, not once missed a 60-day deadline. And during this entire period there has not been a single appeal from any action taken by the rate setting commission with respect to a specific hospital budget.

Nor is there any evidence—and I want to emphasize this, Mr. Chairman—nor is there any evidence, in a State which is generally considered to be the capital and the center of medical care in the United States, that the program is forcing a deterioration in the quality of care rendered by the institutions. Quite the contrary.

I would suggest to you that in our State the arrival of this kind of legislation and this kind of control is forcing our health care institutions to plan together, to think more seriously about what they are doing in relation to the hospital down the street, and in general I think we are going to have a better health care system and be able to provide better health care to our people with this kind of legislation than without it.

Now, the impact on hospital costs has been dramatic. During really our first year of operation, while hospital costs rose nationally by nearly 16 percent, in Massachusetts we held them to 14 percent, and our latest information indicates that while this year the Nation's hospital costs are rising at an annual rate of almost 15 percent, Massachusetts is holding those increases to an annual rate of 10 percent.

And, Mr. Chairman, on a per-unit basis, the differential is even more dramatic. That is, if you were to deal with this on a unit cost basis, then the gap between the national rate of inflation and our own would be, if anything, even greater.

Senator KENNEDY. This is against a background where we have some of the most expensive hospitals in the country.

Governor DUKAKIS. Yes; we do.

Senator KENNEDY. Some of the best, obviously.

Governor DUKAKIS. Well, we have 16 teaching hospitals, which, as you know, is expensive business.

Senator KENNEDY. But we are talking about those hospitals meeting this particular standard as well.

Governor DUKAKIS. Yes; that is correct.

Senator KENNEDY. And that, I think, is a significant factor.

Governor DUKAKIS. Also, Mr. Chairman, I might add that recently our teaching hospitals have, for the first time, begun to meet together, to talk together, and discuss common problems in their planning process together, and I think most people feel that it has been this legislative framework that has impelled that kind of cooperation.

Now, I believe that our program has been successful for two reasons.

First, it built upon existing hospital capacities and did not require a radical change in the type of information that a hospital was required to provide.

Second, the operating rules of the game were stated clearly and explicitly, so that hospitals knew what their budget targets were. We strongly believe, at least based on our experience, that as long as a hospital knows in advance what the rules are, what its budget targets are, and what the limitations are, then it can adjust its actions to live within them.

And the administration's bill appears to incorporate both of these operating principles.

Now, the other components of our cost containment strategy, Mr. Chairman, are certificate of need and planning. An effective certificate of need program must, of necessity, incorporate and implement the results of a health planning process, and particularly planning decisions regarding the amount and the distribution of services.

The Massachusetts certificate of need program has now been operating for 5½ years, and while it has occasionally been the subject of political attack—I guess that is probably an understatement—it has clearly had a significant and beneficial impact on the cost of health care services in the Commonwealth. Denial of new facilities by determination of need can be credited in Massachusetts with saving some $344 million in the unnecessary construction of nursing homes and hospitals between 1973 and 1977. And not building or expanding those facilities means that we do not have to spend today an additional $174 million in medicaid expenses that it would have cost us during that time. And those, Mr. Chairman, are very conservative estimates.

However, even our Massachusetts certificate of need program suffers from one major deficiency. And that is its failure to relate planning decisions to the reality of the limited economic resources that are available for health care services. We are still attempting to define need without reference to overall economic constraints. And, as a result, the planning process tends to perpetuate the myth of an open ended system, a health system of unlimited resources to meet all needs.

For this reason, I strongly endorse the concept contained in title II of the administration's bill limiting new capital investment in hospitals to fixed annual dollar amounts. For, by clearly defining the extent of available resources on an annual basis, the bill will require the planning process to establish priorities among competing proposals and to force it to make the hard decisions among projects, all of which, according to somebody's definition, are "needed."

For all of these reasons, I hope that the Congress will ignore the cries of alarm that it is now hearing about the administration's bill. For our experience strongly suggests that these efforts, and in particular the control of hospital revenue levels, can have marked impact on the cost of hospital care.

Recent studies by the Blue Cross Association show that the rate of increase in hospital expenses and revenue per day over the past year has been significantly lower for Massachusetts and New England than for the Nation as a whole. And it is no coincidence, Mr. Chairman, that

New England has the highest concentration of statewide hospital budget review programs of any region of the country.

The success of the Massachusetts program also leads me to believe that Congress should amend the present bill to allow States which have not yet done so to impose standards stricter than the Federal requirement, if they so desire.

The administration bill allows a 9-percent annual increase in hospital costs, but if a State, like our own, wants to impose a ceiling of 6 percent or 7 percent it seems to me that discretion should be allowed without lengthy and difficult appeal.

That is the position of the National Governors' Conference, and I endorse it fully.

So the Massachusetts experience indicates that programs like those in the administration's bill are not only needed but that they can work and work effectively. They will not destroy the benefits of a good national health care system. Instead, these changes will improve that system by forcing it to develop its priorities for the first time. It will save literally billions of dollars that we need for other very important and desperately needed social tasks, and it will, Mr. Chairman, hasten the day when this Nation can adopt a comprehensive national health insurance system and at long last make decent health care for all of its people, a guarantee of national citizenship.

Thank you.

Senator KENNEDY. That is excellent testimony, enormously helpful to us, given the practical experience that you have had in dealing with this issue. And I think, coming from the Governors' Conference on this particular proposal, it is extremely important for us to have this testimony.

I quite frankly think that the recommendations of making the bill permit those States that want to deal with this particular issue in ways which are consistent with the thrust of the legislation makes a good deal of sense.

I think we should permit it.

I just have a few questions, Governor.

On the issue of quality, which is going to be debated and discussed, can we really continue quality health care with these kinds of limitations. I think you have given a very eloquent answer.

I think you have indicated that you feel that not only is quality maintained, but it may very well be being improved because of the interaction of the various groups which is now necessitated.

I think this is extremely encouraging.

What were the principal objections to your proposal when it was initiated, and during the course of the debate in the legislature? Have those objections really been adequately responded to over the period of the application of the legislation?

Governor DUKAKIS. Well, Senator, we had a lot of the same objections which you are hearing and have been hearing since the administration first indicated that it was going to propose this kind of legislation.

One of them, for example, was a genuine concern about the loss of administrative and fiscal and, for that matter, programmatic autonomy on the part of boards of trustees of hospitals and their administrators.

And that is a perfectly legitimate objection. I think all of us would prefer not to be constrained by government or anybody else, if it is possible, and if we can have a full measure of freedom to do what we think is best for the health of our people and anything else.

So, to the extent that this kind of legislation begins to draw boundaries around what hospital administrators and boards of trustees can do, this was a concern that was voiced loudly and often, and I cannot say that it is wrong. There is no question that we are restricting and constraining, to some extent, the traditional autonomy of the nonprofit hospital to do its thing as it sees it.

We had the kind of complaint that I am sure you have heard, and that was reflected in Senator Schweiker's questions of Secretary Califano, about paperwork, of stifling bureaucracy and over-regulation and that kind of thing.

I am not sure how serious that objection was, because, as you know, even today on medicare and medicaid the hospitals are, whether they like it or not, dealing with both State and Federal bureaucracies, and paperwork requirements and the rest of it. That is not an argument for doubling or tripling those requirements unnecessarily, but I think our major institutions these days are used to dealing with that kind of thing, and the information we require of them. In fact, we have a very simple form, Senator, which works very well and which is used now for our budget review process.

Finally, of course, is the issue of quality, whether or not imposing these kinds of caps and restrictions and limitations would affect quality. Again a perfectly legitimate concern, but one that I think so far has been answered by our experience.

I think those were the three major objections that we heard and that were repeated during the course of a very stormy year and a half.

Senator KENNEDY. Then you feel that they have been responded to in terms of practical experience?

Governor DUKAKIS. I do, and I think most hospital administrators today in Massachusetts would say to you that they are living within the new system, and that so long as it is administered fairly and effectively and responsibly by us that they can work with it and maintain and increase the level of quality.

Senator KENNEDY. Just a final question. How did you avoid the dumping of patients from some areas into the municipal hospitals or the charity hospitals, that would permit the hospitals themselves to correspond more carefully to the ceiling? Was this a problem?

Second, how did you deal with this equity issue, where some hospitals have seen sizable growth in terms of cost because they have been buying the new equipment and others have been tightening their belts? Senator Schweiker has asked questions about this. I have, too. How do you make sure that they are not going to be penalized? The richer hospitals that now have it, and the poorer hospitals that are trying to get it and provide these services are not going to be able to do it under your State administration.

Would you answer those two questions?

Governor DUKAKIS. I do not think we have seen much dumping, Senator, principally because we have one of the more generous medicare programs, as you know, in the country; and the fact that you take a poor patient does not penalize you on the revenue side, with one exception. And that is, as you know, one of the cuts that we had to

make in our medicaid program in 1975, before we drowned in it, was to eliminate medicaid reimbursement out of the State treasury for unemployable general relief recipients and acute care for them.

It was a terrible cut, it was one that we did not want to make. I hope one of these days we can restore it, when revenues are available; but what that has meant—and it has nothing to do with this bill—what that has meant is that the municipal hospitals have had to assume a greater responsibility for those kinds of patients because we cannot reimburse the nonpublic hospitals for their care.

And, as I say, it has nothing to do with the hospital cost control bill, it has everything to do with our inability to provide that kind of reimbursement, because of the runaway cost of health care generally.

So, as to the dumping, that really has not occurred, so far as I know, as a result of this particular bill.

Now, again, Steve Weiner may want to add something here, if you would like him to chime in; but I do not think we have seen any serious problem with respect to the hospitals that have all of the equipment and that are better supplied with that kind of thing than the other hospitals. I do not know what the pattern of hospital and health care is like in other parts of the country, but, generally speaking, you have various levels of hospitals; as you know, our great teaching hospitals in Massachusetts and the so-called tertiary care hospitals, and they are the ones that do the very complicated stuff, and need the very complicated equipment.

Community hospitals generally do not, and that makes sense, because not every hospital in the State needs a CT scanner, and I am sure you have been spending a lot of time on that kind of an issue, as I know you have.

So I do not think this has been a problem. Now, we do have, as I pointed out in my testimony, an exception clause in our bill which does permit the Commission, Steve, as I understand it, to make exceptions where in fact a need can be proved, proven for special kinds of equipment or a special kind of investment of some kind which clearly is needed in that particular hospital.

And we try to administer that fairly and reasonably. But, generally speaking, Senator, I think the trend in Massachusetts is toward a rationalization of the hospital system, toward an allocation of responsibilities between and among the various hospitals, which is a lot more sensible than it was a few years ago, and toward a system in which the teaching hospitals do those complicated procedures and handle the very difficult patients, and the community hospitals do a very good job in a somewhat more limited way of providing for basic community hospital care.

Senator KENNEDY. Senator Schweiker?

Senator SCHWEIKER. Thank you, Mr. Chairman.

Governor, we certainly appreciate your coming today, in view of your experience and knowledge in this area.

You said in your statement, "The second factor is a net increase in the volume of services provided by the hospital. These two factors taken together produce rates of increase roughly equivalent . . ."

Does that mean that if patient load increases in one of your hospitals there is not a penalty—you actually, to some extent, pass on the actual cost?

Do you deduct 50 percent of the cost of that increase. or do you pass through the entire cost?

Governor DUKAKIS. I would like Mr. Weiner to address himself to that, if he could, Senator. But we try to impose some disincentive as the volume increases, so that we are fairly responding to reasonable increases in volume without providing for an automatic passthrough.

Incidentally, this bill has to be looked at in conjunction with other parts of our medicaid management program in which we are very tough on unnecessary, administratively unnecessary days, in which we try to limit the length of stay, force the patients—force the hospitals, at the risk of losing reimbursement on the medicaid program, to move patients back home or in a nursing home. So, looked at together, these two things impose some very tough constraints on hospitals.

Now, perhaps Steve Weiner can deal with this in a more precise way.

Mr. WEINER. We do have something similar to the concept in the administration bill, in terms of a division between the fixed and variable portions of the volume increase. So that if the volume increase is beyond a certain percentage—in fact ours is even tougher, it is not 50/50, it is 60/40. And the hospital will receive only 40 percent of the additional unit cost increase beyond that point.

Senator SCHWEIKER. Where is the cut if it increases beyond that point?

Mr. WEINER. Well, we have a corridor concept there also. Currently it is at 5 percent on the increase side; 10 percent on the decrease side. We plan for the next set of reviews beginning this fall to decrease that to 3 percent up and 5 percent down.

Now, the major difference, I think, there is that we allow full unit cost in that corridor. If, for example, the volume goes up by 3 percent, we will allow the full unit cost increase before applying the fixed and variable relationship.

That is because at the point we put the system into effect, that was in fact the only formula we had available to use. We think, conceptually, it is probably wrong, and that the administration's approach in fact is preferable. Which is to say there should be no increase for the first few percentages up and down.

So, essentially, I think, philosophically we are very similar in our approach to the administration's concept. We are a little bit tougher on the amount of variable costs that will be allowed as increases continue.

Senator SCHWEIKER. Now, Governor, you do allow for some exemptions. I asked Secretary Califano why he did not allow an exemption for life safety code expenditures, some of which HEW requires.

As I read your statement, you do allow for government required expenditures unlike the administration's proposal. Is that right?

Governor DUKAKIS. Well, not exactly, Senator, because those life safety code improvements have to go through our certificate of need program.

Senator SCHWEIKER. I'm sorry, I couldn't quite hear that.

Governor DUKAKIS. Our certificate of need program first, and we may—and we review them intensively before they are approved.

Senator SCHWEIKER. Except that a hospital cannot get medicare or medicaid funding if it doesn't meet those requirements.

Governor DUKAKIS. No, but we make sure that what is being put into that hospital really is required by the life safety code.

Senator SCHWEIKER. We are just finishing a battle in Pittsburgh where a hospital was almost shut down because it did not meet the HEW requirements. So you still have to meet them.

Governor DUKAKIS. All I am saying to you is that we make sure that what the hospital is proposing to do to itself physically is in fact required by the life safety code. I mean, as you know, what the life safety code is and what it means and what it requires is a matter of considerable interpretation.

Now, once they go through that very rigorous review process, through our certificate of need program, then the Massachusetts bill allows that cost to be passed through. But we are very tough on those improvements, not because we don't believe in complying with the life safety code—we do—but because what it really requires is something that should and does get very intensive review before we approve it.

Senator SCHWEIKER. Except the State doesn't necessarily determine what that life safety code is; the Federal Government often determines it. That is why a Pittsburgh hospital was almost shut down.

Governor DUKAKIS. Well, I don't want to quibble with you, but the State does have some responsibility; it can grant waiver under certain circumstances. It is a flexible code in some respects.

Senator SCHWEIKER. I see you also pass on insurance premiums. This is quite a significant passthrough, as I understand what you are saying here, isn't it?

Governor DUKAKIS. Yes, but I hope you will bear in mind that our allowable revenue increase, under the Massachusetts program, is 5¼ percent, not 9 percent. So we are holding the hospitals to a much tougher standard on the revenue side than the administration bill is. Now, I suppose you can develop this in a way which best fits one's own perception of what is appropriate. I think the administration in effect is saying, well, we will allow a much larger revenue increase than Massachusetts does, but we won't grant exceptions for these kinds of increases. I think we prefer to go a tougher route on allowable revenue increases, but permit an exception for these purposes.

Senator SCHWEIKER. I am not criticizing the Massachusetts plan for having these pass-throughs. I think maybe we ought to look at them, particularly the life-safety factor.

Governor DUKAKIS. I understand that. I just want you to understand that in granting this kind of an exception procedure, we are doing so within a context in which our allowable revenue increase is much, much smaller than what the administration is proposing. And all I am saying to you is, that as you consider the bill, you have got two alternatives here: You can make the allowable revenue increase somewhat more generous, but eliminate these kinds of exceptions; or you can be much tougher and grant exceptions.

Senator SCHWEIKER. 2,000 patients in Pittsburgh were almost out on the street because their hospital didn't meet HEW requirements and HEW wouldn't give them the money to meet those requirements. Now, that was an unnecessarily inflexible position. I want to be sure we are not going to design a bill that results in that type of inflexibility.

Governor DUKAKIS. I would just add, however, that if you are going to allow the pass-through, then you ought to reduce the allow-

able revenue increase—that is all I am saying—because if you give them both, then what you are doing is going right back to the old inflationary game.

Senator HATHAWAY. What about pass-through for some personnel costs? Do you have that?

Governor DUKAKIS. We don't allow that, Senator, and it is interesting that at least in the context of the Massachusetts debate and discussion of this issue, that this was not one of our problems. The AFL–CIO statewide were very strong supporters of the bill; the hospital unions were neutral on it, in a kind of active way, if I can use the term—that was a conscious neutrality. It may be because we do allow in our composite index a factor which is designed to accommodate reasonable increases in wages.

But one of the things that is kind of interesting about what has happened in Massachusetts on the labor side is that because of that—and Steve and the people that were working on the bill had long discussions with the hospital workers' unions on this—the hospital workers' unions are now for the first time deeply involved in finding out what is going on financially with the hospitals, in which their employees are employed, and themselves engaged now in insisting that those hospitals be run efficiently, because to the extent that they aren't, they are denied wage increases which might otherwise come out of that inefficiency and waste. So that we think the hospital employees' unions are going to play an increasingly creative role in making our hospital system more efficient. And, as I say, we do include a factor in that index—but we don't allow an automatic pass-through.

Senator HATHAWAY. What do you mean—a 5 percent, whatever the inflationary factor is? Cost of living?

Governor DUKAKIS. Steve?

Mr. WEINER. Very briefly, instead of the GNP deflator, we use a composite price index in our system to determine inflation. With hospital costs we divide them into about 18 or 20 categories, and apply general economic indicators to each of the categories, weighting it, then producing a bottom-line total percentage increase to reflect inflation. In arriving at that bottom-line figure, four of the categories are wages and salaries, and we use general economic indicators—Bureau of Labor Standards, Bureau of Labor Statistics, kind of factors.

We have essentially told the unions in this case that while we have included in the composite index some estimate of increases for w ages and salaries, what we are giving the hospital is a bottom-line inflation figure, whether it be 7 percent, 6 percent, 8 percent, whatever. In arriving at the bottom-line figure, we have made some assumptions about the labor component, but if the unions wish to bargain for higher settlements, then, as the Governor indicated, the unions' responsibility is to look at the other 18 or 16 components and determine where the hospital can achieve savings from our other projections.

So it all balances out to the same bottom-line inflation figure.

And they have been very willing to accept that kind of responsibility.

Senator HATHAWAY. How do nurses' fees or income compare with other parts of the country, other large cities?

Governor DUKAKIS. We pay, I think it is fair to say, quite well in relation to the rest of the country, Senator; on the other hand——

Senator HATHAWAY. You are above average?

Governor DUKAKIS. Yes, we are above the average; on the other hand, we have an above-average cost of living, so I don't want to suggest that——

Senator HATHAWAY. Well, I mean on a comparable basis.

Governor DUKAKIS. I think we are at least comparable, probably a little better.

Senator HATHAWAY. I see. One last question in regard to doctors' fees. Is there any control over fees for various services provided by doctors?

Governor DUKAKIS. Not under this legislation. We do control them through our medicaid mechanism, so that with respect to medicaid——

Senator HATHAWAY. Why is it limited to medicaid?

Governor DUKAKIS. People have asked why or why not—I think there are a number of reasons. To begin with, at least as a percentage of our total health costs, doctors' fees are less important, at least proportionately, than hospital costs and nursing homes—I think we know that. Secondly, it would be an enormously difficult administrative burden to try to review every single doctor or even fee schedules doctor by doctor. And, finally, to the extent that control over the medicaid rates has some impact, if it does, on overall fees, I suppose we are injecting ourselves to some extent—but it would be a very difficult process to try to control those costs.

Senator HATHAWAY. They do it in Canada.

Governor DUKAKIS. Well, I am not ruling it out; I am only saying that we didn't do it.

Senator HATHAWAY. Do you find doctors billed outside rather than through the hospital after your plan went through?

Mr. WEINER. If I may respond to that, we have had generally a movement of hospital-based physicians away from hospital compensation onto a fee-for-service basis. The system adjusts for that automatically. As physicians move off hospital salary onto a fee-for-service basis, we reduced the allowable cost level for the hospital. The system is neutral with respect to that movement, although it has been occurring for other reasons.

Senator HATHAWAY. Does it cover nursing homes as well as hospitals.

Governor DUKAKIS. No.

Senator HATHAWAY. No?

Governor DUKAKIS. It doesn't, and the reason it doesn't, Senator, is because in this case control through the medicaid system is pretty effective, because the vast majority of folks in nursing homes are on medicaid, and so medicaid control really deals with that pretty effectively.

Senator HATHAWAY. Thank you very much, Governor.

Governor DUKAKIS. Incidentally, the same agency controls both; that is, Steve's ratesetting commission is also dealing with the nursing homes. So as a practical matter it is a unified system.

Senator SCHWEIKER. Do you make any provision, Governor, in your plan for teaching or training hospitals? Is that cranked in somehow or is that just judged as it comes up in terms of its acceptance?

Governor DUKAKIS. I don't think we make it as such, although starting from the base that we have started at, clearly that base reflects the fact that some 16 of our hospitals are teaching hospitals,

and, therefore, begin with a budget and revenues that are substantially greater than a community hospital, say.

Senator SCHWEIKER. Is the base related to an individual hospital rather than an aggregate or average figure?

Governor DUKAKIS. Yes.

Senator SCHWEIKER. Here we are relating it to a national average, which wouldn't quite solve that problem the way I think you are solving it, if I understand what you are saying.

Governor DUKAKIS. I don't believe that is what the bill does, but, Steve, you have looked at this bill.

Senator KENNEDY. In terms of cost? Is your cost of living the national average, or is it the State average? Ours is just the national average in terms of the increase in the cost of living. But isn't that the same as yours?

Mr. WEINER. It effectively comes out to the same thing. We use some regional statistics and some national statistics. But we looked, for example, at the relationship between our composite index and the Consumer Price Index, as one example. And it has been a little bit up, a little bit down, but basically very close for the last 3 years.

Senator KENNEDY. Could you tell us how you reached that conclusion?

Governor DUKAKIS. Be happy to. And, incidentally, Mr. Chairman, we would be happy to provide you with whatever information we can on the basis of our experience; I think it would be helpful.

Senator KENNEDY. OK. Governor, thank you very much. Your testimony was extremely helpful.

We are sorry that Mr. Mahon couldn't be with us today. Our next witness is Dr. Gehrig from the American Hospital Association who has been before this committee many times. I look forward to his testimony, and we will ask him to come forward, if you would, please.

Dr. Gehrig, do you want to proceed?

STATEMENT OF LEO J. GEHRIG, M.D., SENIOR VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, ACCOMPANIED BY ALLEN J. MANZANO, VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION; AND IRWIN WOLKSTEIN, ASSOCIATE DIRECTOR, WASHINGTON OFFICE, AMERICAN HOSPITAL ASSOCIATION

Dr. GEHRIG. Thank you, Mr. Chairman. I am Dr. Leo Gehrig, senior vice president of the American Hospital Association. With me today are Allen J. Manzano, vice president of the association, and Irwin Wolkstein, associate director of our Washington office. The AHA, as you know, represents more than 6,500 member institutions, including most of the hospitals of the country. We appreciate the opportunity to appear before you today in this hearing and share with you our views on S. 1391 and the larger issues related to it.

Mr. Chairman, I would like to summarize my written statement and ask that it be made a part of the record.

In considering S. 1391, I believe it is important for me first to review the reasons for cost increases; second, to review the fundamental problems we have with this legislation; and, third, to suggest some alternative courses of action.

The fact that hospital and health care costs are increasing at a rapid rate is not in dispute. Hospitals are concerned and have been working actively to restrain health care cost increases which are within their control.

In my testimony on pages 2 through 7, you will note that there are some six reasons for cost increases indicated. I would like to briefly touch on them.

First is the impact of general inflation. We have seen inflation throughout the economy as a whole, and this has impacted strongly on the costs of goods and services which hospitals must purchase to provide patient care. The Consumer Price Index has been used for comparing increases in hospital costs, but it is not appropriate and it does not reflect the hospital's market basket. Many of the items which hospitals must purchase to provide these services have risen much faster than the CPI.

The AHA has developed a hospital costs index and a hospital intensity index which are based on the price and the utilization of 37 service elements which are common in the delivery of care to patients. These more typically reflect hospitals' market basket. Using these indexes, we have found, for example, in analysis of the 15-percent rise in hospital costs last year, that about 10 percent of that rise was due to pure inflation. The remaining 5 percent resulted from an increased intensity and an improvement in the product. This intensification and improvement of services is a second important factor in increased hospital cost. The hospital product is a changing one. There has been development of increasing sophistication of technology and the ability to do more in a limited time. A day in a hospital today is unlike a day in the hospital 10 years ago.

Senator KENNEDY. That may very well be true, but we don't know what the health implications of that are.

Dr. GEHRIG. I think, Senator, one can debate that, but I think that one only need look at some of the activities, to view the fact very evidently that we are now doing things in both the prolongation of life, the relief of pain and suffering, that we couldn't do 10 years ago.

And I think it is well enough to challenge it in broad perspective. But I think it is also very defensible to say that hospitals, by these actions, are improving the quality of life.

Senator KENNEDY. Why aren't you doing that? Why don't you do an assessment in terms of the health implications, and why aren't we able to examine that from a public policy point of view in terms of these issues, in terms of what this new technology really means. No one questions that a day in a hospital today is a lot different from what it was 10 or 15 years ago, but it is not that different from the way it was down in the inner city or out in rural America.

To tell us that a day in the life of a hospital is a lot different today doesn't really help us very much—in terms of our responsibilities, of saying that we have decided that in this area of technology, this is what this particular equipment is going to mean in terms of improving quality of health, this is what it is going to mean in terms of infant mortality, expenditures in this area are going to improve the quality of health of the American people.

I think the fact that you are saying that a day in the life of a hospital is a good deal different—I don't find terribly persuasive. Maybe I don't see the argument.

Dr. GEHRIG. Senator, I am afraid today, with that position, I probably can't convince you, but I think it is very close that as we look at the research projects at the National Institutes of Health that are carried out in institutions like this across the country—are very busy in the clinical evaluation of the care that is provided to patients, both in terms of attempting to establish the fact that you are questioning, but also to attempt to move the frontiers of such technology further into the future.

But I think that important in talking about costs is the recognition that these changes have occurred, so that you are not comparing, as many do with the CPI, a pound of butter, which was the same 10 years ago, with a pound of butter today—and the change in cost is not reflective of either an increasing intensity or an improvement in the product per se.

The third, I think, that should be mentioned is manpower development—increases in physicians and other health manpower add significantly to the total health bill. It has been estimated by some——

Senator KENNEDY. Where does that show? How can you show that increased numbers of personnel have really improved the quality of health care? No question that you have increased dramatically the numbers of personnel in terms of the various hospitals—but how can you show us what that has meant in terms of improving health, and at what cost?

Dr. GEHRIG. Well, Senator, I think there are two thoughts. One, I am attempting to discuss reasons for cost increase. Now, you have taken me to the position of where has it helped. I think your support for the entire manpower development——

Senator KENNEDY. Well, that is not unrelated; you are not suggesting that they are unrelated, are you?

Dr. GEHRIG. No; not at all.

Senator KENNEDY. Well, that is what I am trying to direct your attention to.

Dr. GEHRIG. I think, Senator, your efforts in the development of health manpower in the physician grouping and many others, the concerns with regard to increasing manpower for National House Service Corps and rural coverage, the improvement that we have seen over the years in the specialization—are all evidences that improved manpower is having impact on health care.

I don't know how better to express it, but I think your own actions in legislation—and your analysis of the presentations that have been made by specialists in the manpower area from our own Government, as well as outside specialists, have very well borne out the——

Senator KENNEDY. Well, I appreciate the kind reference, but that really isn't what we have been driving at in terms of the fashioning of the health manpower or personpower. What we were driving at in terms of that is the fact that there is an enormous change and alteration between the GP's or the primary care function of 25 years ago to where it was 2 to 3 years ago. What we need in this country is the type of health person that is going to be available, both in the inner cities as well as in the rural areas.

But that doesn't get away from the central fact that in hospital after hospital there has been an explosion of just personpower generally—all the way through the hospital administration system. You have got an explosion of health technology, you have got an explosion

in terms of personpower, you have got an explosion in terms of medical procedures, you have got an explosion in terms of lab tests increasing from $5 to $15 billion in the last 7 years.

And I think somebody has to ask what the health implications of each and all of those are going to be in terms of proving it, or why in the world are we expending it—just because we can train more people or just because we have newer gadgets? And what we are asking, as you start off in opposition to the bill—is what you have done and what you are doing in terms of helping us in the Congress to make some rational judgments other than saying there has been some general kind of health care improvement. We are not arguing that old chestnut; we have been able to get the best health care—I have been able to get it; I have been able to get it right in this hospital.

But what we are talking about are these other issues, which I don't really see addressed in your statement.

Dr. GEHRIG. Well, I think, looking at the very comment you have just made—because your question to me, if I have understood it correctly is: "Has the addition of this manpower and their types contributed to the health care that patients receive?" And I think that one can simply state that procedures that are possible today and have been provided in many areas are procedures that are dependent upon this type of skilled and developed manpower.

Senator KENNEDY. The other side of that coin is, does a limitation necessarily mean there is going to be a diminution of the quality of health care? We have just heard the Governor of my own State talk about that factor, and how he believes that with the limitation there has meant an improvement of it.

Dr. GEHRIG. I think, Senator, you are not giving me the opportunity to provide a discussion first of why costs are what they are.

Senator KENNEDY. Well, maybe just on that point you can respond, and then I will let you take whatever time you want.

Dr. GEHRIG. Would you rephrase that question so I can be sure I am answering the right one?

Senator KENNEDY. Yes; you seem to suggest that more is better; that if we get more technology, more personpower, more tests, more everything, we are prolonging life.

I would turn that around—and say with the limitations that we have seen, that have been applied in one particular State—and there are other examples of it in other States—and the testimony that there has actually been an improvement in the quality of care, I don't see how you can respond to that particular point that has been raised by the Governor, that just putting the limitation in this explosion of different services and technology and also equipment and procedures—that there is a diminution of it, of the quality of health care.

Dr. GEHRIG. I must say, Senator, I did listen to the Governor's excellent presentation, and it seemed to me that from his experience 2 years—it was a little difficult for me to draw the conclusion flat out, as you appear to have, that the quality of health care is good—and that it in fact would in any way indicate what the impact of such an imposition 15 years ago might have been, because this building up of expertise, the additional manpower, the additional technology, is not something that happened in the last 2 years.

Much of it, as you well know, is a response to the recommendations of our own Government in the midsixties when there should be given,

by their own decree, more and better health care to more individuals in the United States. And I think hospitals are not defensive about the positive role that they have attempted to carry out in this.

But they appear now to be, in a sense, the bad actors in what I think in many senses is a positive action. If we take a look, there has been an extension of life lived in the United States in terms of longevity; there has been a diminution in the maternal and infant mortality in this country. So that these actions haven't been without some impact.

Senator KENNEDY. Well, you are quite prepared, on the one hand, to question the point that the Governor makes in terms of quality of health care, even after 2 years' experience, and yet you are not prepared, on the other hand, given the wealth of information and authority that you have, to indicate why life has necessarily gotten better in each of those particular areas.

I find it a rather convoluted suggestion where you say, well, we are not prepared to really categorize and say with more technology, with more personpower, with more tests, what these factors are going to mean, and if we had more technology in this area, this is going to be the health implication.

You are not prepared to at least qualify or quantify those particular matters in any way that would be standard, because, quite frankly, I have been, as you well know, listening to the same testimony for about 8 years in terms of the Health Committee. You are not prepared to do that; but, on the other hand, when you talk about the limitation, you don't have much hesitancy in suggesting, at least, that the Governor may very well be talking through his hat when he talks about the maintenance of quality of health care in terms of the Massachusetts hospitals, teaching hospitals, and medical centers.

Dr. GEHRIG. Well, Senator, I think we are talking about an extremely complex issue, and, as you point out, I can't draw conclusions very simply on impacts of health delivery. I have not suggested that I thought the Governor was talking through his hat; I merely stated that I didn't think he convinced me that the quality of health care had improved. My only thought is that I think, as we get into this discussion and we find that hospitals are dealt with with a meat-ax approach, that cutting back on the ability to finance services is in fact going to have a direct impact on service itself.

Senator KENNEDY. Excuse me just 1 minute. I want to say goodbye to my Governor.

[Brief recess]

Senator KENNEDY. OK, we will proceed.

Dr. GEHRIG. Thank you, Senator. I was discussing the impact of manpower development on costs, as we have seen them. And it has been, in fact, estimated by some that the addition of single new physician in fact adds about $250,000 annually to the total health bill—and this doesn't discuss its value. In the development of physicians as well as other health manpower, hospitals have been a very important and a necessary training location. Physician graduate training programs alone have added to the cost of hospital care, and such hospital care costs for stipends and fringe benefits alone appear amount to $1 billion annually.

Fourth, the capital costs involving modernization and maintenance of service capacity has accelerated more than the CPI because of the

changing nature of the facilities, the construction inflation, and the increasing costs of capital.

Fifth is the cost of government regulation. We do believe that government at all levels has added to the hospital burden by many regulations which we believe are not cost-effective—and I could go on to describe some of these in specifics.

Finally, there is an increasing expectation in demand for health services by our growing and aging population. Technological improvements are evident in our ability to treat disease, from intensive care units, for instance, to coronary care units, and such advances as organ transplants, cardiac surgery, and the medical management of many conditions which a short time ago eluded our therapeutic armamentarium.

Senator KENNEDY. Do we need all that open-heart surgery, all those hospitals?

Dr. GEHRIG. I wish I could describe it; I can only say that two folks very close to me have had bypasses in recent time, one of whom is in his upper 60's, and for both of those it was a very valuable operation.

Senator KENNEDY. Yes, but that is a nonanswer if I have ever heard one. What we are talking about is the number of hospitals in which open-heart surgery is being done. As I understand it, two-thirds of those do not even meet the minimum standard in terms of the numbers that ought to be practiced in order that there be quality open-heart surgery units.

And my question is, what is the Hospital Association, if anything, doing about this?

Dr. GEHRIG. Senator, you may recall in the health planning bill—and we are now speaking about excess units for cardiac surgery—we have supported strongly planning and certificate of need, and we would in no way defend the existence of duplicative resources. We have discouraged their implementation and we have stood forthrightly behind legislation to implement a strong certificate of need which we think is one of the direct efforts in covering services that are in a sense duplicative.

Senator KENNEDY. Well, how many have you recommended be closed?

Dr. GEHRIG. We have recommended any area in which there is an excess, they should be closed.

Senator KENNEDY. Well, can you tell us how many you have recommended that should be closed?

Dr. GEHRIG. No, I can't, Senator. As I have indicated, we have supported local planning in its determination of how many there should be and the nongranting of the certificate of need under any circumstance where it is duplicative and unneeded.

Senator KENNEDY. I am talking about the ones that already existed prior to the planning agency. Now, what are you doing? You know that there is unnecessary surgery going on, don't you? And that there are some that aren't competent to provide it?

Dr. GEHRIG. We have discouraged anything of this variety, Senator; as you well recognize, it is not our position to be able to regulate hospitals around the country. This is obviously a governmental function.

Senator KENNEDY. We are not asking you to regulate them. Can't you just point those out?

Dr. GEHRIG. I think the pointing out of excessive or unnecessary services is a community responsibility in which good planning should identify them. We do not collect the sorts of information that would permit us an appropriate judgement, depending upon community needs.

Senator KENNEDY. You already have those that are being practiced, and they are not meeting your own standards in terms of the numbers of surgical operations that ought to be performed in order to maintain quality. If I understand your answer correctly you don't think that you have any other additional responsibility to bring any kind of limitation on that?

Dr. GEHRIG. Our full support has been of the governmental function for local planning determination and certification of need. We do not have the criteria nor do we have the information that——

Senator KENNEDY. Well, do you think it is going on?

Dr. GEHRIG. I believe that there are areas that can be identified that it is going on, yes.

Senator KENNEDY. How many?

Dr. GEHRIG. We urge that it not go on. But I can't give you an accounting of where this may be, because I don't have the criteria to establish that.

Senator KENNEDY. Well, is it very difficult to know how many open-heart surgery operations are being performed. But if you just listen to the question on it—do you know how many hospitals there are in which open-heart surgery takes place?

Dr. GEHRIG. I can't tell you offhand, but we could provide it for you.

Senator KENNEDY. Well, ask your staff.

Dr. GEHRIG. At the present time, it is 571 hospitals across the country. This represents about 8 percent of hospitals.

Senator KENNEDY. All right, and how many procedures have taken place in those hospitals?

Dr. GEHRIG. I don't have that information. This is merely a listing of the types of facilities, services, and specialty beds in the United States; this is the sort of data that I have.

Senator KENNEDY. Well, would you be surprised if two-thirds of those hospitals are doing less than 200 cases a year?

Dr. GEHRIG. I would have no criteria by which to measure that.

Senator KENNEDY. Well, that is not a mysterious figure; It has been generally published. Why is it, that you have never heard of that figure before or that your own experience is that that is an unlikely figure?

Dr. GEHRIG. I do not have that knowledge, that two-thirds of the open-heart surgery units are inadequate.

Senator KENNEDY. Well, would you be surprised if that were the case, that of the number of hospitals that have open-heart surgery units, that two-thirds of them did less than 200? Would that be a shocking figure to you?

Dr. GEHRIG. I just don't know.

Senator KENNEDY. Well, if it happened, what would you say?

Dr. GEHRIG. Well, I would be inclined to hope that it had a greater utilization than that, but I would be inclined also to take a look at

location of unit. I think that if this group that you are talking about all occurred in areas where easily accessible care of this type could otherwise be provided—that gives me one reaction. The other is that I believe there are some areas in the country where such might well occur, and because of lack of other resources might well be appropriate.

Senator KENNEDY. And you don't feel that you or your organization have responsibility to help us in the Congress to find those particular factors out.

Dr. GEHRIG. Senator, I think, as we have indicated to you repeatedly on a host of issues, we would be delighted to work with you and provide you any information that we are able to collect.

Senator KENNEDY. Do you know what the standard for the thoracic surgeons is in terms of open-heart surgery, the number of procedures that ought to be practiced?

Dr. GEHRIG. I don't know offhand.

Senator KENNEDY. Well, I understand that they have strict recommendations in terms of the number of procedures that ought to be performed, and if you put that together with the information that is provided in terms of your own information on the number of units where that open-heart surgery is taking place—and apply those two factors together—it doesn't take a lot of interpretation to understand that there are a great number of hospitals where it is being done today and where it has no right to be done. But I guess we have to put those particular elements together.

Dr. GEHRIG. This, like so many of the areas of cost—and the impact that we have talked about—are a problem in which you, as Government, and government at all levels, and we are providers across the board—labor, management, and the public—are all going to have to have a role in attempting to deal with this sort of a complex issue.

I would like, if I may, Senator, to turn to pages 8 through 15 of my testimony, the "Hospital Cost Containment Act of 1977."

This proposal, S. 1391, doesn't consider the total of the health delivery system, but rather——

Senator KENNEDY. On the top of page 8 you point out that "It is our strong opinion that this bill is inequitable in design, wrong in concept, and impossible to administer." We find both the Secretary, who talked about the administrative problems, and the Governor who mentioned that as well——

Dr. GEHRIG. I was interested in——

Senator KENNEDY. Tell us what your problems are, why you believe it is impossible to administer.

Dr. GEHRIG. If you would let me give you some examples of the impossibility—and I would only refer that I think Governor Dukakis made very clear, as he talked of the Massachusetts plan, that this became an individual review mechanism for institutions. There was not only passthrough but consideration of exceptions on a much less meat-ax approach than what is proposed in this bill.

But if you take, for example, the Secretary's statement that increases in the total—and I would add inpatient revenues—would be limited to an annual rate of about 9 percent, beginning in October 1977—let me point out several factors about that that I think are totally wrong.

One, it is not really a 9-percent limitation, because it is applied really as an allowance of total inpatient revenues, and yet in its implementation it is also applied to each class of purchaser and if one is below 9 percent, less than 9 percent is allowed. I would suggest that hospitals have no way of predicting numbers of admissions, and changes in admissions might make the increase less than 9 percent.

Further, it is not 9 percent in the future. The formula is tied to a gross national product deflator and in its mechanism provides for a ratchet movement of this revenue limit percentage downward, regardless of what happens in the inflation of the total economy. In fact, it rather rapidly moves to what is the level of the gross national product deflator, which is itself an inappropriate index of what hospital inflation is. And, as a matter of fact, I would like to submit for the record a letter from the Department of Commerce that states specifically that fact.

And, finally, the Secretary said even in his short statement that the limitation would begin October 1, 1977. This is not so for the vast majority of hospitals; institutions whose fiscal years begin on dates other than October 1 would be controlled retroactively under this cap back as far as October of last year. Further, these same institutions will never know the allowed rate for an entire budget year at the beginning of that budget year.

I think one can agree that there is no appropriate management or budget action that is possible under such a proposal.

The bill also provides for 1976 to be the base year and moving it forward to 1977 for application of the percentage cap. Here, again, it states that in bringing that base year, ending in 1976, forward to 1977, it would not consider any revenue increase above its increase in the 1974–76 period and not above 15 percent. Now, I allow that that is a big figure, but there are many institutions in this country, because of construction, because of improvements, et cetera, who will have had a percentage increase greater than that—and it will not be considered under any terms in this bill.

The Secretary also mentioned that there would be adjustments for major changes in patient load. I think it is clear that for increases since the base year of up to 2 percent there is no adjustment in contrast to what the Governor had stated. Further, from 2 to 15, since the base year only half of the average per admission cost is allowed; and if you go above 15 percent—and it is conceivable over the years since 1976—there is no consideration of further revenue allowance and literally the per admission revenue would have to decrease.

I think these are defects that are inherent in the approach that this bill takes to it.

The Secretary also stated that there would be a few exceptions considered for major changes in services and facilities; and while he didn't state what a major change is, any change less than 3 percent, we understand, would not be considered at all. And, in fact, the hospital could be driven to insolvency by a commitment that had been approved by a planning mechanism in 1976. And, further, if it in fact was a major change which had a cost impact of over 3 percent, it would not be allowed unless there was an exception approved for the hospital, and this would be dependent on it having a rate of current assets to liabilities that are in the lowest quartile of hospitals covered, and it is insufficient to insure the hospital's solvency. Thus,

an exception to be obtained and to be maintained requires that hospitals' solvency continues to be a serious problem.

And, Mr. Chairman, there is through the bill a number of these other issues, all of which impact on the revenue ability of the hospital to meet its needs that are not considered by the bill.

I would turn to title II, because the bill at this point fixes a limit and establishment for all future years of $2.5 billion for capital expenditures. Now, this limit, if one looks down the road, would probably not meet the costs of replacement, because the present understated straight line depreciation of hospital plants runs at about $2.1 billion annually. I don't believe it is the national goal to let the hospital system deteriorate.

It is interesting to note that under this title even if a hospital received all of the review and approvals for modernization of its plant that was needed, and it fit within this arbitrary cap, it still could not obtain assurance of approval for revenue increases above the limit allowed to cover such modernization, unless it could obtain an exception. Of course, any favorable consideration of the exception would require that the hospital be threatened with insolvency, a condition which would probably preclude its serious consideration for any financing in the capital market.

This bill, Mr. Chairman, is price-and-wage control; it is filled with many of these catch-22 requirements. And I would add that while this is expressing strong opposition to S. 1391, it doesn't mean that we don't recognize the problem of the growth of health and hospital costs, and we recognize that it is a complex problem with many interrelationships which don't necessarily lend themselves to unilateral and quick solutions. And, therefore, we offer no quick fixes or panaceas. We do, however, offer our cooperation in dealing with the problem of health-care cost with a variety of directions which we believe can be leading us to solutions which we all seek.

And my testimony on pages 16 to 22 notes eight areas of alternate considerations.

The planning and capital controls—and I have already expressed that we have been fully cooperative with this legislation and its implementation, and have strongly urged, even before Congress passed this law, the development of State-level certificate of need legislation.

There is a problem of excess capacity, and we believe an approach that is included in Senator Talmadge's bill, S. 1470, does provide initial steps for assistance to institutions in the conversion, mothballing, or closing of excess capacity.

We do believe also that there can be developed meaningful limitations on hospital capital investment while maintaining the needed resources in providing for reasonable advances in health care delivery.

We support the fraud and abuse provisions in line with the actions presently under consideration in the House of Representatives in H.R. 3, and originally initiated last year by the Senate Finance Committee.

We have supported, and we continue to support, the development of improved utilization controls, through both PSRO, institutional programs of medical audit, and utilization review. We believe, further, that the data developed from these activities should be given, as it becomes available, greater attention, particularly in areas of the country where there appears to be unduly high utilization of services.

We do believe that public disclosure of hospital costs can assist in the public making more informed health care decisions and a better understanding of these costs themselves.

Now, reform of the methods of payment to hospitals is really the issue that is primarily under discussion today. In S. 1470, the Medicare-Medicaid Administrative and Reimbursement and Reform Act, there is presented an approach for making payments to hospitals which deserves, in our opinion, very serious consideration. It is based on a classification system nationally which pays particular attention to the differences in hospitals and provides for incentives and penalties. It also provides very importantly the delegation to States with rate review programs. Payment for services under Federal programs could be delegated to States who have developed their programs and are capable of assuming this responsibility.

I think, too, in looking to other issues, we must give attention to patient demand. We are concerned with any economic barrier to health care. Now, some have been proposed, and probably further evaluation should be made, to the extent that whether there would be any value in copayments under very, very strict conditions, which might provide a greater incentive to patients, economic incentives, at the time they choose their health care.

And then, finally—and I have already mentioned it—we certainly think that government should examine not only its existing but any future regulations that aren't cost-benefit wise in the health field.

And, finally, we recognize this is a difficult task—but you have mentioned it so many times. We certainly encourage the preventive measures of more personal health responsibility through health education.

So, in conclusion, Mr. Chairman, I have tried to describe why costs are what they are, some of the problems we see with S. 1391, and, finally, have suggested some alternate courses of action which we believe can lead to the sort of solutions that we all seek.

Senator KENNEDY. Thank you. If we followed your recommendations, what do you think the dollar savings would be in the next 5 years?

Dr. GEHRIG. When you mention 5 years, I have real difficulty. I would have to, very honestly, see——

Senator KENNEDY. Well, let's take 4 years. The Talmadge bill doesn't go into effect for 3. So what are you talking about in terms of your savings, your recommendations? The Secretary of HEW talked about $40 billion in terms of savings. I want to hear what you think your program would save.

Dr. GEHRIG. Well, I think that in the implementation of a bill like the Talmadge bill—it is true that the reimbursement methodology in section 2 would not become fully implementable for 3 years. I think that to——

Senator KENNEDY. Do you know how much it will save?

Dr. GEHRIG. No, I really don't——

Senator KENNEDY. $250 million, by their own estimate. Have you heard what the projections—not by HEW nor by the Senate Health Committee—but what the Congressional Budget Office has said is going to be the explosion in terms of hospital costs in the next 5 years? And what is your proposal, even if we follow it, how is it going to save the public anything? It is going to come out of the worker's pocket, and

it is going to come out of the housewife's budget, and it is going to come out of the taxpayer's pocket—that is what we are talking about.

Dr. GEHRIG. Well, I think, Senator, what I am really saying is that I recognize in the 1 year or the 2 years the level of savings that the Secretary intends to get by this meat-ax approach would not be obtainable by what I am talking about.

Senator KENNEDY. Well, what would yours say? Secretary Califano estimates $40 billion. Now, if they don't save it, that is going to be made up in additional taxes; there is no way around it—additional taxes, or additional premiums. Now, how much are you going to save?

Dr. GEHRIG. My feeling, Senator, is that I couldn't give you a figure at this point in time. I would like to look rationally at it and the suggestions we have made, and try to provide you something, but——

Senator KENNEDY. We are testifying here on the administration's bill—and you come up here opposed to it. You have the Secretary who says that this is what it is going to save; lays out the figures and the statistics—and you can either dispute them or argue, and if you have comments on them we would welcome them. But he shows very clearly where the estimates come from—and he builds them not on his own estimates, but in terms of the nonpartisan, nonpolitical Congressional Budget Office.

Now, you come up and say that is no good, and you say that yours is better—and I ask you specifically what that is going to mean in terms of saving to the average taxpayer or the one who is going in the hospital.

Now, what is your answer to that?

Dr. GEHRIG. Well, Senator, I can say, No. 1, I can't give you the definite figure he mentions——

Senator KENNEDY. Well, can you give us an approximation?

Dr. GEHRIG. I can suggest that it will not impact, as he suggests, immediately; I think that its impact, however, over the next 5 years will be a growing one, and I think it will be done in a constructive fashion that doesn't also disregard the fact that you are not intending—and I am sure this is not your feeling or anyone else's—to impact adversely on a system that is providing an essential service. I think we can move in the direction you want to go, but we don't have to take this sort of an approach.

Senator KENNEDY. Well, it wasn't adverse on Massachusetts. We have a practical application where the States are ahead of the Federal Government, saving the taxpayers there tens of millions of dollars—over $100 million just in terms of the construction budget.

I understand that your testimony opposes this bill however you are not able to give us an approximate figure on how much we can estimate to save if we adopt your particular program.

Dr. GEHRIG. That's correct.

Senator KENNEDY. You can't tell us that?

Dr. GEHRIG. No, I do not know, and, Senator, we have tried to be credible with you in this discussion——

Senator KENNEDY. But can you give us a ball park figure? I mean, are we talking——

Dr. GEHRIG. No.

Senator KENNEDY. Are you you talking less than a billion?

Dr. GEHRIG. I can't ball park it; I don't know it. And I think it would be inappropriate for me to offer you a suggestion that is off the top of my head.

Senator KENNEDY. You must have some estimate from your various programs of what it would mean?

Dr. GEHRIG. No, I do not.

Senator KENNEDY. Can you submit it to us later?

Dr. GEHRIG. I doubt very much if we can. I think what we are trying——

Senator KENNEDY. Secretary Califano testified prior to you at which time he stated a number of important points relating to the administration's proposal: (1) that it is a temporary program which needs perfecting, (2) that it could save up to $40 billion, and (3) that they are willing to work with the Congress on making the program more precise and sophisticated. Your testimony is in opposition to that program, even though it is going to save and even though the Congressional Budget Office can tell us that health costs are going to increase up to $250 billion by 1982 or 1983. Yet, you can't tell us where that money is going to come from—we know where it is going to come from; it is going to come from the taxpayers or premiums—but you can't tell us what is going to be saved on it?

Dr. GEHRIG. I can't tell you what that is, but I would like to have Mr. Manzano respond.

Mr. MANZANO. Senator, I appreciate your concern for getting some estimate of what the program we propose would save. I can assure you it would be very difficult to do. If you look at the process that was involved in estimating the savings from the administration's bill, what they did was project the rate of increase over a number of years, and then define a rate of increase—and, therefore, the savings was the difference between the two.

They also did a similar calculation of what they expected to be the savings from a control on capital investment. Now, if you talk about the sort of things that that will result in, it's very difficult to know as to what actual changes that would produce in terms of delivery of care, utilization, provision of technology, or any of those things. We don't know. We know that there will be pressures to do things of that kind.

Now, in the proposal which we have put forward, what we are suggesting is that if you control the elements that add to cost—in other words, control demand—it is difficult to know what that will produce in terms of savings. Control capital; make it only that which is appropriate. Control technology; make it only that which is appropriate.

We don't know what will have been denied to that process over time; it is exceedingly difficult to estimate. When you talk about controlling utilization, keeping services in their appropriate place and denying inappropriate services—it is also extremely difficult for us to estimate what that would produce. Certainly, the Talmadge bill, which is in effect an estimate of what would be reduced from payments to hospitals, can be estimated. But the majority of these things, like controlling the volume of manpower, it is exceedingly difficult for us—and I believe for anyone—to really say that will save so much in the future.

I guess the problem is that if you estimate savings by saying, cost will be so much in the future if we do nothing, and if we do this it will produce this difference. I would recognize that as a way to produce an estimate, but I can't tell you, from the sorts of things which we have produced, what actually would be saved over time. I wish I could.

Senator KENNEDY. I think that is a helpful and responsible answer.

The response I would make is that every indicator in which we make these judgments appears to be skyrocketing up, whether we are talking about laboratory tests, or various procedures outside of some of the HMOs and some of the prepaid programs.

Looking at the OTA panel's projections in terms of health technology we can see that we are in an age of technological explosion. In the last 5–10 years medical costs have risen dramatically. This is clearly evidenced when we look at the financing mechanisms written into medicare-medicaid as medically necessary procedures.

These issues have been plaguing us since I became chairman of the subcommittee 8 years ago and I am singularly unimpressed with the willingness of the association to really help us come to grips with hard, reasonable, rational, and thoughtful conclusions on how best to deal with it.

That is my dilemma. I feel that talking about the growth of malpractice insurance on it, is absolutely incidental in terms of a budget. If you came up here and said, pass that through, I would say, fine. You talk about your various kinds of energy—I happen to be chairman of the Energy Committee of the Joint Economic Committee, and we have done very extensive hearings on what can be done on it in terms of institutions. There is no question in my mind that that is a manageable item in terms of it—but, you know that it is the explosion of tests, the explosion of procedures, the explosion of costs that are the heartbeat items which are raising the costs. The insurance mechanism is putting people into the hospital, into the high-cost area. And you know that, and I know it.

The consumers of Massachusetts understand that very, very clearly. What you are trying to do is hopefully give some authority and flexibility to a hospital administrator who sees tests or procedures, or overutilization of the hospital going right up through the roof. When you talk about the increases in malpractice and the increase of energy or government regulations as being the thrust of your testimony, I have difficulty in giving your recommendations credence.

Now, it is your turn on it.

Dr. GEHRIG. Senator—well, really, in looking at the issue, because we have had a good number of discussions across the table—but in the issues you just talked about—the value of certain types of technology, whether a patient should be admitted to a hospital or not, and a host of the other issues, are not addressed by this bill. I mean, this is part of the multiple alternatives that we are trying to talk of—because we do believe that PSRO utilization review is one of the ways to begin to determine whether the hospital or any other modality of treatment is appropriate.

Senator KENNEDY. Would you extend it to all physicians?

Dr. GEHRIG. Yes, and I notice that Senator Talmadge has indicated a willingness to explore the possibility. There is really a technical problem, as we see it, here—we would extend the bill across all payors,

as Talmadge has suggested, but I think there is some work to be done to determine just how this is done, because we deal with charge payors and cost payors.

Senator KENNEDY. You know, the problem, when we try to deal with this issue in a comprehensive way, I have tried to deal with it comprehensively through health security. We get the opposition that it is too all-encompassing, it is too comprehensive. I am not accusing you of this, but I am hearing an old argument.

And then, when we try to deal with it and peel off those particular aspects of it, then it is not comprehensive enough to be responsive to the nature of the problem. And that is, I guess, the problem that we are going to have to deal with from a legislative point of view.

But I think that that is really a public policy dilemma.

Dr. GEHRIG. Well, Senator, I couldn't agree with you more—and, as you recognize, our support for national health insurance has been a comprehensive approach. But I think we are looking in this bill at putting a floor under——

Senator KENNEDY. And you are not worried about the cost, because I saw where HEW cost you out a little more than health security.

Dr. GEHRIG. As a matter of fact, your staff told me they need to look at their bill again to see if it could go up a bit. That was not the intent, but it did express the comprehensiveness of approach.

But I think singling out a piece of an industry for a control process, without taking anything into consideration with regard to why the costs are going up, is not the approach here—and we are willing to cooperate with you on alternatives that I think can be perfected in this area.

Senator KENNEDY. We have these sessions back and forward, and I always appreciate the fact that you are willing to exchange views. There is going to be a tough legislative process and we do welcome your suggestions—and you know where we are on these matters, but obviously there are areas that we can work together on, and I look forward to it.

We want to thank you very much for your testimony.

Dr. GEHRIG. We appreciate your position. I must say, Senator, I have waltzed with others and I have enjoyed it more. [Laughter.]

Senator KENNEDY. Well, we will remember it next time.

[The prepared statement of Dr. Gehrig follows:]

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STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION
TO THE SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
OF THE SENATE HUMAN RESOURCES COMMITTEE
ON S.1391, THE HOSPITAL COST CONTAINMENT ACT OF 1977

May 24, 1977

Mr. Chairman, I am Leo J. Gehrig, M.D., Senior Vice President of the American Hospital Association. With me today are Allen J. Manzano, Vice President of the Association, and Irwin Wolkstein, Associate Director of our Washington Office. The AHA represents more than 6,500 member institutions, including most of the hospitals in 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 share with you our views on S.1391 and the larger issues related to it.

This hearing is focused on a proposal which, in our view, deals with only one aspect of an extremely complex and interdependent system of providing health care services to the citizens of our nation. The Administration's bill does not consider our total health delivery system, but rather only its hospital component; and in that case, it does not address the factors which determine hospital costs, but merely limits payments to institutions.

Our presentation today will discuss the nature of hospital cost increases, will review in detail S.1391, and, finally, identify alternative courses of action to deal with this issue.

CABLE ADDRESS: AMERHOSP

The fact that hospital and health care costs are increasing at a rapid rate is not in dispute. Hospitals are concerned and are working actively to restrain health care 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.

In considering this issue, it is well to look at the increase in health care expenditures in other nations as well as in the United States. Health care expenditures in all Western nations are increasing at a rate greater than their gross national products. This worldwide phenomenon reflects the inherent values of our civilization, which support the application of resources to improve and maintain health, to ease suffering, and to extend life. We recognize that at some point each nation must decide how much of its resources shall go to health and how those resources must be allocated. It is necessary that to do so a coherent health policy be developed on a basis on which such decisions can be made.

HOSPITAL COST INCREASES

Impact of General Inflation

Hospitals must pay higher prices and wages charged for goods and services they use in the delivery of patient care. Thus, the cost of hospital services is adversely impacted by our inability to control inflation in the general economy. The Consumer Price Index (CPI) has been used as a standard for comparison with increases in hospital care costs. Unfortunately, hospitals buy a mix of goods and services the costs of which move at a rate greater than the CPI. The hospital market basket is especially hard hit by inflation. For example, malpractice insurance costs have increased 800 percent in the past seven years, and energy costs since 1973 have increased at over 20 percent per year. Further, for the

short run, the bad weather last winter and the prolonged drought will undoubtedly raise food costs substantially, an item which typically comprises about 10 percent of inpatient costs.

The American Hospital Association has undertaken an extensive study to better describe the true nature of the cost changes. Using data collected over a number of years, we have developed two new indices that can assist in gaining a better understanding of such cost changes.

These indices are the Hospital Costs Index (HCI) and the Hospital Intensity Index (HII). The HCI reflects increases in the price of 37 service elements used in the delivery of care to patients. The HII uses the same 37 service elements and indicates increases in the quantity of services provided in a typical patient day. Using these indices, we have reviewed the approximately 15 percent annual increase in hospital costs and find that about 10 percent of the increase is related to price inflation in the goods and services which hospitals must purchase to provide patient care, and the additional 5 percent is the result of increases intensity of service provided. Indications are that this cost-push problem is not being ameliorated but will become more acute as we experience the cost effects of such actions as the national drive to increase product safety through more stringent regulatory controls, and the proposal to increase energy costs in the interest of conservation and energy independence.

Demand for Services

The growing public demand for health care services is one of the major factors influencing the growth in hospital expenditures. Increased demand is in part a reflection of our growing and aging population. We are living longer and the illnesses that beset us as the population ages are the kind that require more care and treatment. As we extend life expectancy, we are more likely to fall victim to such illnesses as heart disease, cancer, stroke, diabetes, and kidney failure—all of which require long-term medical management and are costly to treat.

Demand also has been stimulated by our deliberate decision to remove financial barriers to access to health care. Both the private and public sectors have worked to implement this decision by expanding benefits, broadening coverage, and increasingly eliminating economic barriers to utilization of the health care system. In the United States, we prefer and select health benefit plans with the broadest coverage and smallest direct self payment. Further, when coverage is not comprehensive, our health financing programs, for the most part, continue to favor high cost inpatient alternatives.

Another major factor which influences the demand for health care is the expansion of health manpower. The continuing increase in the number of physicians and the growth in high technology specialties has had and probably will continue to have a strong impact on health care costs. We know that every new physician will result in further identification of health problems, with a corresponding increase in demand for treatment. It is estimated that each new physician, through his activities in the health care system, will add approximately $250,000 annually to health care expenditures.

Further, research and scientific developments result in an increasing sophistication of our medical technology and health work force. Such developments and the increased capability of health manpower are rapidly converted into patient treatment demands.

Finally, it must be acknowledged that many individuals with poor personal habits which affect their health adversely--such as overeating, smoking, and alcohol abuse--add to the demand for services. Moreover, despite dramatic technical advances, public expectations create demands exceeding the professional capabilities of the health care system, as well as available economic resources.

Intensification of Services

A third factor pushing up hospital costs is that of intensification of services. The kinds and volumes of services being used by patients are increasing in intensity both in terms of use and sophistication of technology, with inevitable cost consequences. This

intensification is a product of a number of developments in our health system--the change in the mix of patients treated, the availability of new technologies in the treatment arsenal, and the changing character of physician practice. The intensification of services has resulted from our ability to diagnose and treat patients today for illnesses for which previously there existed no capability for definitive care. Further, technological and research advances have increased the scope and rapidity with which diagnostic testing can be accomplished. Accompanying these diagnostic improvements are advances in treatment capability of physicians, such as artificial hip replacements, open heart surgery and organ transplants, and support resources such as coronary care units, and renal dialysis equipment, all of which contribute to the intensification of services.

Modernization and Maintenance of Service Capacity

Another factor in hospital costs has been the modernization and maintenance of hospital service capacity. The costs of these efforts, too, have accelerated more rapidly than the CPI because of changes in the nature of facilities, construction inflation, and the increased costs of capital.

The trend in hospital construction has been toward substituting semi-private and private accommodations for wards, closing long-term facilities for patients with respiratory and mental illness and providing relevant short-term services for such patients in acute care hospitals, and replacing obsolescent resources with modern facilities for better treatment and patient safety. Construction costs also have increased both in terms of the cost of materials as well as labor. Finally, hospital capital costs have greatly increased because of the need to use debt financing, a result of the declining availability of grants and philanthropy.

Manpower Development

In addition to the impact on demand caused by increasing health manpower, hospital costs also are affected by the need to continue to rely on patient care revenues to finance manpower training in hospitals. The stimulus government has provided through its support

of medical education has resulted in a major expansion in physician internship and residency training programs. Much of the cost of providing this graduate medical education must be included in the hospital budget. The costs of residency programs can range from 3 to 10 percent of hospital budgets and total well in excess of one billion dollars annually. In addition to physicians, the education of nurses and other allied health personnel similarly are reflected in hospital costs. While there is no substitute for the clinical training provided these professionals in hospitals, such training impacts on hospital costs.

Cost of Hospital Regulation

Government at all levels has not adequately met its responsibility in assessing the cost impact, effectiveness, and benefits of many regulations it has imposed on hospitals. Hospitals have been experiencing a steady and excessive increase in reporting and inspections, some of which are duplicative or conflicting. The regulation of hospitals is increasingly characterized by multiple centers of authority and accountability. As a result, AHA and several state hospital associations have conducted studies to determine the extent of regulation and to identify where duplication or conflict exist in order to make recommendations for the elimination of unnecessary regulatory activity, needless costs and resulting hospital frustrations.

These studies clearly indicate the need for action. For example: the Hospital Association of New York State, in its 1976 Report of the Task Force on Regulation, found that 40 federal agencies, 96 state agencies, 18 city and county agencies, and 10 voluntary and quasi-public groups--a total of 164 agencies--regulate 109 areas of hospital operations. Of the 109 areas, 82 are monitored by at least 10 different agencies.

New York is generally acknowledged as one of the states with the most wide-ranging multiplicity of regulations. However, recent studies by other state hospital associations in Minnesota, Pennsylvania, and Michigan have documented similar problems in varying degrees. Thus, while calling for containment of hospital costs, government has

required compliance with regulations which all too often add to costs without commensurate improvement in the quality of health care provided.

A current example is the imposition of fire and safety codes developed by the National Fire Protection Association and required as a condition of Medicare participation. All too often these requirements call for enormous expenditures if hospitals are to comply, without clear demonstration of need or cost effectiveness.

The labor intensive nature of hospitals makes them peculiarly cost sensitive to laws and regulations impacting upon employees wages and benefits. As another example, while we maintain that hospital employees must be compensated commensurately with employees performing comparable work in their communities, proposals to raise the federal minimum wage would increase hospital costs by an estimated $2.8 billion by 1978; and the scheduled increase in Social Security contributions will cost hospitals some $70 million more in 1978.

Meanwhile, adding to the cost issue, are recently promulgated regulations implementing Section 504 of the "Rehabilitation Act of 1973." The nation's hospitals fully appreciate the benefits that will result for disabled citizens from these new provisions. However, we estimate that hospitals will have to spend several hundred million dollars over the next three years in order to comply with the regulations.

Hospital reporting requirements are also expanding rapidly and producing new costs. Some key examples are data needed for PSROs, Hill-Burton assurance reports, data requirements for health planning, and public information requirements. Without regard to the merits of these changes, it must be recognized that these imposed requirements raise the rate of increase in hospital expenditures.

HOSPITAL COST CONTAINMENT ACT OF 1977

General

The American Hospital Association strongly opposes enactment of the Administration's hospital cost containment bill, S.1391. Many of the sections of this bill are written in a manner that makes it difficult to interpret. We will not review all the minor technical problems that we have with the bill, but will concentrate our discussion on the major issues. It is our strong opinion that this bill is inequitable in design, wrong in concept, and impossible to administer. We believe that its enactment would seriously jeopardize the present and future ability of hospitals to provide quality care to the American people.

This bill is inequitable because it would establish unique economic controls on hospitals while ignoring the fact that they must acquire goods and services from segments of the economy which are uncontrolled and experiencing high rates of inflation. This bill is also inequitable because it simplistically would apply the same controls to all hospitals, ignoring known special characteristics of subgroups of hospitals—rural hospitals, public general hospitals, specialty hospitals, and hospitals heavily involved in training and research, for example.

Conceptually, these controls are wrong because they would operate through a formula that continuously screws down increases in hospital inpatient revenues so that in the future they would be limited to a rate about equal to the rate of general inflation (as measured by the GNP deflator). Such an approach would eliminate all ability to incorporate improvements in care and fail even to keep up with the known rate of inflation in the hospital market basket. The priority assigned to health care by virtue of this formula is significantly less than the priority assigned to health in other Western countries.

The bill would be impossible to administer. While its authors believe it would be administrable because few exceptions would be allowed, we believe

the resulting inequities would be intolerable. Further evidence of the unworkability of this legislation is that hospitals would lack the basic information needed to measure and monitor their own compliance and by which to adjust their operations accordingly. For instance, the overwhelming majority of hospitals would not know their revenue limitations at the time they developed their annual budgets. In many cases, the data necessary to determine compliance would not be available until the hospital's fiscal year ends, making noncompliance likely, resulting in retroactive paybacks and possibly in penalties. Third-party payers would be in a somewhat similar position. Because of the complex interrelationships of per admission controls, admissions corridors and overall adjusted inpatient admissions limitations, payers also would be less able to forecast accurately their share of a hospital's revenues than at present, complicating the budgeting, planning, and managing of their operations.

Inpatient Revenue Limit

The approach of using uniform percentage limits on increases in revenues taken by this proposal would exert the heaviest pressures where they are least appropriate--on the most efficient hospitals. While this formula is intended to squeeze out excessive costs, the lean hospital could only curtail essential services and sacrifice the quality of care to survive within the formula constraints. The message the bill sends to hospitals seems to be: "We will punish you for being cost-effective."

We also find significant problems with the application of the basic control formula. The first application of the controls would be retroactive to hospitals' fiscal years beginning after October 1, 1976. Therefore, if passed, except for hospitals with fiscal years beginning October 1, the controls would apply retroactively and could apply for some hospitals as far back as some seven months ago. Such retroactivity is contrary to all past practices for such legislation and seems to sacrifice equity in order to meet the Administration's budget target for fiscal year 1978, no matter what the impact on hospitals.

An adjustment to the bill's basic formula is provided by the "admission load factor" which would allow for modifications in revenue limits reflecting changes in admissions between the base year and the controlled year. Unfortunately, this adjustment incorrectly assumes that hospitals can accommodate up to 2 percent additional admissions without need for increases revenues to cover the costs added by the admissions. Admissions above 2 percent would be reimbursed at the rate of one-half the average cost of an admission. This penalty would be applied each year that Title I of the bill remains in effect. The assumption is that added admissions to a hospital are to be deterred even though the increases occupancy of a hospital can be an important way to improve its effectiveness.

The Act would allow adjustments to the revenue limitations based on exceptions, but this exception provision is deceiving. In order for a hospital to qualify for an exception, it would have to meet a series of tests that are designed to eliminate virtually all exception requests, primarily for the program's administrative convenience and regardless of reasonableness.

In order to qualify for exceptions, a hospital would have to experience major changes in admissions or capacity or character of inpatient services, or renovate or replace its physical plant. Capacity, service, or plant changes would have to be approved by the local Health Systems Agency and increase in patient per admission cost by more than one-third of the difference between inflation and revenue growth. This means that a change increasing costs by less than 3 percent in the first year or two would not permit exception even if it would require the hospital to go into default. Further, the hospitals' current ratio (current assets to current liabilities) would have to rank in the bottom quarter of all hospitals covered by this Act, and the exception would be allowed to the extent that all revenues and resources would be insufficient to assure solvency if less is provided.

A hospital would have to deplete its resources to meet the last requirement. For example, a rural hospital that has received donated farm land from which it derives income to offset the cost of providing care may have to sell the land and use the

proceeds in meeting its costs before it could even apply for an exception. Likewise, a hospital would be forced to liquidate unrestricted investments such as stocks and bonds and use them to pay costs before it could apply for an exception. Once this had happened, the hospital could never restore its reserves. Over time, the unrestricted endowments of hospitals would be depleted, and philanthropy would not be permitted to prevent this result. Philanthropy for hospitals would be discouraged and would almost certainly disappear,with significant impact on other sources of funding.

Income from a city, county or other local governmental source used in support of the public hospital also would be restricted because the government either would be considered a class of purchaser or treated as a source of funds that would work against a hospital seeking a justifiable exception.

If a hospital qualified for an exception, it would be allowed additional revenues only to the extent that its current ratio remained in the bottom quartile. If the hospital improved its status beyond this point, the exception would be removed, in effect leaving the hospital constantly on the brink of insolvency.

A major inequity in this system is that the current ratio test for an exception would not reflect a hospital's day-to-day cash flow problems. A hospital could have a high current ratio because it has a large amount of accounts receivable and have no cash to meet its obligations.

No exception could be made for very large price increases of items used by a hospital. Cost increases over which it has no control, such as in malpractice premiums or fuel, would have to be absorbed by the hospital, no matter how large. Costs of complying with government regulations which may hit some hospitals very hard also would not be a basis for exception and would not be passed through.

The bill does provide for a pass through of non-supervisory wage increases which exceed the allowed control level. But this pass through is contrary to effective management and it would induce often inappropriate wage pressures. If the staff eligible for such pass throughs received high wage increases, compression in wage differentials would occur. This, in turn, would induce comparable increases for personnel for whom such increases could not be passed through. The result of this pass through can be predicted: wage compression, dislocations in staffing structures and organizational relationships, morale problems, and interpersonal stress. In addition, this limited wage pass through could inappropriately influence decisions concerning the mix of capital and labor in the production of hospital services.

Title II of the bill provides for a control on capital expenditures. One would think that if a project were approved through the system in Title II, that the added operational costs associated with that project would automatically be an allowable exception. This does not happen. The two titles are not coordinated and both approval and exception are required. Without the assurance of an exception for funds to operate new capital projects, obtaining financing would become more difficult and the cost of available financing would become much higher.

The result of this exception process, as we have already said, would be to put hospitals on the verge of insolvency. If this occurs, they would become poor lending risks. Because most construction is financed through borrowing, the result could be a virtual halt in hospital construction.

Another major flaw in the exception process is that it does not recognize what may be a series of events that each alone may not be enough to justify an exception but in total would have a major effect on the institution. For example, a change in the deflator of less than one percent is not recognized, nor are changes in services and facilities that are not major,nor is an increase in admissions of less than 2 percent. A hospital may experience all these events but would be held to a limit several

percentage points below actual costs, yet not be entitled to seek an exception. Without relief forthcoming through the exception process, the sum total of a series of events like these could be fatal to a hospital.

Changes in patient mix also are not a basis for exception. In a small rural hospital, a single auto accident might require the admission of two or three high cost cases, but the hospital might be barred from collecting its costs under the revenue limit. No exception for such a change in case mix would be allowed under the bill.

The revenue limit system provides for exceptions in relation to revenues of the hospital as a whole, but enforces its limit at the level of the class of purchaser. However, there is no exception provided for increased admission costs of a purchaser because of expanded benefits or a change in patient mix insured, or for the special impact of a new service on one insuror.

The exception process has supposedly been put into the Act to provide equitable remedies for conditions that endanger the viability of the hospital. It is a sham. Very few hospitals would qualify under this process, and the result would be a drastic reduction in the quantity and quality of health care available.

Implementation and Enforcement

It is apparent that it would be extremely difficult, if not impossible, for hospitals to properly assure themselves ahead of time what they would have to do to be in compliance with the Act. Only the minority of hospitals operating on an October fiscal year would know their increase limit at the beginning of the year and even this limit would change if admissions or services or facilities change from one year to the next.

Consider the fact that the mix of payers for most health care institutions varies between cost reimbursers and charge payers. As we have said, the bill bases its control limitations on aggregate inpatient revenues of the hospital, but applies them

by class of payer. The bill's language seems to be unclear as to how these dual levels of control may be reconciled. The way we understand it, however, more or less revenue could be received than the nominal overall limit suggests. Hospitals and payers would be unable to know if they are in compliance with the provisions of this bill until fiscal year-end settlements would be made. In some instances, such settlements would not occur until months or even years after the close of a fiscal year. Then, further payments or recoveries by the classes of payers would be likely to be required.

Because hospitals would not know what their future would hold, they would be encouraged to include a safety factor in their charges and to hold the income from the safety factor in escrow, because if revenues were short, they would otherwise be unable to collect the additional allowable amount on settled claims of charge payers.

It appears, therefore, that the implementation and compliance sections of this proposal do not foster actions that are in the best interest of proper budgeting and cost containment. Yet, we have been told by the Administration that this bill would encourage effective prospective budgeting. This does not appear to be the case.

State Delegation

While it is intended that hospitals operating in certain states that have their own rate review programs, which meet criteria established by the Act, may be exempted from its provisions, our initial analysis of the criteria shows that out of 25 existing rate review programs, only three are likely to qualify. In order to be exempted, the governor of a qualifying state must certify that the program in his/her state would not allow the aggregate rate of increase to exceed the inpatient revenue limit established by the Secretary of HEW. This suggests that such states would have to apply even more stringent controls on hospitals than would be required by the bill under administration by the federal government. The provisions for exceptions, admissions load adjustment, and pass through of non-supervisory wage increases appear not to apply in states permitted to operate their own programs.

Limitation on Hospital Capital Expenditures

Title II of the bill establishes a capital expenditure ceiling of $2.5 billion a year for acute general hospitals that 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 facilities required to meet the needs of their communities.

As has been estimated by the Administration, the permanent limitation of $2.5 billion a year on all capital expenditures over $100,000 at least halves the current amount for such expenditures. We are concerned that such a drastic reduction was chosen without consideration of its long-term impact upon the hospital delivery system.

Even more disturbing is that the capital expenditures approved under Title II are not automatically reflected in pass throughs for the higher operating expenses that would result. While Title I of the bill does provide for an exceptions process, hospitals implementing Title II approved projects or services could not get revenue adjustment exceptions unless the cost impact of such projects would otherwise endanger their solvency, which, by an intriguing Catch 22, would in turn nullify the conditions of most debt financing.

While the $2.5 billion exceeds the annual estimated $2.1 billion depreciation of current plant, it does not meet true replacement cost. By fixing the dollar amount of capital expenditures for FY 1978 and all succeeding years at no more than this figure, the bill would, in effect, decrease the real dollars available for capital needs. For example, if we were to assume the same rate of inflation (using the GNP deflator) that occurred over the past 4 years, the purchasing power of $2.5 billion in 1981 will have been effectively eroded by approximately 25 percent or $620 million.

ALTERNATIVE CONSIDERATIONS

Mr. Chairman, while we have stated the opposition of the American Hospital Association to the Administration's hospital cost containment bill, we are by no means negativistic with regard to viable alternatives for the containment of health care costs. Neither do we feel any less committed to seeking solutions to the nation's problems of health care costs than is the federal government.

Our Association has consistently 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 in the process of formulation through legislative and administrative initiatives, state and federal.

There are no easy solutions; and none, if they are to retain high quality of care and enhance access to health care services, can come over night. I would like to propose several alternatives, therefore, that are more promising than the proposal under consideration today.

Planning and Capital Controls

The American Hospital Association has strongly supported comprehensive health planning and the development of local, community planning capability. We also have urged the development of strong certificate of need laws at the state level to avoid the development of duplicative or unneeded health resources and to coordinate the allocation of available resources. Efforts in this direction which are presently in progress must be continued and strengthened.

At the present time, considerable attention has been directed to the issue of excess hospital capacity--overbedding. We recognize that excess capacity does exist in some areas. However, in broad terms, the issue of excess capacity can be viewed as a maldistribution of resources in that excess capacity in one institution or in one geographic area does not meet the need for modernization in another community, nor does

such excess capacity meet needs for additional capacity in another area where population shifts have resulted in a shortage of beds. Further, in areas in which there is excess bed capacity, hospital management has generally adjusted variable cost factors, such as staffing, to meet existing needs.

Confronted with these circumstances, certainly all efforts to convert, mothball, or close unneeded capacity should be carried out. In this regard, the positive actions included in legislation recently introduced by Senator Herman Talmadge (S.1470) as well as in H.R.7079, introduced by Representative Paul Rogers, which recognize costs associated with conversion or closure of beds, will provide an incentive and assistance to institutions taking such actions.

Another approach which promises to assist in the efficient use of existing capacity in our small, rural hospitals is the inclusion in this same legislation of a provision to facilitate the alternate use of acute care beds for either long-term or acute care patients through a simplified cost reimbursement method and the elimination of certain regulatory requirements which have effectively precluded such mixed use. We support this proposal which we believe can permit rural hospitals to manage their resources more efficiently, as well as provide a more adequate range of care for the communities served.

With respect to prospective capital budgeting controls, we believe that meaningful limitations can be placed on hospital capital investment which will further limit such expenditures while recognizing the need to maintain needed resources and provide for reasonable advances in health care delivery.

Fraud and Abuse

The AHA fully supports legislation to strengthen the capability of the government to detect, prosecute and punish fradulent activities under the Medicare and Medicaid programs, as embodied in H.R.3.

We believe that the vast majority of health care providers and institutions are doing an honest, professional job in seeking to provide medically necessary care of high quality to beneficiaries of government health care programs. The fraud and abuse that does, however, exist in Medicare and Medicaid damages the reputations of honest providers, undermines public support for the programs, and defrauds both beneficiaries and taxpayers. More effective measures to detect and curb fraud and abuse in Medicare and Medicaid are thus desirable and can result in savings in these programs.

Utilization Control

AHA has supported the development of improved utilization review and medical audit. We have worked for the development of cost effective institutional quality assurance programs as a part of Professional Standards Review activities. We recognize that utilization review is a difficult and complex process and it is important that we avoid excessive administrative costs. The objective of such quality assurance programs should be the maintenance of high quality care which is medically necessary and rendered in an appropriate setting. We believe these efforts can be important in identification and analysis of areas of high hospital utilization. Where such utilization patterns are determined to be inappropriate, corrective action can be taken which will have a beneficial impact on health care expenditures.

Public Disclosure

We understand and accept the need for greater public disclosure of hospital cost data. We would, therefore, support the collection and disclosure of hospital financial information by selected public entities. It is our hope that such disclosure will enable the public to make informed decisions in the use of hospital services and have a better understanding of the nature of hospital costs.

Controls on Payments to Hospitals

We believe that S.1470 and H.R.7079 present an approach for a change in the payment for hospital services which deserves serious consideration. Section 2 of this legislation

is based on the concept of classifying hospitals into groups in a manner which will make possible more accurate comparisons for the purpose of identifying efficient and inefficient operations. In order to make such comparisons among hospitals valid, the bills provide for taking into account differences in area wages and patient mix. Further, because some differences in hospital costs are unrelated to efficiency, the bills remove considerations of costs related to capital, energy for heating and cooling, malpractice insurance, and educational programs. The bills' methodology of payment provides for incentives for efficient operations and penalties where institutional costs significantly exceed the average for comparable institutions.

This legislation incorporates a plan for phasing in and expanding to other cost centers this new payment system so that it may be tested and defects corrected before it is fully applied. This is an appropriate and judicious approach to making such basic changes in the method of payment to hospitals.

We recommend that such a system for payment be extended to include all purchasers of care. Further, this plan provides for allowing states with rate review programs which apply to all other purchasers of care, as well as to most of the hospitals in the state, to obtain a delegation of authority to set the payment level for the federal programs of Medicare and Medicaid.

It is important to continue to support state programs as laboratories in which to test and evaluate alternate approaches to rate review since there is no single program which has demonstrated balanced effectiveness over time. These various programs can be compared to explore a variety of approaches to reimbursement and can be compared for administrative and programmatic effectiveness.

Controlling Patient Demand

One of the important factors in the increase in hospital expenses that we referred to earlier is the fact that patient demand is generally unrestrained by the need to make

out-of-pocket payments when services are used. If we wish patients to be more cost conscious when they seek services, we will need to include some incentive for patients to be so. While we will have to be careful not to reduce access to needed care by imposing financial barriers, we will need to restructure present copayments required of patients so as to more closely reflect the costs of care they receive.

The restructuring of copayments could take the form of modifying the current hospital deductible and coinsurance that is now the same for every hospital into a form that varies with the costs of receiving services in the hospital that is selected. It could take the form of requiring a small percentage coinsurance on services received throughout a stay and reducing Medicare coinsurance for very long stays. Such devices certainly deserve consideration.

Government Regulations

We believe government must analyze the cost-benefits of the regulations it imposes on hospitals. As we have stated, government regulations have significantly contributed to the cost of hospital care. We are convinced that substantial reductions in hospital costs could be accomplished if government practiced restraint by (1) issuing only those regulations which, if implemented, would provide improvements in health care commensurate with their costs, and (2) rescinding existing regulations which do not meet these criteria.

Personal Health Responsibility

Finally, we urge that programs be continued and expanded to encourage individuals with poor personal habits--such as smoking, alcohol abuse, and overeating--to change their attitudes and habits in the interest of prevention of illness. While we recognize the difficulties of such an effort, such changes would not only result in better health and an increase in national productivity, but also would reduce total expenditures for health care.

Summary

Mr. Chairman, I have reviewed key factors which are involved in hospital cost increases and indicated this Association's strong opposition to S.1391. I have also pointed out a series of alternatives, some of which are already under way and can be strengthened, as well as others which can be initiated, to address the issue of health care cost increases. I thank you for the opportunity to present the position of the American Hospital Association and will be pleased to respond to your questions.

Senator KENNEDY. Next we will have Mr. Charles O'Brien, the administrator of the Georgetown University Hospital. I will ask him to summarize his testimony. You have all been very patient. We won't be much longer.

Mr. O'Brien, we want to thank you very much, you have been enormously helpful to this committee in terms of setting up these hearings. It has been a very valuable hearing for all of us. And I think, as I mentioned earlier, it is the tradition of a great university's search for helping the people understand public policy questions better—and we want to thank you very much, for the record and personally.

We look forward to your testimony.

STATEMENT OF CHARLES M. O'BRIEN, JR., ADMINISTRATOR, GEORGETOWN UNIVERSITY HOSPITAL, ACCOMPANIED BY THOMAS J. GLETNER, ASSISTANT ADMINISTRATOR FOR FINANCE

Mr. O'BRIEN. Thank you very much, Mr. Chairman. For the record, I will submit the testimony that we had prepared, but, in the interests of time, which I think has been very well spent, very interesting certainly for us this morning, I will defer that written testimony.

The point of view that we would like to put across today is so different from the other three witnesses this morning—and that is the nitty-gritty kinds of issues that are raised by a public policy issue of this nature. And I think the other three spokesmen were certainly eloquent in the positions that they took.

But I think, as a public policy issue, it might be appropriate to just dwell on a couple of points, and then make some conclusions.

First of all, I would like to introduce myself. I am Charles O'Brien, administrator of the University Hospital. I would like to welcome you all, and all the witnesses, to Georgetown.

To describe briefly the Georgetown Hospital, we are a 450-bed facility which serves as a primary clinical arm of the Georgetown University Medical Center, and through such we have a central role in both the educational as well as the clinical delivery of care in this metropolitan area. We specialize in tertiary care and we provide clinical experience for undergraduate students, for graduate medical education students, and for continuing post-graduate education of the allied health sciences and for practicing physicians.

There are a variety of factors that have impacted on hospitals that are external to the control of hospitals, and I was interested to listen to the discussion back and forth relative to the issue of passthroughs. I would like to just point out one specific instance in the life of Georgetown University Hospital. A year ago we were notified that our professional liability premium would increase from $350,000 per year to $3 million; that is an average cost of $26 per day per patient. We felt that increase in the middle of our last fiscal year.

We felt that we had—and insurance experts have told us that our professional liability experience in the past is excellent; it is reflective of the type of institution we are, which is one where the latest advances take place. So it was a surprise to us and it certainly was a substantial

increase in our cost; in fact, it caused us to have to inflate our patient per diem rate by that amount.

Another aspect of a hospital such as Georgetown is the type of hospital that we are. As a teaching institution, we get involved in a variety of programs that are, I would say, in the forefront—not just Georgetown, but all the university hospitals—of clinical breakthroughs. The two that I would like to point out today—I would like to point out in terms of, they are programs that are in the expanding mode in Georgetown, and an impact of an arbitrary cap, a single cap applied nationally, could be, in my judgment, detrimental. And if I could just get into that section a little bit, I think I can make my point.

As the demographics of the American population change, the health care institutions are providing service to patients with so-called degenerative illnesses such as strokes, cardiovascular disease, cancer, and the like. The treatment of these disease processes requires substantial health-care professional man-hours and the increased use of highly technological equipment. In earlier decades, advances in health care dealt with infectious and communicable diseases, resulting in dramatic shifts in morbidity and mortality tables when breakthroughs were found. In delivery of health care today for the degenerative diseases, the impact on mortality rates and morbidity comes more slowly. However, in terms of prolonging life and alleviating suffering, the continued aggressive programs by the health care establishment is the standard desired by every patient, family, and friends in time of health problems.

As a university hospital, we have a variety of programs which deal with degenerative diseases. I am going to pick the two that are the most in our minds at this point in time.

And the first is our cancer program. We are 1 of 19 designated comprehensive cancer treatment centers in the United States. Over the last several years an imposing array of dedicated multidisciplinary health professionals has been recruited to Georgetown for an attack on this deadly killer. One out of every four Americans now living will be touched personally by cancer. The community of cancer specialists believes that in order to have an effective cancer treatment and research program, it is necessary to have centers of highly concentrated resources of both personnel and facilities. This approach requires that not only the medical needs of the patient must be considered, but also that the psychosocial treatment of the patient and family likewise be considered. The clinical treatment of patients involves the close coordination of the medical/surgical, radiation oncology, and multiple other disciplines within medicine and other allied health sciences.

While no overall cure for cancer has yet been found, there is good data suggesting that with proper treatment such cancers as Hodgkins disease, vesticular cancer, and numerous other cancers can be treated successfully with no recurrence over a 10-year period. This was not possible a decade ago. Further successes with the use of chemotherapy and surgery in other areas of cancer treatment can be expected, but only if continued resources in the research, experimentation, and patient care in cancer are forthcoming. Enactment of the proposed legislation with single limits in any hospital would limit—would halt the enhancement and development of additional cancer therapy

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modalities, as well as prevent the expansion of current capabilities to additional patients. And by this statement, I am not implying that they are saying that there is no way that you can expand, but under the tables that they have proposed in Senate bill 1391, the range of costs that they permit become very difficult to operate a cancer program which in and of itself is a very labor-intensive type and high-technology type of a service.

In the area of both cancer and stroke treatment, to get into the area of technology, the CT scanner, which has been mentioned today as a potential source of increased health cost, was developed at Georgetown. While CT scanning is a proper concern in relation to potential escalation of costs, we have witnessed at Georgetown significant changes in the diagnosis and treatment of patients as a result of its use. And I should state right here that, in preparing testimony last night, I did talk to some of the people on our medical staff, and this is where I got some of the information related to the way they felt the instrument was used, and the fact that the studies, the documentation that I think there is a dispute over what the value of an active scan or CT scanning is, will take some time, because it is a new instrument; it will probably take 3, 4, or 5 years for the documentation and data to be developed.

But these are some anecdotal items which I think bear considering in discussion of public policy.

Studies of the brain at one time were accomplished mainly by means of injecting air into the artery. This method is not without risk. With the development of CT scanning, it is now possible for a hydrocephalic child, for example, to be diagnosed on an outpatient basis without the painful and risky air injections on an inpatient basis. Additionally, CT scanner has allowed for improved accuracy in the detection of changes in tumors related to cancer treatment which patients are already undergoing, so it enables the medical or the surgical or the radiation therapy staff to get an idea of what impact their therapy is having on the condition of the patient.

Another major program at the Georgetown University Medical Center has been the endstage renal disease program. Georgetown has long been in the forefront of the treatment of renal diseases, both medically and surgically. By June 30, 1977, we anticipate completing 12 renal transplants. Prior to the announcement of Senate bill 1391 cost-containment procedures, transplantation for at least 30 patients was planned for 1977–78. There are now 78 patients in a pool who have been worked up for transplantation. They currently are awaiting only donor kidneys and the time when the operation can be done. The current proposed guidelines imply a limit in terms of numbers of cases, which is related to last year's volume; in other words, this last fiscal year's volume, so if you are talking about a new program—and the transplant program, while not a new program, is certainly an expanding program within our context at Georgetown, it is a difficult decision that is going to have to be made related to program priorities. Obviously, operating a kidney program involves highly specialized teamwork, with professionals in multidisciplines such as nephrology, immunology, social work, dietetics, nursing, et cetera.

These are only two of the many various programs we have at Georgetown that we believe, along with others—not only medical

centers, but also hospitals throughout the country—are in the forefront of developing new knowledge. We certainly realize that these activities are expensive, that the social concern of the escalating health costs cannot be overlooked. We also recognize that as public policy planners you have a difficult job weighing the testimony of those who are for the regulations as proposed and those who either are against them in total or against them in part.

We do have certain concerns regarding the mechanics of the proposed regulations. It is our understanding that the current regulations use as a base year starting point the fiscal year ending in 1976. In our case, that is our fiscal year that ended June 30, 1976—and, in fact, is over a year away. During that period of time we did open a new treatment facility which was over 10 years in the planning, and which had obtained all the proper planning agency approvals. Because of the overhead associated with a new facility, the appreciation, et cetera, the percentage increased cost to Georgetown is more than the 15-percent carry-through that is allowed for the base period add-on.

In addition, our fiscal year starts in July and runs through June 30. Under the proposed Senate bill 1391, the Secretary would not announce the total factor, the deflator factor, until sometime between July and October, so we would be in the process of being into our fiscal year for 3 months before we knew precisely what the last 9 months of our budget target was going to be. I won't go into some other details, because I think they are covered in the record relating to the accounting processes involved in keeping detailed track of your exact mix of commercial insurance, Blue Cross, medicare-medicaid, because the mix of patients can shift from time to time—and when you are mixing cost-base reimbursement, charge-base reimbursement, programs, it can become an administrative difficulty—certainly not impossible; nothing is impossible.

In terms of alternatives that we would like to suggest, we believe that healthwide planning, areawide planning, is the major instrument for effective limitation on health care cost. Just as an example, the metropolitan area in which we reside right now is a jurisdiction where planning will be done by three separate States and four separate planning bodies. It is our contention that in a multi-State jurisdiction involving a metropolitan area, that at least the tertiary types of care—by "tertiary types of care" I mean the kidney transplant programs, the open-heart surgery—ought to be done on a metropolitanwide basis, as opposed to a strictly political jurisdiction basis. I realize the political implications of that; individuals in the various States would have good reason to be jealous of their political rights in surrending that to a larger group over which they have really no political control.

But I think to do a rational job of health planning, that is imperative, particularly for the tertiary types of care. I think the primary types of care can best be done planningwise in the local communities. But when you are talking of a metropolitan area such as Washington, there are also about 19 other such metropolitan areas.

We believe that if a single limitation is to be provided, that it certainly should not be retroactive, and that it should take into consideration the facilities and programs which have already been approved in a specific institution.

We believe that the exception process ought to be clearer, and that it ought to be relatively simple, so that one does not get caught up in bureaucratic delays.

And, finally, we believe that the planning process will eventually have to be tied to a reimbursement cost review commission, such as the State of Maryland.

And, Senator, thank you very much. I would be willing to answer any questions. We are delighted, again, to have you at Georgetown this morning.

Senator KENNEDY. Thank you very much for your testimony. Obviously, in these areas of high service the transplants, the renal function, the cancer program, there is no intention that there be reduction or diminution of those in terms of quality.

However there are places and I know of a major city where there are probably too many hospitals doing too many of those particular transplants.

There may be some time in the future when those hospitals which are providing important and expensive functions will want to get together with hospitals that have been operating in a number of the States which have already been capped in terms of the limitation of increases. It will be helpful to these hospitals to see how they can best implement cost controls, because, obviously, there is no interest in seeing a termination or a reduction in terms of services that are not consistent in terms of quality.

I want to again thank you very much. I want to thank all of our listening audience for their patience during the course of our hearing. It has been extremely helpful to me and I know to the other members of the committee as well. Thank you very much.

[The prepared statement of Mr. O'Brien follows:]

STATEMENT OF THE GEORGETOWN UNIVERSITY HOSPITAL TO THE SUBCOMMITTEE ON HEALTH AND SCIENCE RESEARCH OF THE SENATE HUMAN RESOURCES COMMITTEE ON S. 1391, THE HOSPITAL COST-CONTAINMENT ACT OF 1977

Mr. Chairman: I am Charles M. O'Brien, Jr., administrator of the Georgetown University Hospital. With me today is Thomas J. Gletner, Assistant Administrator for Finance. On behalf of the hospital and the Georgetown University Medical Center, we welcome you, your staffs, and the other witnesses testifying on Senate Bill 1391. I would also like to express my appreciation to you for inviting the Georgetown University to present testimony to you today.

The Georgetown University Hospital is one of the five divisions of the Georgetown University Medical Center. The other divisions are the School of Medicine, School of Dentistry, School of Nursing, and the Medical Center Library. The Chancellor of the Medical Center is with us today.

The Georgetown University Hospital is a 450-bed facility which serves as the primary clinical teaching arm of the Georgetown University Medical Center. The hospital has a central role in the health science clinical education process. In this role it has capabilities in most of the clinical specialties and subspecialties, and it is a referral center for tertiary-type care. It provides clinical experience for students from the schools of medicine, dentistry and nursing at the undergraduate level, graduate medical education for interns and residents, continuing postgraduate education for practicing clinicians, and education for allied health science disciplines. Fifteen thousand inpatients are treated annually, and there are over 100,000 ambulatory

visits each year. It is a resource for health science manpower locally, regionally and nationally; thus its programs have both patient care impact and educational impact.

Inherent in being a component of a private university is the necessity for the Georgetown University Hospital being self-supporting in terms of operational revenue, including an annual provision of one and three-quarter million dollars in free or below-cost care.

From this brief summary of the Georgetown University Hospital and its almost 78 years of service to the public, we will comment in three parts concerning S. 1391, as follows:

(1) Factors affecting increased costs at the Georgetown University Hospital;

(2) Problems inherent in the proposed legislation;

(3) Alternatives for controlling health care costs.

Inflation in the hospital field has been brought about by a number of factors, many of which are external to hospital control. An example for the Georgetown University Hospital is the impact in the last year of traumatic increases in malpractice insurance. Despite an excellent track record in the professional liability area at the Georgetown University, premiums for malpractice insurance increased from $350,000 to $3,000,000, or approximately $26 per day.

In our judgment, part of the over-all rationale associated with escalating professional liability insurance premiums is the rising expectation of the public related to medical care and the impact of recent court decisions which establish, or by common law imply, expectations of infallible results by hospitals and health professionals

in the health care rendered. Physicians nationally have necessarily responded by practicing "defensive" medicine and have perhaps ordered, either consciously or unconsciously, additional tests and services -- which has had a significant impact on serving to increase hospital and physician costs.

General inflation is another major factor which has impacted substantially upon hospitals. As an example, fuel costs for the Georgetown University Hospital have risen an average of 25% for each of the last two years. In addition, many of the products used in this hospital are petroleum derivatives. Syringes, tubing, catheters and many pharmaceuticals fall into this category.

Very important but expense-laden government regulations add operating and capital costs to the hospital. To participate in the Medicare program requires compliance with the Life Safety Code for Health Care Facilities. The main wings of the Georgetown University Hospital, constructed in 1947, are presently undergoing necessary and basic Code compliance renovation at an expense of several million dollars. With the decrease in federal funding available for such renovations, this hospital is utilizing its internal depreciation allowance and external borrowing, both methods incurring, either directly or indirectly, additional but essential expense.

Legislation in the recent past such as OSHA and PSRO has resulted in additional costs. With respect to the PSRO, the hiring of six full-time professional and administrative personnel was required to provide administrative and recording service, in addition to the hundreds of hours of physicians' time.

Further in the area of regulatory costs, the administrative reporting required of federally-sponsored programs has added substantially in the volume of paperwork. It requires, for example, two full-time persons to handle the financial reporting related to the endstage renal disease program. Additional are the efforts of the financial staff and medical staff in preparing cost reports for that particular program.

Recent regulations of the DHEW dealing with public ease of access for handicapped persons will add further to capital requirements on the part of the Georgetown University Hospital and, we believe, many hospitals throughout the country. The objective is certainly worthy (and we at Georgetown have been working to implement it in the renovation program), but it will add to the per diem cost.

A final example of governmental regulation which would increase hospital costs is the pending regulation by DHEW to require every hospital to install a new uniform system of accounting which meets the needs of the DHEW but does not necessarily meet the needs of the hospital. The implementation of such a new chart of accounts will entail high system conversion costs, the re-training of many levels of personnel, the necessity of maintaining for at least one year dual charts of accounts to meet the operating requirements of the individual hospital, university, etc. Since this change by DHEW has not yet been published, it is urged that a uniform system of <u>reporting</u>, as opposed to a uniform system of <u>accounting</u>, be developed by DHEW.

These cited regulatory requirements are for the most part desirable. We endorse their intent and welcome their emphasis.

However, if cost benefit is to be the criterion of S-1391, we then wish to identify that significant cost of hospital operation is being added annually by developments completely external to the control of hospitals, of which many such additions are regulatory in nature.

Change in treatment modalities and increasing demand for tertiary services:

As the demographics of the American population change, health care institutions are providing service to patients with so-called degenerative illnesses such as strokes, cardiovascular disease, cancer and the like. The treatment of these disease processes requires substantial health-care professional man-hours and increased use of highly technological equipment. In earlier decades, advances in health care dealt with infectious and communicable diseases resulting in dramatic shifts in morbidity and mortality rates when breakthroughs were found. In delivering health care today for the degenerative diseases, the impact on mortality rates comes slowly. However, in terms of prolonging life and alleviating suffering, the continued aggressive programs by the health care establishment is the standard desired by every patient, family and friends in time of health problems.

As a university hospital, Georgetown has a variety of programs which deal with degenerative diseases and in which progress in the treatment processes has been real. While time does not permit detailing each and every significant such program, I believe it desirable to highlight several because of their projected expanding nature in the next several years and the catastrophic impact on the benefit these programs could contribute if legislation similar to S. 1391 is enacted.

The Georgetown University Medical Center is one of nineteen

designated comprehensive cancer treatment centers in the United States. Over the last several years an imposing array of dedicated multidisciplinary health professionals has been recruited to Georgetown for attack on this deadly killer. One out of four Americans now living will be touched personally by cancer. The community of cancer specialists believes that in order to have an effective cancer treatment and research program, it is necessary to have centers of highly concentrated resources of both personnel and facilities. This approach requires that not only the medical needs of the patient must be considered, but also that the psycho-socio treatment of the patient and family be likewise considered. The clinical treatment of patients involves the close coordination of the medical/surgical, radiation oncology, and multiple other disciplines within medicine.

While no over-all cure for cancer has yet been found, there is good data suggesting that with proper treatment, such cancers as Hodgkins disease, vesticular cancer, and numerous other cancers can be treated successfully with no recurrence over a ten-year period. This was not possible a decade ago. Further successes with the use of chemotherapy and surgery in other areas of cancer treatment can be expected, but only if continued resources in the research, experimentation, and patient care in cancer are forthcoming. Enactment of the proposed legislation to limit health care costs would halt the enhancement and development of additional cancer therapy modalities, as well as prevent the expansion of current capabilities to additional patients. What a social planner might see as an inconsequential impact becomes very traumatic indeed to a family whose child is denied the latest advances and potential hope for expanded cancer treatment and research.

In the area of both cancer and stroke treatment, the first

United States CAT scanner was developed here at Georgetown. While CAT scanning is certainly a proper concern in relation to potential escalation of costs, we have witnessed at Georgetown significant changes in the diagnosis and treatment of patients as a result of its use. Studies of the brain at one time were accomplished mainly by means of injecting air into an artery. This method is not without risk. With the development of CAT-scanning technology, it is now possible for a hydrocephalic child to be diagnosed on an outpatient basis without the painful and risky air-injection method. Additionally, the CAT scanner has allowed for improved accuracy in detecting changes in tumors related to treatment by either chemotherapy, radiation therapy, or surgery. When surrounded by the proper professional backup staff, CAT scanning has very significantly contributed to the better diagnosis and treatment of certain disease processes.

Another major program at the Georgetown University Medical Center is the endstage renal disease program. Georgetown has long been in the forefront in the treatment of renal disease, both medically and surgically. By June 30, 1977, we anticipate completing 12 renal transplants. Prior to the announcement of S. 1391 cost-containment procedures, transplantation for at least 30 patients was planned for 1977/1978. There are now 78 patients in a pool who have been worked up for transplantation. They await only donor kidneys and the time when the operation can be done. The current proposed guidelines imply a limit on the number of kidney transplants for next year, related to the number of such transplants this year.

Operating a kidney program involves highly specialized teamwork, with professionals of multidisciplines such as nephrology, immunology, social work, dietetics, nursing, etc. It is not an inexpensive program, yet it is

literally life-saving in returning productive individuals to society.

In addition to these two programs, Georgetown has many other patient care programs which are at the forefront of development in their respective disciplines. Part of our role is the development of new knowledge and the implementation of that knowledge through clinical programs, the contribution of which does add to the cost of care but the results are alleviation of pain and suffering for many members of our society. The impact of the proposed cost-containment legislation will be to freeze at the current state the developments or expansion of new treatment courses. Other examples of such program commitments relate to high-risk pregnancy, neonatal intensive care, cardiovascular surgical and medical treatment, neurological disorders, psychiatric dysfunctions, etc.

Turning from the impact of the proposed guidelines on the programs which are in place or expanding at the Georgetown University Hospital, I would like to discuss some of the mechanics of this legislation which we believe suggests that the program is administratively unworkable and entirely too complex to be equitably applied.

Section 112 of S. 1391 states that the Secretary will announce an "Adjusted inpatient hospital revenue increase limit between July and October of any given year." Since the fiscal year for the Georgetown University Hospital ends June 30 (for which the internal fiscal planning at the G.U. Medical Center requires budget programming eight months prior to the beginning of the fiscal year), the "July and October" would create difficulties in the fiscal budgetary process. Avoidance of this difficulty would require hospitals to change their fiscal year to October through September.

Implied in the proposed legislation is the ability of hospitals, on a continuing basis, to monitor the relationship of costs, charges and admissions. These three factors are complex in themselves and require extensive analyses. In addition, a need to monitor changes in financial mix of patients becomes a most improbable objective in that in many cases income equals cost, while in others, income equals some percentage of charges. As a result, the coupling of these three factors -- admissions, cost and charges -- expands the need for information availability and timeliness, adding to the cost of operations. To propose guidelines that retroactively would restrict costs and/or charges for any industry would seem to be highly impracticable.

On June 30, 1976, the Georgetown University Hospital opened a new and innovative facility which was ten years in the planning and for which proper planning agency approvals had been obtained. Despite this contribution to local, regional and national care, we now find ourselves in a position that the operational cost of this new facility may not be allowable under the proposed cost limitations unless a doubtful exception process is sought. On initial reading, the exception suggests a considerable time lag which would require operation under uncertainty and a virtual assurance (based on dealing with past federal programs) that no exception would be granted. Experience under the wage/price stablilization program of a previous Administration indicates that in programs of this type, the exception process is the last written and exceptions seldom granted.

To conclude: I should make it abundantly clear that we, too, are very much concerned about hospital costs. We believe it is a highly complex matter and not one which can be dealt with under the

provisions of this legislation. It is particularly burdensome to those institutions which, having gone through the proper planning channels, have developed new facilities and new programs -- only to find, on a retroactive basis, that the recovery of costs is prohibited. If a single percentage limit upon costs is to be applied nationally (a concept with which we do not agree) then certainly we do believe it should be applied prospectively.

We believe that Congress and the DHEW can be of assistance in controlling health costs through the implementation of proper planning. Public Law 94-641 which Congress passed in 1975 is being implemented in this metropolitan area on a fragmented basis by four separate and distinct planning agencies. Although the three state jurisdictions have agreed to the sharing of information, there is no indication that planning for tertiary-type services and facilities will be done on a metropolitan-wide basis. We believe that planning ought to be metropolitan-wide in scope.

Programs which involve high technology and a multidisciplinary team approach should be concentrated in a rather limited number of institutions in each region. Said institutions should be those with (a) the capability to develop new knowledge; (b) capability to test the effectiveness of new programs, and (c) educate the health care community in the uses of these new modalities. The implementation of such a program of limiting highly sophisticated technology to a few institutions in each region would eliminate much of the duplication of services and would promote lower overall hospital costs nationally. I should point out, however, that those institutions which are designated regional referral centers will have higher costs.

Again I express my appreciation at being able to present our views on S. 1391. If you have any questions, I would be pleased to answer them.

Senator KENNEDY. The subcommittee stands in recess.
[The subcommittee recessed at 12:50 p.m.]

HOSPITAL COST CONTAINMENT ACT OF 1977

THURSDAY, MAY 26, 1977

U.S. SENATE,
SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
OF THE COMMITTEE ON HUMAN RESOURCES,
Washington, D.C.

The subcommittee met, pursuant to recess, at 10:15, in room 1114, Dirksen Senate Office Building, Senator Edward M. Kennedy (chairman of the subcommittee) presiding.

Present: Senators Kennedy, Schweiker, and Chafee.

Committee staff present: Stuart Shapiro and Robert Wenger, professional staff members; David Winston and David Main, minority.

Senator KENNEDY. The committee will come to order.

Americans can no longer afford to pour unlimited dollars into our fragmented nonsystem of health care. Americans now work more than 1 full month of every year just to pay for their health care—2 weeks, wages for hospital costs alone.

Last year, the Nation's total hospital bill was $55.4 billion, and it is climbing at more than 15 percent a year. In 3 years, the average hospital stay will cost more than $2,000, when a decade ago, it was less than $300. Not many of us can afford to get sick and go to a hospital.

We are pouring so much money right now into hospitals to cure illnesses that we haven't had enough money to spend on basic preventive health care. It is a lot more humane and a lot less expensive to prevent illness than to have to put someone into a hospital to cure them.

Vital programs such as immunizing children have not been given the priority they deserve. Nearly 9 cents of every Federal dollar spent goes to the hospital industry while far less than 1 penny is spent on preventive care.

It is not just the Federal budget that is fueling the hospital industry. Individual States and county governments paid twice as much for medicaid in 1976 than they did in 1971. States are being forced to cut back on medicaid benefits for the poor rather than face bankruptcy.

For too long, we have paid hospitals whatever they have wanted. The cost of a hospital stay has risen 2½ times faster than the 6-percent increase in the Consumer Price Index; so it is not just the costs of supplies and equipment that is causing costs to go up.

How much longer can we let this go on? Unless we enact legislation that changes the incentive systems within hospitals, they will continue to add expensive new facilities, personnel, and technologies.

Few are asking "Do we really need all the laboratory tests and X-rays?" We spent nearly three times as much for laboratory tests in 1975 than we did in 1971. A recent study by the prestigious Institute

of Medicine documented that this Nation as a whole has 100,000 more hospital beds than it needs, and this unneeded excess capacity costs all of us well over $2 billion per year.

This open-ended reimbursement has allowed the massive proliferation of expensive equipment in both hospitals and doctors' offices. The 1,000 CAT scanners now installed or on order have the capacity to scan over 3 million patients a year, and most often this expensive procedure has little clinical efficacy and could have been avoided by a careful physical examination by the doctor.

Today is the second in a series of hearings on S. 1391, "The Hospital Cost Containment Act of 1977," and other potential solutions to the double-digit increases in health care costs.

I have indicated hundreds of times over the past 8 years, since I became chairman of the Senate Health Subcommittee, that we need sweeping reform in the way we finance and deliver health care in America.

We have waited too long already for national health insurance, but even if it were signed into law tomorrow, it would require substantial leadtime to implement. In the meantime, we can no longer afford the 31-percent increases in hospital care of the past 2 years.

That is why we need a transitional cost control program now. I am committed to the speedy passage of a program that is administratively simple, does not create new, expensive bureaucracy, and will result in significant savings. S. 1391 is not perfect—but it is a good starting point. Recent estimates by the Congressional Budget Office demonstrate that S. 1391, as drafted, would save over $40 billion in the next 5 years.

At the hearing 2 days ago, the American Hospital Association was strongly opposed to the bill, but they refused to present meaningful alternatives.

I hope that the witnesses today who will oppose the bill will have constructive suggestions. I plan to move forward with a transitional cost control bill that will have an impact by next year. Americans work too hard to waste one more penny on unnecessary hospitalization, unnecessary surgery, unnecessary drugs, unnecessary laboratory tests, or unnecessary doctor visits.

Senator Schweiker?

Senator SCHWEIKER. Thank you, Mr. Chairman.

I do not have a formal statement, but I do want to say in deference to the witnesses, Mr. Chairman, that unfortunately our Labor-HEW Appropriations Subcommittee has scheduled a markup at the same time this hearing is to take place. Since I am active in health matters over there, I will probably have to leave shortly to attend to those duties. I am stating this to the witnesses to indicate that my absence indicates no discourtesy or disinterest in their statements; which I will make a point of reading in the record.

Senator KENNEDY. Senator Chafee?

Senator CHAFEE. Thank you very much, Mr. Chairman.

I, too, would hope that any witnesses that are in opposition, Mr. Chairman, will give us some constructive alternatives. I do not think this bill necessarily is the end all, but we are not making much progress unless we hear from the witnesses in opposition as to what they would include as an alternative. And I state that because the problem is here and I think we all recognize it and we are all dedicated to trying to do

something about the problem; but unless we hear some constructive alternatives, we are not making much progress.

Thank you, Mr. Chairman.

Senator KENNEDY. We want to welcome two old friends: Douglas A. Fraser, president, International Union, United Auto Workers, accompaned by Melvin A. Glasser, director, Social Security Department, UAW. Both of these men have been extremely helpful to this subcommittee and to me personally in focusing on health care issues.

The United Mine Workers and others in the trade union movement have been enormously active and concerned about health care costs.

The fact is that their workers are now working 1 month a year, to pay for health care; and more is being spent by the auto industry on health care than on steel prices.

One of the interesting phenomena that I have found constructive is that auto workers in this country pay a great deal more in terms of their health care costs than their brothers do just across the border in Canada. They spend about twice as much working for a health care system which in so many ways is not as comprehensive as that which is right across the border in Canada.

These statistics and figures have always interested me.

I might add that the auto workers have one of the best health care programs in the country. And the fact that they are as concerned as they are about the issue of application of good health care is, I think, a great tribute to its leadership and its membership.

We are delighted to welcome Douglas Fraser and look forward to his testimony.

STATEMENT OF DOUGLAS A. FRASER, PRESIDENT, INTERNATIONAL UNION, UNITED AUTO WORKERS; ACCOMPANIED BY MELVIN A. GLASSER, DIRECTOR, SOCIAL SECURITY DEPARTMENT, UAW

Mr. FRASER. Thank you.

As you indicated, with me is Melvin Glasser, director of the UAW social security department.

I would like to read a short statement if you don't mind and then submit to questions.

Our UAW members have been shocked by the skyrocketing of health care costs. As President Carter told our convention recently, hospital costs, if unchecked, will double every 5 years.

The cost of our negotiated health care benefits programs with the 3 auto companies is now 95¢ to $1 per hour.

Each penny is worth about $8 million at General Motors alone. This is money which is being diverted from wages and other benefits to pay hospitals and doctors.

Most of the increases our union has been able to negotiate has gone to pay increasing health care premiums for benefits which we have already bargained. Most of this money does not go to pay for improved health care coverages. About 6 weeks' wages of the Big 3 autoworker—rather than the 4 weeks you mentioned—goes to pay the premiums for hospitals and doctors' bills each year.

Senator KENNEDY. That is really extraordinary.

Mr. FRASER. It is.

Senator KENNEDY. It is easy to lose track of figures, tests and statistics; but what really puts this matter into its proper perspective is the fact that 6 weeks of the workers' annual wages goes to their health care. This has been an increasing trend over the last few years.

Mr. FRASER. It is an albatross at the bargaining table, because here you have the massive amount of money lying right in the center of that bargaining table along with your proposals for wage increases and pensions and holidays and vacations and all the other benefits that go into a collective bargaining agreement; and you have this massive amount of money you must set aside for health care. And obviously the amount of money that you set aside just detracts proportionately from the amount of money you can pay in wages and other benefits.

Senator KENNEDY. What you are pointing out here is that in terms of the whole collective bargaining process health care takes an inordinate proportion of the funds available to the disadvantage of other benefits such as additional wages, additional security in terms of their families, retirement benefits and other factors.

Mr. FRASER. It enormously complicates the bargaining process. For example, we had a strike in Ford in 1976 and part of the reason for that strike was because the Ford Motor Co.—understandably, with these enormous costs—desired that the workers assume part of that cost. And I think we are the only trade union movement in the world that has to concern itself with the health care of their members at the bargaining table. I know of no other country in the world, except to a limited extent, Canada, where you have to be concerned about bargaining for benefits in terms of health care for your members. And it obviously complicates the collective bargaining process.

Senator KENNEDY. Well, I want you to continue with your statement, but this is a cost to management, too; is it not?

Mr. FRASER. An enormous cost.

Senator KENNEDY. It seems to me that they ought to have as much interest, if not more, in terms of trying to get some cost control; because not only is it impacting what the wage earner is taking home; but I would think it has an important impact in terms of profit for the companies as well.

Mr. FRASER. Yes. The fact of the matter is, as I will point out in my statement, they sort of ignored this problem for years but now just in the last negotiations in 1976 have we made agreements in several areas to try to contain some of the costs. And I guess the costs became so burdensome to them that they set aside their philosophical hangups and are now embarking upon a cost-containment program with us.

Senator CHAFEE. Mr. Fraser, just one question.

In the contracts you negotiate, would the individual worker have a deductible feature when he goes to the hospital?

Would he have to pay x dollars or would your program entirely cover his hospital costs?

Mr. FRASER. His hospital costs are almost completely covered. There are a few incidentals that would not be covered. In terms of the doctors' fees, it is the reasonable and customary fees.

So in terms of the protection, I suppose it is fair to say that the auto worker is better protected probably than any other worker in America.

Senator CHAFEE. I suppose the converse of that, or one of the things I suppose we will be considering here is whether such a contract encourages overutilization. Dr. Knoll was on the TV today on the Today show and I think one if his points was that Americans use too much hospital care. And I just wonder if, when there is no incentive on the user to discourage him from using the hospital, whether he in fact uses it more than is necessary? I don't know the answer.

Mr. FRASER. I would make the observation from just a couple of studies—and there are probably many more available—I do not think there is any evidence that deductibles deter people from medical care.

The other point I wish to make, particularly in relation to this legislation, is that only doctors admit people to the hospitals; the patient does not admit himself. And I could cite you the State of Michigan situation chapter and verse, Senator, of just the horrible waste that takes place by doctors unnecessarily putting people in the hospitals and, once there, keeping them in the hospital too long. But you know, a patient simply does not admit himself to the hospital. It is the action of the doctor that does it.

Senator CHAFEE. Thank you.

Senator KENNEDY. On this point I think it would be helpful to look at the experiences of some other countries.

In the Canadian experience, when they went towards a comprehensive coverage with the universal health-insurance program, there was some bulge in terms of utilization as many of the unmet needs of the people in Canada were being attended to. Now as I understand from our meetings with Mark Lalaun, the Canadian Minister of Health, that they are just about back to normal in terms of what the utilization was. There has been some increase, but a very marginal increase, in terms of utilization. And they vary in terms of different counties and in terms of deductibles; but it is generally back to normal.

I understand the Saskatchewans vary with the deductibles, as well as those in other places—but even in those areas, it has not increased so dramatically.

And I have always found where the overutilization comes is from people who have an awful lot of time on their hands and have a good deal of affluence rather than from the working people who are too busy either on their jobs or looking after their families.

I do not know whether that has been your experience in terms of the UAW, but it has certainly been my impression in reviewing this matter.

Mr. FRASER. Any auto worker that I know, Senator, does not want to spend his time waiting in a doctor's office. He has other things that he wants to do.

If I might put the Canadian example in the collective bargaining context again. At Chrysler where I had the collective bargaining responsibility, we have an international agreement. They do not have this in Ford and General Motors. The cost of health benefits at Chrysler last year, in terms of cents per hour, in the United States was 59 cents per hour more than it was in Canada. And this is despite the fact that they have more complete coverage in Canada than we do in the United States. And this is under the same collective bargaining agreement.

Senator SCHWEIKER. I have some questions, Mr. Chairman.

Senator KENNEDY. Yes.

Senator SCHWEIKER. Does the package for health benefits for your workers include health maintenance organizations, or do you use a standard group insurance plan?

Mr. FRASER. It includes health maintenance organizations. The fact of the matter is that in several places of the country we have dual choice. We have one in Detroit which is called the Metro Health Plan; we have out in California—we have Kaiser-Permanente; we have one in Cleveland—but there are too few.

And here again, if I might digress once more, if you take the health plan in Detroit and you measure the number of patient days per thousand subscribers, the Metro Health Plan, the prepaid group practice plan as against the Blue Cross and Blue Shield, Mr. Chairman, Metro Health Plan members use less than half the days per 1,000. And more startling, far fewer of these surgical procedures occur in a group health plan as against the fee-for-service plan. They are both covered by the same collective bargaining agreement. And every year we give each worker a choice as to which plan he wishes to take or if he wishes to change.

Senator SCHWEIKER. Does each worker, Mr. Fraser, no matter where he works, have that choice, considering the availability of HMO's?

Mr. FRASER. If there is a plan, Senator.

Senator SCHWEIKER. That is what I mean.

How many instances are there where people would like to join an HMO but do not have one available? In other words, how many situations are there where they would like to exercise full choice but cannot?

Mr. FRASER. Oh, the majority of our locations. I think the opportunity of choice available to the auto workers, Senator, is just in a few locations. I suspect that is true for the other workers.

Senator SCHWEIKER. And how does your union population break down between the conventional plan and the MHO plan?

Mr. FRASER. The conventional plan has the vast majority except where you have a system that has been in place for an extended period of time, such as Kaiser-Permanente in California.

It is admittedly difficult to get people to convert from one plan to the other.

Mr. GLASSER. May I supplement it and put in two numbers?

In Kaiser, in northern California, about half of our members are under the Kaiser Plan and half are under Blue Cross-Blue Shield. It is on the basis of individual choice, Senator.

In southern California, the number is about one-fourth—and that would be higher except that Los Angeles is so dispersed, Senator, that accessibility is a factor in the choice.

Mr. FRASER. Health care costs for the first time in many years are an important factor in labor strife. The insistence of the Ford Motor Co. last fall in containing its health-insurance expenses through shifting a portion of them to workers was a contributing factor to the 5-week strike which occurred.

And yet UAW coverages now exclude many needed health care benefits such as doctor and office and home visits, custodial nursing-home care care, ambulance care and preventive services for children.

Our union believes that the bill before you may contain hospital cost increases for a limited period and therefore we support it.

However, the bill cannot contain health care costs for any lengthy period because it does not deal with the causes of the cost escalation.

Fortunately, President Carter understands this.

In addressing the UAW convention in May 16th, he stated:

"We must move immediately to start bringing health care costs under control." And he also stated the administration is aiming to submit legislative proposals for national health insurance "early next year." We believe this is a sound approach. It has our full support.

S. 1391 is a modest proposal indeed; 150 percent of the cost of living is too high a ceiling on hospital costs which have been rising at 2½ times the cost of living for several years now. This has been without any appreciable lowering of death or sickness levels in the population as a whole.

In our view the major deficiency in this bill is that it does not go far enough. It should be extended to include cost controls on nursing homes.

There are about 15,000 nursing homes providing some level of nursing care. Over half of the revenues of these institutions comes from medicaid and medicare. Eighty percent of the nursing homes are private for profit operations. This contrasts with 10 percent of the short-term general hospitals.

It is hardly surprising, therefore, that nursing home expenditures in the last 2 years increased almost a third more rapidly than even hospital expenditures. In fiscal year 1975 over 1974, their expenditures increased 31.9 percent.

Senator KENNEDY. Could I ask about the nursing homes, Mr. Fraser?

Is it your experience that there is some fat in the nursing home budget, too?

Do you have any figures that would reflect that possibility?

You suggest that you would include nursing homes within the same framework; but I am just wondering whether you think that there is some opportunity to cut back on unnecessary costs within nursing homes.

Mr. FRASER. Well, first of all, I hate to even suggest that the quality of care in nursing homes be modified in any way because, as you know, it is appalling. I think you can monitor the cost of nursing homes because, as I point out, 50 percent of their revenues are medicare and medicaid. And when you look at the profit situation, at the profit position of nursing care homes, obviously it seems to us it can reduce the cost.

Well, let me pick up here.

It is hard to accept that these apparently unwarranted increases are due to excessive costs in providing patient care. On the contrary, the voluminous testimony before Senator Moss' Senate Subcommittee on the Aging, and a number of in-depth State investigations, particularly in New York State, demonstrated that much of the care was substandard, callous, and shocking.

And many of the expenditures charged to public programs were for the personal profit and aggrandizement of the operators and had no relevance to patient care.

Monitoring of nursing homes could be done similarly as for hospitals by public payors on the basis of total nursing home revenues. Revenues could be certified by such payor agencies using prefiled statements of

nursing home revenues for the most recent base year and comparing current increases in total revenues to the base year.

There are serious defects in the monitoring and control system proposed in the bill, if it was to continue for any lengthy period.

Experience with medicare and medicaid has shown that where monitoring is left to a variety of intermediaries and third-party payers, it is uneven, frequently inequitable among hospitals and interpreted differently in different regions.

And while we appreciate the administration's efforts to hold down administrative costs, we have serious questions as to whether all hospitals required to participate will be treated equitably and the administration of exceptions will be dealt with comparably in California, Michigan, and Georgia.

A more basic problem with S. 1391 is that even in a limited period, restricting the ceiling to hospital revenues will force up other system costs. As a result of the ceiling on hospital inpatient revenues, hospital outpatient charges and physician fees can be expected to increase steeply.

And these charges are not, for the most part, adequately covered by insurance. Our union members do not wish to see hospital costs controlled at the expense of increased payments out of their pockets for outpatient medical care. This is not likely to occur if the administration proposes a sound national health insurance program next year and the Congress acts on it with reasonable speed.

Senator KENNEDY. I think this is an important point you make here, Mr. Fraser, and is one of the reasons that we have to view this as a temporary mechanism. If we do import some fiscal restraint in terms of the hospitals, I think you quite appropriately point out that there will probably be some expansion in terms of some of these other costs. The only way you can really deal with this is in a comprehensive plan. I think that is worth noting the reasons you have outlined as to why this ought to be a temporary measure.

Mr. FRASER. We were pleased to see that HMO hospitals were exempted from the ceiling formula. A problem remains, however, for those high quality prepaid group practice plans not yet federally approved.

The Federal approval process is a lengthy one. Many States have enacted HMO regulations which conflict with the Federal regulations. This problem needs to be addressed if the objectives of this exception are to be achieved.

The bill exempts low-wage workers' pay from the formula limit. This makes sense because wage increases have been responsible for only a small part of the overall increase in the cost of hospital care.

Increases in nonsupervisory workers' pay have not been a major source of the hospital cost problem. Many hospital workers still do not earn enough to maintain a moderate standard of living, and they should not be penalized by a needed hospital cost containment program.

On the other hand, the exemption in the bill for States with cost containment programs should be removed. Most of these programs have not proven effective. And, it is highly unlikely that new State programs started between now and next year will have any short-range impact on cost containment.

In the Occupational Safety and Health Act of 1970 a similar exception was made for State programs which match or exceed the Federal standards.

This exemption has not worked. It has weakened the Federal law. Providing State exemptions is contrary to the objectives of nationwide hospital cost containment. It would create further uncertainty for hospitals in administration of the program, and inequity for hospitals in different geographic areas.

CAPITAL EXPENDITURE CONTAINMENT PROVISIONS

S. 1391 deals in an effective way with the necessary containment of hospital capital expenditures. A recent Institute of Medicine report indicates that the evidence shows clearly that: "There are significant surplusses of short-term hospital beds and that they are contributing significantly to rising hospital care costs."

A standard of four beds per thousand is probably a generous one. We would hope that within a year, based on more precise information which HEW should collect, a lower ceiling would be set.

The allocation based strictly on population of each State probably needs to be tuned more finely. This is so that hospitals in areas of special need are able to expend greater proportions of the total moneys subject to the ceiling for new capital expenditures.

Good as it is, this section of S. 1391 does not go far enough in dealing with the problems of existing excess beds. Such beds may be staffed or partially staffed although lying empty. Or they may be occupied by patients who could be taken care of equally well in less intensive facilites or at home.

Provisions should be added to the bill for local health systems agencies and State planning agencies to designate specific hospitals having certain numbers of "excess" beds and to mandate proportionate reductions in hospital reimbursements by all payers to hospitals so designated.

HOSPITALS PROTEST TOO MUCH

We agree with HEW Secretary Califano's recent statement that slowdowns in hospital cost inflation do not have to be at the expense of quality health care. In fact, less medically unnecessary surgery, less medically unnecessary days in hospitals, less unused hospital beds and less drug prescribing will probably result in improving the quality of health care.

If hospital-based anesthesiologists and radiologists are paid on a salary basis rather than on a percentage of gross revenues from their franchised outlets, does anybody really think the quality of patient care will suffer? If we close substandard excess hospital beds, will patients suffer?

If we limit the proliferation of CAT scanners, will patients suffer? We think not.

Mr. Chairman, our union holds in high regard doctors and those charged with the operation of our voluntary nonprofit hospitals. With few exceptions they are men and women of competence and goodwill.

But we believe these traits should not insulate them from accountability for the social costs of their actions.

We believe the American Hospital Association, speaking in behalf of hospital administrators, is incorrect in stating that hospitals are "the victims rather than the causes of inflation."

We believe that AHA is misleading when they tell consumers that it is unfair to place ceilings upon hospital revenues when they have to pay more for the goods and services they need to function.

Why should hospitals charge 2½ times more for the services they sell than for the costs of goods and services hospitals purchase?

We believe it important for this committee to recognize that the American Hospital Association fails to distinguish between public purpose and private rights.

An important factor in our support of S. 1391 is that the bill places a ceiling on annual hospital expenditures, which comprise over 40 percent to the Nation's health care expenditures.

We recognize that through a variety of measures hospital administrators may be able in part to circumvent the annual ceiling. That is why the ceiling is probably too generous. But we are hoping the ceiling will persuade doctors and hospital administrators and hospital boards that they are part of the problem.

If the public must face up to the hard problem of paying more and more out-of-pocket each year for hospital costs, then those in charge of hospitals must take appropriate action to reduce the increasing numbers of hospital staff per bed.

They must lessen the purchase of expensive and underused equipment—some, at least, of doubtful value. Hospital boards must discontinue services which needlessly duplicate those neighboring hospitals. They must provide expensive services 7 days, not 5 days, a week, to minimize unnecessary days in hospital per patient stay.

In Michigan, the public is being asked to accept an average rate increase in the Blue Cross-Blue Shield premium of 12.4 percent. The Michigan Blue Cross-Blue Shield premium for a Chrysler worker with a family is already $147.05 a month, excluding dental coverage.

This proposed increase comes at the same time that we were told that Blues' subscribers in Michigan are using fewer hospital days per 1,000 than in the previous year.

Hospital bed occupancy is down from the previous year. Average medical-surgical length of stay is also decreasing. Our members cannot understand how when fewer hospital services are being provided and fewer days of care are being used, costs continue to rise, apparently without regard to these factors. In Michigan, premiums have been rising at a rate of 20 percent per year for the last 3 years, if this year's Blues' rate increase is approved by the insurance commissioner.

TRANSITION TO WHAT?

We are often asked why the UAW has put so much effort into securing the passage of comprehensive national health insurance when our members already have among the best health insurance programs in the Nation. But we know that we are not getting a sufficient quantity and quality of care for the exorbitant prices we are already paying.

We saw too and were frightened in 1975 by the specter of some 30 million Americans who lost their health insurance coverage when they lost their jobs.

Tens of millions of Americans, including those who are union members, cannot afford the benefits the UAW has been able to negotiate. Millions of other Americans cannot get adequate care even if they have basic private and public health insurance. This is because care is not accessible in many of our urban and rural areas and because there are legions of specialists and subspecialists and not enough family doctors.

Those who provide care are not accountable to those who pay for it. Too much of our collective bargaining moneys go to pay hospitals and doctors, and our health is not being proportionately improved. And by most reliable estimates, some 40 million Americans under the age of 65 do not have adequate access to our health-care system.

The administration's bill is described as a transitional hospital cost containment proposal. We believe that it may work temporarily to restrain hospital costs if it is transitional to early passage of a decent national health insurance plan as promised by President Carter last week.

Last August in the campaign the President made a commitment "to decisively phase in simultaneous reform of services and refinancing of costs" under the following principles:

Coverage must be universal and mandatory. Every citizen must be entitled to the same level of comprehensive benefits;

Barriers to early and preventive care must be reduced in order to lower the need for hospitalization;

Benefits should be insured by a combination of resources: employer and employee shared payroll taxes and general tax revenues;

Uniform standards and levels of quality and payment must be approved for the Nation as a part of rational health planning;

Strong and clear cost and quality controls must be built into the program;

Rates for institutional care and physicians' charges must be set in advance;

Consumer representation in the development and administration of the health program should be assured;

Incentives for reorganization of delivery must be an essential part of the payment mechanism; and

National priorities of need and feasibility should determine the stages of the system's implementation.

We see S. 1391 as a beginning to be followed by an administration national health insurance proposal based on the President's stated principles.

We urge therefore the passage of this bill. In addition, we strongly recommend this committee and the leadership of the Senate begin the preparatory work to make possible early and full consideration of the President's plan for national health insurance shortly after the first of next year.

Senator KENNEDY. Thank you very much.

Thank you, Mr. Fraser, for a very comprehensive statement. One of the things we have observed from those who have expressed reservations about this approach is that with this kind of cap there will be adverse impact in terms of the quality of care that will be provided for the consumers.

Now, how can you, representing the consumers and representing over 1 million auto workers, support a program that, at least as some

believe, is going to be diminishing the quality of care of the workers you represent? Do you believe that to be the case?

Mr. FRASER. No; I do not, Senator. There is such horrendous waste in the whole system that the fact of the matter is that we think the cost containment provisions of S. 1391 are a bit too generous and we could recite many chapter and verse areas where costs could be reduced without affecting the quality of care.

Senator KENNEDY. So you do not believe that it would be a diminution of the quality of care? We have heard impressive testimony from the State of Massachusetts. They have been able to apply cost containment provisions now for close to 2 years, and the quality of care may well have been strengthened and improved that is against the background of 9 percent of the hospitals in the country last year including some of the most impressive health facilities like Johns Hopkins and Massachusetts General Hospital. I think this is going to be a strawman that is going to be raised constantly. I think your interest and concern about it is very important.

Second, are you concerned that the limitations in terms of construction costs will mean a diminution of quality?

If we are not able to get the construction resources to improve or expand the facilities and bring in new technology and other types of hardware, do you think that that is going to mean a diminution in the quality delivered to the workers?

Mr. FRASER. Certainly not. And I think all the evidence is to the contrary, Senator. These are, as you point out, straw men. We have heard them before. We heard the same arguments, for example—and I do not like to be parochial about this but this is my experience in the State of Michigan—we heard the identical argument every time that we argued for cost containment, Senator, before the insurance commissioner. And the arguments proved to be false.

Mr. GLASSER. Mr. Senator, may I introduce two specific illustrations of why a cap may in fact improve the quality of health care?

First, it is widely known that we have far too many open-heart facilities in the country and in every major city, and without exception as far as I know. They cost anywhere from $1 million to $2 million a year to maintain. It is generally conceded that an open-heart surgery facility that performs a number of operations each day, that because its staff is better qualified and experienced, it is more likely to be successful than one which performs several surgeries a week.

But yet we have both situations prevailing. Our view would be that if we close many of these open-heart surgeries and therefore saved money, patient care would improve.

The second illustration has to do with the fact the number of births in this country, as we all know, has gone down dramatically. The hospitals of the United States are replete with obstetrical units which are highly underutilized and that, therefore, are costing hospitals a great deal of money. And yet the professionals in medicine advise us that, as a rough figure, a hospital should be delivering, that a unit should be handling from 2,000 to 3,000 deliveries a year in order to have the range of services needed to give maximum protection to the mother and the infant.

There are hundreds of hospitals that are now maintaining units that are delivering several hundred on up to 1,000 babies a year, and cannot support quality services. And they are at the same time losing money.

A hospital cost containment provision in our view would force many of these hospitals to close out these units and consolidate—and that would provide for improved care.

Senator KENNEDY. Do you think that is true in other procedures as well, such as hysterectomies and tonsilectomies.

Mr. GLASSER. The list is long.

Mr. FRASER. One of the most recent developments, again speaking about the Michigan area, is that practically every hospital now wants a CAT scanner, and that is at enormous cost. And they are almost all underutilized, except in one or two situations.

Senator CHAFEE. I think we are going to have to recognize, Mr. Fraser—and I think you will agree with me—that while there are some empty hospitals and empty beds, that this provision is going to go much further than getting rid of just excess beds—in some instances, some hospitals are going to have to be closed. And in areas with relatively stable populations or in fact I suppose you could call it declining populations, or where the rate of growth of the population has declined—like up in my area, for instance—I think some pretty good hospitals are going to have to be closed.

Now, this is always a traumatic thing, as you know. And it is not just the hospital administrators or the doctors who are against it; the people in the area are against it.

And even closing down units such as obstetrical units, creates a tremendous uproar. So this is not just the hospital people we are dealing with; we are dealing with the citizens.

I am not saying it cannot be done, but sometimes it is not the easiest thing. In our area we tried to propose a closedown of some obstetrical units, or the planning groups have tried to do so, and it just does not work. So what you do is run into too much of a buzz saw.

The other thing that I would like to mention and I'd like to know if you agree with this, is that in your statement you talked a good deal about the use of unnecessary techniques. I think part of this may be due to the practice of so-called defensive medicine, due to these tremendous suits resulting from malpractice.

Mr. FRASER. I agree. I do not think there is any question about the fact that a lot of doctors and institutions are practicing so-called defensive medicine.

Senator CHAFEE. It is just the easiest thing to do, you know, go ahead and operate, rather than take the chance of being hit with a lawsuit.

Mr. FRASER. And they go through a lot of unnecessary preparatory procedures, aside from surgery.

Senator KENNEDY. We had testimony from the Secretary of HEW who said that defensive medicine costing $8 billion to $10 billion a year is practiced in this country right now, which is bad economics, bad health care, and a waste of money. And as the Senator may know, we have tried to deal with the malpractice situation.

Last year, I introduced three different bills with different approaches to it to see if we could not work out at least some kind of means to deal with it. But there were such reservations in terms of the States wanting to deal with this issue, that it did not succeed.

So what you are going to find is a polyglot of different State regulations. And I daresay 5 to 7 years from now we are going to be sitting here trying to deal with it because in many instances the commissioners

of insurance have very little idea of comprehensiveness in terms of trying to deal effectively with malpractice insurance. But it is a problem we have to recognize.

But I do think in keeping with that kind of factor, it is still a relatively small percentage of the hospital budget.

Senator CHAFEE. Well, I found your testimony about the Canadian experience extremely interesting and I hope we are able to get a little deeper into how it is done there. I always think there might be other factors involved than just the difference of a river.

Just crossing the river into Canada cannot seem to make all this difference in terms of approach. Maybe there is something I don't know about or maybe they just run their affairs better up there. I do not know the answer.

But I would certainly look forward to getting some more testimony on that because the very figures you point out are extremely interesting.

The other factor that we have already gotten your testimony on—it just seems to me that there ought to be some way—maybe not through the union contracts or through third party arrangements—but there should be some way to encourage the greater use of ambulatory facilities or out-patient facilities. And while it is true that no auto worker wants to voluntarily go into a hospital, and it is the doctor who sends him there, I cannot believe that the doctor subconsciously is not thinking: well, it is really not going to cost him anything so I will send him off to the hospital, and we will take a look at it tomorrow.

Do you agree with that?

Do you think that the lack of the incentive, as it were, with the individual under a plan—for instance, your plan—provides for greater utilization of the hospital than normally would be true?

Mr. FRASER. No; I do not.

Your remarks lead me to the conclusion that we desperately need a national health security plan. That is the only solution to the kinds of problems that you have posed, which I do not know the answer to.

Senator CHAFEE. Well, that is a big issue in itself. We have enough to wrestle with right here with this problem.

OK; fine.

Well, I certainly appreciate your testimony today, and I might say that I campaigned on some form of national insurance—not that I think Senator Kennedy's and my ideas are completely in synchronization on this, but we believe in the objectives.

It is a pleasure to hear from you.

Senator KENNEDY. I want to thank you very much, Mr. Fraser and Mr. Glasser, for your testimony. It has been very helpful. We appreciate your appearance here today.

Our next witness is Bert Seidman, American Federation of Labor and Congress of Industrial Organizations.

Mr. Seidman, we welcome you here to the committee. We have worked very closely with you on a number of different health issues such as the changes last year in our HMO legislation.

We appreciate the thoughtfulness that you give these various issues and look forward to your testimony.

STATEMENT OF BERT SEIDMAN, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS; ACCOMPANIED BY ROBERT McGLOTTEN, DEPARTMENT OF LEGISLATION, AFL–CIO; AND RICHARD E. SHOEMAKER, DEPARTMENT OF SOCIAL SECURITY

Mr. SEIDMAN. Thank you very much, Mr. Chairman.

First, let me convey the very sincere regrets of Andrew Biemiller, director of the Department of Legislation of the AFL–CIO for not being able to be here this morning.

Second, I would like to introduce my colleague.

To my left is Robert McClotten, who is a member of the Department of Legislation of the AFL–CIO.

To my right is Mr. Richard Shoemaker, who is a member of my department, the Department of Social Security.

May I also ask that Mr. Biemiller's full statement be included in the record of the hearing? And I will give a summary of it.

Senator CHAFEE. Fine.

Mr. SEIDMAN. On behalf of the AFL–CIO, we wish to express our appreciation for the opportunity to testify before the Subcommittee on Health on the Hospital Cost Containment Act of 1977, S. 1391.

S. 1391 establishes a Federal program of hospital cost containment which is designed to place a ceiling on future increases in hospital costs.

The average cost of a hospital stay has been increasing at about double the rate of the increase of the Consumer Price Index. Clearly, something must be done to contain the escalation in hospital costs.

The administration's bill has some strengths and some weaknesses.

One strength is its provisions to place a ceiling on total hospital revenues. This comprehensive approach would contain not only hospital charges but also excessive utilization of hospital beds and extravagant use of personnel and capital resources, some of which is of marginal value in diagnosing and curing disease.

However, a ceiling on hospital revenues can only be a short-term solution to the hospital cost escalation problem.

As time goes on, any attempt to regulate a single industry to the exclusion of others tends to build up distortions and stresses with respect to the allocation of human and capital resources.

The high cost inefficient hospital would receive the same 9-percent increase in revenues as the low-cost efficient hospital. Inefficiency would, therefore, be rewarded and efficiency would be penalized.

Also, even if hospital costs are contained, S. 1391 does nothing about the escalation of doctor fees or the increasing costs of drugs, nursing home care and home health services. Voluntary hospitals will inevitably attempt to transfer their expensive patients onto the public hospitals in order to contain their costs.

We see no reason why big city public general hospitals should be covered under the bill. Such hospitals are already under stringent municipal and county budget controls. In fact, these hospitals are underfunded.

A much more effective way in which to control hospital costs would be to phase in the principles of the health security bill, S. 3, introduced by the distinguished chairman of this subcommittee.

Under this approach, the Health Security Board would be empowered to negotiate hospital budgets on a hospital-by-hospital basis. Such an approach would provide flexibility, equity and maximum adaption to local circumstances.

The wages of nonsupervisory employees lag behind wages of such employees in private industry generally and in the service industry. For this reason, the wages of hospital employees should be established through free collective bargaining and not be restrained by the hospital cost containment program.

In recent years, the average wages of nonsupervisory employees in hospitals have risen less than 9 percent annually and, therefore, pose no threat to the 9-percent increase in hospital revenues which would be allowed by this bill.

The recent staff report of the Council on Wage and Price Stability, "The Rapid Rise of Hospital Costs," clearly shows that hospital wages have only been a minor factor in escalating hospital costs. Total labor costs were the source of only about one-tenth of the annual increase in average costs per patient, per day.

According to the American Hospital Association, payroll expenses have steadily declined as a proportion of total hospital expenses from 66 percent in 1962 to 51 percent in the last quarter of 1976. But AHA payroll data includes salaries of supervisory employees. The percent of hospital expenses represented by nonsupervisory employees is only 35 percent.

Thus, since wage increases of nonsupervisory employees have no bearing on the runaway inflation in hospital costs, we strongly urge the exclusion of the wage nonsupervisory employees from the hospital's base accounting year for purposes of determining the allowable increase.

However, requests for such exclusion should not be optional with the hospitals as is provided in section 124 of S. 1391. This section purports to exempt nonsupervisory personnel wage increases from the hospital revenue limit.

Instead, it provides an incentive for hospitals to continue to increase expenditures in those areas which have been most responsible for health care inflation.

This loophole is provided by the optional nature of the recalculation of revenue limits as stated in section 124. In short, if hospitals request a modification of their revenues to eliminate the effects of nonsupervisory wages, then nonlabor costs can only rise by the permissible limit, that is 9 percent.

If, on the other hand, a hospital does not request such a modification, then it is possible for nonlabor costs to rise by as much as 14 percent by shifting the burden of the program onto the shoulders of low-wage workers by not granting such workers an increase.

The example that is contained in our full statement, on page 6, illustrates the problem.

The solution to this flaw in the legislation is to require the Secretary to modify for all hospitals the in-patient hospital revenue limit to assure exclusion from the base of any wage increases of nonsupervisory

employees. This can readily be accomplished by dropping the language at the beginning of section 124(a), which states:

"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."

A major problem with the bill is that it initially allows a minimum of six States to opt out of the Federal hospital cost containment program and operate their own program as long as such States meet the Federal criteria.

However, the provisions in the Federal law which are designed to provide for free collective bargaining are not included as one of the requisites for such State administration. In addition, the other States could opt out of the Federal program in future years thereby emasculating uniform and effective administration.

The AFL–CIO strongly favors a Federal program with uniform standards and uniform administration. If, however, States are allowed to administer their own programs, one criterion that should be required of the States would be that they adopt the Federal standard which would exclude nonsupervisory wages from the cost containment formula. This is implied in President Carter's health message but it is not specifically included in the bill.

Highly objectionable to the AFL–CIO is the provision in the bill which provides that the Secretary of the Department of Health, Education, and Welfare would have the authority to review but one aspect of the program—the provisions relating to wages—and subsequently be able to modify or eliminate the exclusion of nonsupervisory wages.

It is the position of the AFL–CIO that the Secretary should report to the Congress as to how the entire program is working within 18 months so that Congress can take whatever action it deems appropriate.

S. 1391 cannot be more than a temporary program since the regulation of a single industry involves many complexities and potentially serious distortions. The entire program, therefore, should be reviewed by March 31, 1979.

The disclosure requirement of the bill are completely inadequate. As stated by AFL–CIO President George Meany:

> For too long, hospitals have operated under a veil of secrecy despite the fact that tax dollars are a major source of hospital income.
> Taxpayers have a right to know how these funds are expended.

Public disclosure of each hospital's total receipts, expenses, assets and liabilities should be required. Hospitals should disclose the salaries of all highly paid employees, including their fringe benefits.

Detailed conflict-of-interest statements should be required of highly paid administrators and hospital trustees.

In particular, the total receipts of a hospital's pathology and radiology departments should be disclosed. If anesthesiologists, pathologists and radiologists bill separately for their services, all such physicians should disclose their gross and net incomes.

Additional information that the public should know would be hospital charges and whether the hospital has a preadmission certification program, whether the hospital requires a second opinion for elec-

tive surgery and whether the hospital shares services with other hospitals to avoid duplication of services.

Voluntary nonprofit and for-profit hospitals should not be allowed to transfer their expensive and nonpaying patients onto the public hospitals. The provision of S. 1391 intended to deal with those problems need to be strengthened.

The AFL–CIO favors the proposed limitation on hospital capital expenditures but would suggest prepaid group practice plans to be given a priority for such capital expenditures as HMO hospitals reduce the total need for hospital beds.

In conclusion, Mr. Chairman, we approve the basic thrust of this bill which would establish a ceiling on hospital cost increases but the burden of cost containment must not be borne by low-paid hospital employees.

We strongly urge that the improvements we have suggested be incorporated into the final bill that is reported out and passed by the Senate.

Senator KENNEDY. I thank you very much for your testimony. I think your appendix B illustrates graphically the point you have been making about nonsupervisory employees.

Basically, what you are doing is comparing for comparable employment, Mr. Seidman, the hospital service—the total and private—and the distinction between the employees' wages, as I understand it?

Mr. SEIDMAN. That is correct.

Senator KENNEDY. Then what you are doing is using the average hourly earnings—and this could be a dishwasher's earnings in the hospital—versus a dishwasher in the service and versus a dishwasher in private industry—and they might not be getting this hourly wage; but the differential for the exact same service in each of these areas is different. And the difference is reflected on these charts as an average; am I correct in my interpretation?

Mr. SEIDMAN. That is correct.

It might differ from one occupation to another, but on average this is what it would be. And we have no doubt that if you took occupation by occupation, you would find similar gaps as you see in this table.

Senator KENNEDY. And your concern is that any attempt to try and get some movement in this area requires a passthrough procedure. Without that there will continue to be wage discrimination against nonsupervisory hospital personnel.

Mr. SEIDMAN. Yes.

We see no reason why there should be this kind of discrimination against the hospital workers. And we would like to see this applied wherever the program is, even if—against our recommendation, I might say—there is this provision for waivers for the States.

Senator KENNEDY. And the other point as I understand it is that actually over the long term, say the last 20 to 30 years, or the very immediate short term, that the amount of increase by the supervisory personnel have been within the 9 percent index that we set in the bill.

Mr. SEIDMAN. The average annual wage increases have been much lower than 9 percent, but the Council on Wage and Price Stability, their study—incidentally conducted by a Harvard professor named Martin Feldstein—shows that the increase in wages of hospital workers

played an extremely small role in the tremendous escalation that has taken place in the hospital industry.

Senator KENNEDY. Now, what is your reaction to those that say if you get 9 percent and the other features, that this will either be some kind of limit or some kind of floor in terms of collective-bargaining for wages for hospital workers?

Mr. SEIDMAN. We think that the collective bargaining situation will be determined by the relative strength of labor and management in the hospital industry.

But of course, if there is an incentive for the hospitals to control wages, and particularly in situations where the unions are weak or just getting organized, those workers are going to suffer very badly. And that is why we think that wages of hospital workers should simply be taken out of this picture.

We do not see any threat of runaway escalation of hospital costs as a result of that. Quite the contrary.

Senator KENNEDY. Now, another very important point that you raise is in terms of the disclosure for various salaried personnel within the hospital system.

As I understand it, 40 percent of all the hospital costs are paid for by Federal, State, and local contributions. And what you are saying is that since there is such a public commitment in terms of resources, that there ought to be public disclosure in terms of how those moneys are being spent within the hospital institutions?

Do I understand correctly?

Mr. SEIDMAN. Yes, we certainly do think so, particularly in light of the tremendous escalation in cost which has taken place.

Senator KENNEDY. We will have a more complete idea of where these dollars are going?

Mr. SEIDMAN. Yes. May I say, Senator, I happen also to be very familiar with ERISA pension reform law, and we are asking essentially the same kinds of information, not exactly the same, but the same kinds of information, as required under that law.

Senator KENNEDY. In trying to deal with the issue of cost containment which involves such a large public investment and commitment that that kind of information ought to be available.

Mr. SEIDMAN. It is not, that is correct.

Senator KENNEDY. I think it should be. I have just one other question.

We have seen where the States, particularly my own State, have enacted legislation which I think has been very constructive and meaningful in addressing this. I understand your general concerns about the States moving in this area in terms of the development of different types of legislation.

It seems to me in some instances, such as in my own State of Massachusettes and also in Maryland, that some States have been quite innovative in attempting to come to grips with this problem. We have to deal with the issue of health insurance in a comprehensive way. States who have initiated controls on their own, some of which go even further than those suggested by the Federal Government, should not be precluded from some degree of flexibility and innovativeness in this system.

I know we have a differing view on it, but perhaps you would just elaborate a bit more on it. I do think some States have experimented,

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or are experimenting, and I think we probably can learn clearly from their cost control programs. For example, a number of features of this type were taken right out of the statute that was passed in Massachusetts.

I would be interested if you would elaborate on that point.

Mr. SEIDMAN. Mr. Chairman, I think we can learn from the experience of the States. But unfortunately, what we can learn is that it has not been all that good. A study was conducted by an organization, research organization, called ICF, Incorporated for Federation of American Hospitals. That study indicates that in 1974 to 1975 the States with mandatory rate setting programs had slightly smaller increases in hospital expenditures per case than States without controls.

However, this reduction was more than offset by increased utilization. The result was that the annual increase in hospital expenditures on a per capita basis was a little bit higher for the States with controls, 19.1 percent, than the States without controls, where it was 18.7 percent.

Now, I am not saying that these programs were completely ineffective, and there may be some differences between the States. But we do think the same principles should apply in all States, if we are going to be giving waivers, and we think this is going to fragment and weaken the effectiveness of the program, but if they are going to be giving these waivers, then we certainly think that the same principles should apply in the State administered programs as in the federally administered programs, not just with respect to the wages of nonsupervisory employees, although we are very much concerned about uniformity with respect to them, but also with respect to other aspects of the program.

Senator KENNEDY. I think, as I understand it, there were no States that had the overall cap in terms of hospital expenditures, and this program does envision an overall cap.

I do not know whether it would be more effective. In our own State of Massachusetts we have an overall cap which we did not have at the time of that particular study.

I think it is really the most important reason why we have a general revenue cap included in this, health security. If the States are going to achieve the goal that has been established in this legislation and do it through their own devices or means, I am wondering whether we ought to preclude them from dealing with it.

Mr. SEIDMAN. Of course the States do not have the same principles as this program does.

Senator KENNEDY. If they do not, then they obviously should be.

Mr. SEIDMAN. It seems to me if the Federal Government wishes to contract with States, for example, to administer programs based on these principles, including the one which we would hope would be included in the Federal laws that are not now included in the bill, that might be a possibility. But we do not think that it makes much sense to have a very different kind of program, and we will by no means be sure as to what the outcome of these different kinds of State programs would be, particularly if you conceive of this as we do, as a short-term interim measure leading to a comprehensive national insurance program, and not the kind of a program which in and of itself is going to be able to exist in this form for very long.

Senator KENNEDY. If the States abide by strict guidelines, then you would be satisfied?

Mr. SEIDMAN. If the guidelines are such that they would include all of the principles, major principles that are involved in the Federal legislation, then, in effect, they would be administering the Federal legislation, and we would not object to that as much as we would to simply permitting States to develop other programs.

Senator CHAFEE. What we are trying to do here is embark in an area in which we do not have a great deal of familiarity, and it seems we should encourage the States to take an approach that within the objective might well be quite different than what we are considering here.

In other words, I do not think all knowledge resides necessarily in this committee, or in the Congress. We have heard from the Governor of Massachusetts on an approach they have taken.

In my State they have taken a somewhat different approach. But from all this, hopefully, will come some pretty good ideas.

I have a little trouble following your reluctance to encourage any experimentation on the part of the States, as long as they stay within this 9 percent. I know your problem about the nonsupervisory employees.

But frankly, I, for one, would like, with the provisions of this act—to say to the States, go ahead and try something as long as you stay within the 9 percent.

Mr. SEIDMAN. If they are going to stay within the 9 percent, they are going to have to do the same kind of things that the Federal bill calls for. If they do not, they will not stay within the 9 percent.

So that it seems to me, it is not clear to me what these variations would be, if they are going to achieve the same objectives as Federal law.

The same thing we would say is, well, in some of these States the State laws do permit increases in nonlabor cost at the expense of labor costs.

We do not want to see that kind of discrimination from State to State against hospital workers. So if there are going to be these waivers, then we strongly urge that the bill be changed so that it is clear that that principle applies in all State laws.

Senator CHAFEE. I do not know of any State—I would be interested, if you could tell us for the record—if any State freezes nonsupervisory wages, and yet permits increases in expenditures for equipment, and so forth.

Mr. SEIDMAN. The way it does this, if it has an overall increase, and it does not permit an increase in wages, then it means that the overall increase will be that much greater in nonlabor costs.

Senator CHAFEE. Thank you very much.

Mr. SEIDMAN. Mr. Shoemaker wants to supplement the comments.

Mr. SHOEMAKER. Mr. Chairman and Senator Chafee, I think one thing to be kept in mind is that we do not want—let me put it this way—the administration indicates they will have at least guidelines for national health insurance program developed by March 31, 1978.

Now, the problem in dealing with temporary programs is that you setting—and you do not know what national health insurance program is going to be like, that you are already preempting it to a certain

extent, and setting formulations which probably may be in contradiction to any program to be handed down.

Now, certainly one of the big issues of national health insurance, whether the program should require a single payer, or a Federal-State program, or whatnot, I think that the committee ought to be concerned that we do not set up a program that would be contradictory to something that may be handed down by the administration at a later time.

Senator KENNEDY. Thank you very much for the helpful testimony.

Mr. SEIDMAN. Thank you.

[The prepared statement of Mr. Biemiller follows:]

STATEMENT OF ANDREW J. BIEMILLER, DIRECTOR, DEPARTMENT OF LEGISLATION
AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS
BEFORE THE SENATE HEALTH SUBCOMMITTEE
OF THE HUMAN RESOURCES COMMITTEE
ON THE HOSPITAL COST CONTAINMENT ACT OF 1977

May 26, 1977

On behalf of the AFL-CIO I wish to thank you for the opportunity to share with the Health Subcommittee of the Senate Human Resources Committee our views with regard to S. 1391 the Hospital Cost Containment Act of 1977.

This bill would establish a Federal program to place a ceiling on general and public, non-Federal hospital revenue increases of about nine percent per year, allow states with established hospital cost containment programs and some others to opt out of the Federal program, provide for an automatic adjustment to the ceiling for hospitals in growing communities and declining communities and allow for an exception process for hospitals which might experience hardship in meeting the ceiling. Since wages of nonsupervisory workers have not contributed significantly to hospital cost inflation, they are appropriately not taken into account in determining the ceiling under the Federal program. The bill has minimal disclosure provisions and Title II would place a limit on hospital capital expenditures.

The average cost per day of a hospital stay has been increasing at a rate of about double the rate of increase of the Consumers Price Index. According to the Council on Wage and Price Stability the average cost per day of a hospital confinement was $191 in September 1976. This represents an 18.4 percent increase over the same month in the previous year.

Clearly, something must be done.

We believe the basic approach of S. 1391 is a feasible one over the short run. It will not be, nor can it ever be, a permanent solution to the escalating cost of health care. Any attempt to single out a single industry to the exclusion of others tends to build up distortions and stresses with respect to the allocation of manpower and capital resources. In addition, the high cost, inefficient hospital is allowed the same percentage increase in revenues as the low cost, efficient hospital. Clearly, this is inequitable.

The bill exempts from coverage federal hospitals and health maintenance organization (HMO) hospitals from the hospital revenue and capital expenditures ceilings. We agree that Federal and HMO hospitals deserve an exemption because they are not responsible for overbedding and waste. But we would urge that large urban public hospitals also receive an exemption from the controls. They are already under budget control and are underfunded. Big-city public hospitals are desperately in need of new equipment and, in some cases, new facilities.

Disaccreditations of large urban public hospitals by the joint Commission on Accreditation of Hospitals have increased dramatically in recent years. Capital shortages for hospital improvements in Philadelphia, for example, led directly to disaccreditation of the city's only public hospital. Similar problems plague large public hospitals in New York, Boston, St. Louis, Chicago, New Orleans, Los Angeles and Washington, D. C.

Moreover, S. 1391 singles out only one segment of the health industry, albeit a large segment, without controlling physician fees and incomes, the high cost of drugs, nursing home care and home health services and without recognizing the inevitable impact on costs of dumping expensive long-term chronically ill patients onto the public hospital sector.

A far more effective and flexible means of cost control over hospital expenditures would be to phase-in coverage for hospitalization under the principles of the Health Security Bill (S. 3) introduced by the distinguished Chairman of this Subcommittee. Under the Health Security Program the Health Security Board would have the leverage of being the sole source of payment for hospital services. This establishes a situation where negotiation between two parties, each having considerable power, can strike a bargain as to each hospital's total budget. These negotiations would take place on a hospital-by-hospital basis to provide maximum flexibility, equity and adaptation to local circumstances. Under Health Security there would be no arbitrary ceilings, no complicated prospective reimbursement formulas nor a deluge of complicated regulations.

It should be pointed out that negotiation between payors and providers of health services is a characteristic of western European national health insurance schemes. Payors and providers mutually respect the power and integrity

of each other. In this country, the providers have all the power to set charges and fees and all third parties play the passive role of paying bills unilaterally determined by the providers. America has made a rather unique contribution to provider reimbursement in that the United States is the only country in the world that reimburses hospitals and usual and customary fees for physicians. No wonder the United States has outstripped every other country in the world in the percentage of the gross national product it devotes to health care. For example, in the year ending June 30, 1975 Canada spent 7.0 percent of their GNP on comprehensive health services without any deductibles and covered 99 percent of their population while the United States spent 8.3 percent of the GNP for health care with deductibles, with substantial benefit gaps and left 12 percent of the population without any health insurance at all, public or private.

But for the short run, the AFL-CIO supports the Administration's plan to establish limits on total hospital revenues, or hospital budgets, especially since, unlike current programs, such limits would apply equally to all third party payors including Blue Cross, Blue Shield and commercial insurance as well as to Federal reimbursement under the Medicare, Medicaid and Maternal and Child Health Programs.

President Carter's health message stated with respect to the Hospital Cost Containment Program:

> "This legislation is not a wage-price control program. It places no restrictions on the hospital's ability to determine its charges for any particular service. It places no limit on the size of any wage demand or settlement. The program establishes an overall limit on the rate of increase in reimbursements, permitting doctors and hospital administrators to allocate their own resources efficiently."

Commenting on the President's statement, AFL-CIO President George Meany on April 25, 1977 stated:

> "In his message, the President recognizes that hospital workers have not been responsible for hospital cost inflation and proposes adjustments in the containment formula for wage increases for nonsupervisory hospital employees." (The complete text of President Meany's release is attached as Appendix A of this statement).

We strongly support the concept that the wages of nonsupervisory employees must be determined by free collective bargaining.

Hospital wages still lag behind the average wage for all private nonsupervisory employees and even behind the average wage for service employees. In 1976, the average hourly earnings of nonsupervisory employees in all nonfarm employment amounted to $4.87. For service employees, it was $4.36 and for hospital workers only $4.18. Assuming a full work-year of 2080 hours, the annual earnings of the average hospital worker would come to $8694, substantially below the level of an austerity budget of $10,041 for a family of four in an urban community. From 1968 to 1976 the wages of hospital employees increased by only $1.87 while those of employees in service jobs increased by $1.93 and of all nonsupervisory employees in private industry by $2.02 even though it was during this period that hospital employees gained coverage under the Fair Labor Standards Act and for the first time large numbers of them were benefited by collective bargaining negotiations. (See Appendix B for the average hourly earnings for all private employment, all service employment and hospital employment from 1968 to 1976).

Clearly, hospital workers are still underpaid.

The Administration hopes that through this program, hospital expenditures can be contained to about a nine percent increase annually. Elimination of wages from the base will not compromise this goal. In fact, an average wage increase of nine percent per year is better than what unions in this industry have been achieving. Collective bargaining settlements have averaged much less. In 1975, the median bargained wage increase amounted to 7.7 percent. In that year, the cost-of-living rose 9.1 percent. Even organized hospitals were unable to keep up with the cost-of-living. In 1976, the average negotiated wage increase amounted to 6.4 percent while the cost-of-living increased 5.8 percent which still meant a drop in real wages over the two-year period. Nor do anticipated wage increases in this industry represent a threat to the nine percent ceiling.

The AFL-CIO unions with substantial membership in the hospital industry are the Service Employees International Union, the American Federation of State, County and Municipal Employees and Local 1199, of the Retail, Wholesale and Department Store Union. These unions will be submitting statements in more detail with respect to wages in the hospital industry and with respect to their collective bargaining contracts.

The recent staff report of the Council on Wage and Price Stability, "The Rapid Rise of Hospital Costs," clearly shows that hospital wages have only been a minor factor in escalating hospital costs. Total labor costs were the source of only about one-tenth of the annual increase in average costs per patient, per day. According to the American Hospital Association, payroll expenses have steadily declined as a proportion of total hospital expenses from 66 percent in 1962 to 51 percent in the last quarter of 1976. But AHA payroll data includes salaries of supervisory employees. The percent of hospital expenses represented by nonsupervisory employees is only 35 percent.

Thus, since wage increases of nonsupervisory employees have no bearing on the runaway inflation in hospital costs, we strongly urge the exclusion of the wages of nonsupervisory employees from the hospital's base accounting year for purposes of determining the allowable increase.

However, request for such exclusion should not be optional with the hospitals as is provided in Section 124 of S. 1391. This section purports to exempt nonsupervisory personnel wage increases from the hospital revenue limit. Instead, it provides an incentive for hospitals to continue to increase expenditures in those areas which have been most responsible for health care inflation. This loophole is provided by the optional nature of the recalculation of revenue limits as stated in Section 124. In short, if hospitals request a modification of their revenues to eliminate the effects of nonsupervisory wages, then nonlabor costs can only rise by the permissible limit (e.g., nine percent). If, on the other hand, a hospital does not request such a modification, then it is possible for nonlabor costs to rise by as much as 14 percent by shifting the burden of the program onto the shoulders of low-wage workers by not granting such workers any increases.

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The following numerical example illustrates the problem:

Assumptions:

1. Nonsupervisory labor costs = 35 percent of total operating costs.
2. Nonlabor expenses plus administrative salaries = 65 percent of total operating costs.
3. Cap = nine percent.

If a hospital can hold wage increases to zero percent the net effect is as follows:

Labor costs held to 0 percent x .35 = 0

Nonlabor costs rise by 13.85 percent x .65 = 9 percent

Total increase 9 percent

In other words, nonlabor costs which have been the source of health care inflation could increase by nearly 14 percent.

The solution to this flaw in the legislation is to require the Secretary to modify for all hospitals the inpatient hospital revenue limit to assure exclusion from the base of wage increases of nonsupervisory employees.

This can readily be accomplished by dropping the language at the beginning of Section 124(a) which states:

"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."

Section 124(a) would then begin:

"The Secretary shall modify ... etc.

The principal cause of hospital cost inflation is not wages but the control doctors exercise over the manpower and capital resources of the hospital. This control in voluntary hospitals is exercised without any accountability to either the hospital or to the public. The result is dual administration, poor planning, duplication of expensive and seldom used equipment and the purchase of new equipment the effectiveness of which is seldom evaluated.

Unfortunately, the bill provides initially for the exclusion of at least six states, provided the Governors of these states request exclusion and the Secretary of the Department of Health, Education and Welfare approves. The states that could opt out of the program under Section 117(a) include: Massachusetts, Connecticut, Maryland and Washington. Section 117(b) would also allow the states of New York and New Jersey to opt out of the Federal program.

The AFL-CIO strongly favors a national program with uniform standards and uniform administration. We find no convincing evidence that these states have performed an effective job of controlling hospital costs. A study conducted by ICF Incorporated for the Federation of American Hospitals indicates that in 1974-75 the states with mandatory rate-setting programs had slightly smaller increases in hospital expenditures per case than states without controls. However, this reduction was more than offset by increased utilization. The result was that the annual increase in hospital expenditures on a per capita basis was 19.1 percent for the states with controls versus 18.7 percent for the states with no controls for the years 1974 and 1975.

Furthermore, Section 117 would leave the door wide open for other states to opt out of the Federal program in the future. Section 118 would also allow any state to opt out of the Federal Hospital Cost Containment Law simply by establishing an experimental or demonstration program of prospective reimbursement under Medicare. Sections 117 and 118 are nothing less than an invitation to the states to assume the responsibility for hospital cost containment, a task they have been unable to perform in a satisfactory manner in the past.

However, if despite our recommendations, the possibility for states to opt out remains, then state hospital cost containment programs must include all of the requirements of the Federal law including the exclusion of non-supervisory wages from the nine percent ceiling. The President's health message clearly stated:

"Allow states which operate cost containment programs, and are capable of meeting the Federal program's criteria, to continue their own regulatory approaches."

S. 1391 does not conform to the President's message. One of the specific criteria stated by the President is "an adjustment for hospitals which provide wage increases to their nonsupervisory employees." But S. 1391 would not require of a state that opted out of the Federal program that it meet this criterion. If waivers are to be permitted, this must be made explicit in the statute.

Section 124(d) would single out for review the adjustment to hospital revenue that would result from the exclusion of nonsupervisory wages from the base year. Wages should not be singled out for review in eighteen months. The AFL-CIO believes the whole program should be reviewed within eighteen months by Congress and not only by the Administration. The dislocations and inequities that will inevitably develop through time of a ceiling on one industry's expenditures would require annual review in our opinion. Eighteen months is the maximum amount of time that should be allowed for the Administration and Congress to review the whole program.

Disclosure

One of the major disappointments of the Administration's bill is the weak disclosure provisions. The Medicare Cost Report (SSA Form 2552) is a potentially useful but baffling mass of data covering some 33 pages. The Report is unquestionably designed to meet the needs of fiscal intermediaries, but it is of limited use to consumers and hospital employees. It fails to list specific administrative salary and major cost information on such important areas as pathology and radiology. In fact, only a trained hospital accountant could conceivably make good use of the Medicare Cost Report.

As stated by President Meany, "the President's proposal also lacks adequate disclosure provisions of hospital finances and expenses. For too long, hospitals have operated under a veil of secrecy, despite the fact that tax dollars are a major source of hospital income. Taypayers have a right to know how these funds are expended and we will urge Congress to include adequate disclosure provisions in the final bill."

Unfortunately, S. 1391 does not require adequate disclosure. Therefore, with respect to disclosure, we urge the following:

* Each hospital should provide promptly on request by any citizen all cost reports submitted to Medicare, Medicaid and third-party payors during 1975 through the present. In addition, the hospital should disclose on request its IRS Form 990 or an equivalent complete listing of its total receipts, expenses and disbursements, including its total assets and liabilities for the period 1975 through the present.
* Each hospital should disclose on request the total wages, including all fringes and benefits (for example automobile, housing, etc.) paid to its ten highest paid employees; and in the case of hospitals which pay such salaries, the hospital should disclose the names, salaries and all fringe benefits of employees receiving in excess of $30,000 per year.
* Detailed conflict-of-interest statements should be disclosed by the hospital on request for all hospital governing board members, administrative staff and medical staff chairmen. Conflict-of-interest statements must list all investments and holdings representing an interest in excess of 0.5 percent in any concern doing business with the hospital.

* The hospital should disclose on request for the current and three most recent fiscal years, the total receipts of its pathology and radiology departments, including the gross income received by the physicians in charge of these departments. In the case of anesthesiologists, pathologists and radiologists who practice in the hospital but who bill separately for services, all such physicians should disclose their gross and net incomes for the current and three most recent fiscal years.

In addition, it would be desirable to disclose the following:

* Each health systems agency should have authority to collect from each hospital in its health service area a listing of the total cost for an average stay in the hospital for the ten most common medical and ten most common surgical procedures performed by acute care hospitals in the health service area at least every six months. The health systems agency should be required to promptly compile the listings and each hospital should prominently post the listings at its main entrance area and make the listing available on request to any person.
* Each hospital should prominently post in its main entrance area the following information:
  (1) whether or not the hospital conducts preadmission certification for all elective admissions.
  (2) whether or not the hospital requires a second opinion for all elective surgery.
  (3) whether or not the hospital shares services with other neighboring hospitals and what services are shared.

We are concerned about another problem. For-profit and voluntary nonprofit hospitals should not be allowed to transfer their underinsured patients -- those without Medicare, Medicaid or private insurance or with

minimal private insurance -- on public hospitals. A ceiling on hospital revenues will provide an incentive to private hospitals to accelerate and expand such practices which already are all too prevalent.

We, therefore, recommend that S. 1391 contain strong provisions forbidding hospitals to reduce their share of care of "unprofitable" patients except within the context of a coordinated and systematic community health plan. Hospitals should be required to maintain their patient mix, bad debt ratio and gross to net revenue ratio.

Allowable cost reimbursement formulas can be adjusted to reward hospitals which continue to serve the poor and underinsured and penalize those which transfer such patients onto public hospitals. Section 126 attempts to meet this problem by allowing an aggrieved hospital to file a complaint with the local Health Systems Agency. The HSA is authorized to investigate the complaint and upon a finding that the complaint is justified, the Secretary may exclude the offending hospital from participation in Medicare, Medicaid and the Maternal and Child Health Programs.

This section is not strong enough. For one thing, the Health Systems Agencies have insufficient funds to conduct such investigations nor are they staffed to perform this function. We believe this section should be strengthened by providing incentives for voluntary hospitals not to transfer unprofitable patients and reward public hospitals for accepting such patients.

Title II -- Limitations on Hospital Capital Expenditures

This title would set an annual national limit on new capital expenditures for hospital construction. The national limit would be allocated to the states on a formula basis which would also take into account other factors such as the number of beds in the state or local service area.

The AFL-CIO strongly supports this limit on new hospital construction. As stated by President Meany, "we endorse the Administration's plan to limit capital expenditures for new hospitals and the proposed efforts to encourage

Health Maintenance Organizations." With respect to the construction of new hospitals for HMOs, the construction or modernization of a one hundred bed hospital would reduce the need for hospital beds in a given community by more than two hundred beds. Prepaid group practice plans only need 1.5 beds per thousand subscribers while the standard for fee-for-service hospitals is 4.0 beds per thousand. Priority should be given, therefore, to construction funds for HMO hospitals.

In conclusion, Mr. Chairman, we approve the basic thrust of this bill which would establish a ceiling on hospital cost increases but the burden of cost containment must not be borne by low-paid hospital employees. We strongly urge that the improvements we have suggested be incorporated into the final bill that is reported out and passed by the Senate.

Appendix A

Statement
Of
AFL-CIO President George Meany
On
Administration's Hospital Cost Containment Program

April 25, 1977

AFL-CIO President George Meany today made the following comment on President Carter's health message:

President Carter's health message has focused public attention on the need to contain hospital costs now rising at a rate of more than 15 percent annually.

The AFL-CIO has a long history of supporting efforts to achieve effective and equitable containment of health care costs. In fact, the Health Security bill, which we support, contains the most stringent and effective cost controls of any national health insurance proposal.

The President's program, however, will only restrain and not stop the escalation in health care costs, for example there are no controls over physician fees.

Union-negotiated health plans are under extreme pressure to reduce benefits because of unacceptable extravagance in the hospital industry. Waste, unnecessary hospitalization and surgery, duplication of expensive hospital services and outlandish salaries and fees, such as those paid to radiologists and pathologists, must be brought under control.

Specifically, we endorse the Administration's plan to limit capital expenditures for new hospitals and the proposed efforts to encourage Health Maintenance Organizations.

In his message, the President recognizes that hospital workers have not been responsible for hospital cost inflation and proposes adjustments in the containment formula for wage increases for nonsupervisory hospital employees.

If states are permitted to operate their own hospital cost containment programs, as the President proposes, their programs must meet all of the criteria of the federal program, including the provisions concerning wage increases for hospital employees. We will ask Congress to make this explicit in any legislation.

The President's proposal also lacks adequate disclosure provisions of hospital finances and expenses. For too long, hospitals have operated under a veil of secrecy, despite the fact that tax dollars are a major source of hospital income. Taxpayers have a right to know how these funds are expended, and we will urge Congress to include adequate disclosure provisions in the final bill.

The President's message also outlines a $180 million program to extend benefits and expand availability of comprehensive health services for low-income children, which the AFL-CIO strongly supports.

Further, we welcome the President's renewed commitment to developing a workable program of national health insurance. We believe that the Health Security bill presently pending in the Congress is such a program and can truly contain health care costs and provide comprehensive health care services to all Americans.

Appendix B

Average Hourly Earnings
(Nonsupervisory Employees)

	Total Private	Service	Hospitals
1968	$2.85	$2.43	$2.31
1969	3.04	2.61	2.57
1970	3.22	2.81	2.79
1971	3.43	3.01	2.96
1972	3.65	3.40	3.08
1973	3.92	3.46	3.22
1974	4.22	3.76	3.45
1975	4.54	4.06	3.83
1976	4.87	4.36	4.18
Dollar Increase 1968-76	$2.02	$1.93	$1.87

Source: Bureau of Labor Statistics

Senator KENNEDY. Our next witness is Michael D. Bromberg, director, Federation of American Hospitals, and Andrew W. Miller, president-elect.

STATEMENT OF MICHAEL D. BROMBERG, DIRECTOR, FEDERATION OF AMERICAN HOSPITALS, ACCOMPANIED BY ANDREW W. MILLER, PRESIDENT-ELECT

Mr. BROMBERG. Thank you very much, Mr. Chairman.

With your permission, Mr. Miller and I will divide the allotted time, and make every effort to give some constructive alternatives to the bill before the committee.

The federation represents the Nation's 1,050 investor-owned hospitals with over 111,000 beds, encompassing small rural hospitals as well as large urban and suburban medical centers. These facilities were all built or acquired with private capital, thus saving billions of dollars in public funds.

In addition, our member hospital management companies now manage under contract over 165 additional hospitals, including teaching hospitals, public institutions, religious, and other community nonprofit hospitals.

Because of the investment of private risk capital and management of other hospitals under contract, our members are very conscious of cost containment.

We, therefore, share with the administration and the Congress a common desire to restrain inflation in the health delivery system.

When medicare and medicaid were first enacted 11 years ago, and until quite recently, Congress perceived its role to be one of increasing and assuring access for the elderly and the disadvantaged to quality health care. That public policy decision triggered the demand-pull inflation which is a major reason for these hearings.

Since Government has become the largest single purchaser of health care, the marketplace has become increasingly artificial as Government control over both the supply and demand intensifies.

The hospital industry has been hit with severe inflationary pressures for the past 10 years, and in particular, following the expiration of the economic stabilization program in early 1974. Those major pressures included catch-up wages in a labor intensive industry; escalation of prices for the goods and services purchased by hospitals, particularly in food, fuel, and malpractice insurance; a rapidly changing medical technology in which new diagnostic and therapeutic techniques and expensive new equipment are centered in the hospital; inflated material costs for hospital modernization and expansion programs; the increased costs of borrowing capital; increased costs of compliance with Government regulations; and the medicare-medicaid retrospective cost reimbursement formula which provides no incentives for efficient management and fails to meet its fair share of the total financial requirements of hospitals, forcing institutions to shift additional costs of private patients.

This combination of demand-pull and cost-push inflation has created a hospital industry with an annual inflation rate well above the overall consumer price index.

A hospital stay today is not comparable to a hospital stay 5 or 10 years ago. The quality of the service is so different that cost comparisons are just not possible without major adjustments for such proven innovations as intensive and coronary care units, burn units, blood banks, cobalt therapy, nuclear medicine, and a host of other techniques that are now standard in many hospitals to save and sustain life.

Duplication of these techniques and the expensive equipment needed to deliver that new technology should be avoided. Stronger planning laws have already been enacted, although not adequately financed, for that purpose.

While we support planning laws designed to meet community needs, without duplicating expensive services, we believe that arbitrary rationing of medical advances and technology by Government would not be in the public interest.

There is a clear conflict of interest when the major purchaser of services—Government—sets a ceiling on the prices, the technology, and the quality involved in delivering those services.

If Congress votes to place a ceiling on hospital revenues and on hospital based technology, then Congress will be voting to establishing itself as the moral judge of the dollar value of increased life spans, fewer fatal heart attacks, reduced infant mortality, significant survival rates for cancer patients, and every lifesaving device or technique.

Community health needs cannot be determined in advance by a Government-mandated dollar ceiling. Rationing can be forced through that approach, but if Congress adopts that approach to resource allocation, it will be telling the American people that our values have changed from assuring that community health needs are met to reducing medical advances to a level set by the Federal Government based on the advice of economists instead of community representatives, consumers, or health professionals.

Controllable costs in a hospital (wages, administrative, hotel services) have been increasing at a much slower rate than those over which the hospital has little or no control (medical services, drugs, intensity of care, malpractice insurance, costs of regulation, and patient mix). It is ironic that the proposed legislation under consideration today would place a stricter ceiling on noncontrollable costs of the hospital.

There are positive steps which can be taken to encourage efficiencies in hospital management and a reduction of the inflation rates in health programs.

HEW has cited three reasons for soaring hospital costs:

Unrestrained demand because patients pay little or nothing at the time the service is received for hospital care which is insured by third parties;

Lack of competition among hospitals; and

Cost reimbursement which encourages spending and provides no incentives for efficiency.

HEW has identified these three major reasons for high inflation rates, but instead of addressing those underlying costs of inflation, HEW has opted for an arbitrary ceiling on revenues and capital—a ceiling imposed on top of the same system which lacks competition, encourages inefficiency, and produces unrestrained consumer demand.

Senator CHAFEE. Mr. Bromberg, going back to your three reasons for soaring hospital costs cited by HEW—one being unrestrained

demand because patients pay little or nothing at the time service is received.

You were here when Mr. Fraser was testifying, and it was his belief that encouragement for patients to go into the hospital because they do not bear up front share of the costs.

What is your view on that?

Mr. BROMBERG. I disagree, but for a different reason. Later in our testimony, one of the 12 alternative suggestions we will make to the committee is a different kind of cost sharing, where the patient would have a stake in having to pay a greater part of the bill only if the patient selected, through his physician, or her physician, a higher cost institution than comparable institutions.

What we are trying to say is that the consumer might be able to have some influence on the physician as to which of the available hospitals that patient goes to. For example, if there are four hospitals in Providence, R.I., they all can do a simple hernia operation, and the range in cost may vary by hundreds of dollars a day, even among similar comparable institutions, teaching institutions, or smaller institutions, should have to bear some of that cost.

The patient would then discuss it with the doctor, as they do in outpatient side. There is consumer influence on pricing in the outpatient side, because there is consumer participation.

We would think there is a definite need for some kind of cost sharing in any national health, or even in medicare, as it now exists.

Senator KENNEDY. How in the world are you going to do that under the current system, where doctors are affiliated with one hospital, maybe two, so that when a patient gets sick, a stomach ache for example, he goes to the neighborhood doctor who is affiliated with one place and so the doctor assigns him to that hospital which he is going to go to.

Here you are suggesting that the doctor whom the patient visits sends him to a particular hospital, and because of this the patient quite possibly could bear more of the burden of the expense. We are not shopping for cars, where you go down and look at three different types of stationwagons, and find out what the rebates are on the various kinds of things.

Under the existing health care system, a doctor is affiliated with one hospital, and is assigned to that hospital, and that is the health care system we are dealing with. But to suggest a provision whereby the patient, because x doctor is affiliated with a teaching hospital and is assigned there, incurs a bigger bill and ends up paying more for it, is ridiculous. I do not think that we are dealing in the real world.

Senator CHAFEE. And furthermore, another point is that part of the whole thrust of this is to eliminate unnecessary beds, so presumably you are going to get more specializations in hospitals, and so the man is not going to be able to shop around for his hernia operation. There are not that many hospitals that he can shop for.

Mr. BROMBERG. Under present law there is a similar provision to what we are suggesting. It was enacted by Congress 3 or 4 years ago, as part of the medicare law, in which it stated any hospital which exceeds 80 percentile of average cost per day of its class would be cut off for medicare reimbursement, but could charge the patient the difference.

Very few hospitals have opted to do that, for public relations and community relations reasons. I think if there were more public disclosure of what hospital rates are, that public disclosure, the attendent publicity on it, would have a definite impact, psychologically and otherwise on hospital administrators and boards to take a close look at their charge and cost structures.

There are situations where those costs are legitimate, and patients are paying the difference.

Senator KENNEDY. Are you for public disclosure then of all hospital expenses, including the salaries of all the people employed there?

Mr. BROMBERG. We are for a very broad public disclosure, charges and salaries, absolutely. I think you cannot have competition until you have, or advise the public on disclosure.

Senator KENNEDY. Would you support the recommendation, if we make it in terms of public disclosure, as suggested by Mr. Seidman, AFL–CIO.

Mr. BROMBERG. I would have to look closely at the exact recommendations. I think you have to disclose something that the consumer can understand. Medicare cost report may not be the right document; perhaps a charge list would be.

Senator KENNEDY. If he cannot understand it, what is the harm of publishing it in any event? Maybe somebody else can understand it.

Mr. MILLER. It would just be added cost.

Senator KENNEDY. How do you feel about complete disclosure of salaried personnel in the hospital administration?

Mr. MILLER. Certainly I have no problem.

Mr. BROMBERG. I have no problem. I am not sure that benefits the consumer. I think he needs more.

Senator KENNEDY. You do not mind if we include that?

Mr. BROMBERG. We have no objection.

Senator KENNEDY. You would encourage us to do it?

Mr. BROMBERG. I would encourage you to go much further, and publish the charges of the 10 most common services in a hospital, and the average cost and charges per day of all hospitals, so there will be more awareness of what the comparable costs are.

Senator KENNEDY. How about the information regarding relationship between members of hospital governing boards and firms which deal with the hospitals. Is it possible to get information to the consumers who will understand about potential conflicts of interest?

Mr. BROMBERG. Three years ago our organization adopted a resolution recommending exactly that, that disclosure be made of the names of every owner of a for-profit hospital, or every board member of a nonprofit or for-profit hospital, and every company now doing business with that hospital, and that has been incorporated in H.R. 3, and we endorsed that several years ago.

Senator KENNEDY. You would support that in this bill?

Mr. BROMBERG. Absolutely.

Senator KENNEDY. Good. OK.

Senator CHAFEE. Are you going to continue on page 5?

Mr. BROMBERG. I am on page 6.

The next point we would like to make is we believe there is slight misunderstanding of the roles of hospitals on people who drafted this legislation.

Hospitals provide services. They do not order them. They have no legal authority to decide which medical services to order and which to reject. Physicians have that authority.

Senator KENNEDY. You do not think that in terms of getting new facilities and new technologies that a hospital administrator has a very significant kind of authority regarding that particular decision?

Mr. BROMBERG. I think he has significant influence, but I am beyond that now, in terms of once that equipment is in, he cannot tell the physician not to order the test.

Senator KENNEDY. What about closing down an excess wing of the hospital? Cannot a hospital administrator make decisions like that?

Mr. BROMBERG. Under present law that authority is now with the planning agency. The administrator makes recommendations, yes.

Senator KENNEDY. As might be gathered by reading this, the hospital provides services, they do not order them, they have no legal authority to decide which medical services and which physicians have that authority. I would not want that to go unchallenged, because hospital administrators have extremely broad authority and impact both directly and indirectly affecting a whole range of different services.

Mr. BROMBERG. You are absolutely right.

Senator KENNEDY. Let us continue.

The idea I wanted to comment on is it is just a facility there, and that the administrator has little authority, responsibility, or influence in terms of the whole range of different services that have been included in the legislation.

Mr. MILLER. If I might respond, I think it is important to note in context, within living within the 9 percent cap that new technology from year to year would have an impact on that, changing the physician practice patterns, different laboratory tests with existing technology would give us a great deal of a problem.

Mr. BROMBERG. In other words, ordering services, as opposed to deciding in advance what the scope of that service would be. If there is a problem with defensive medicine, if there is a problem of overutilizing what exists in place today, and we are not the ones to judge that necessarily, the hospital would have no legal authority to step in in that situation.

The administrator can serve on the utilization review committee, but the legal decision is the physician's.

Senator KENNEDY. Why don't the hospital administrators bring together some of those people from other areas of the country, or from other States, that work in those areas, to try and help.

Mr. BROMBERG. What you are really saying is the same thing that the Secretary is saying. He hopes hospitals will exert pressures on physicians. Congress has already decided again that peer review, PSRO, is a job for physicians. You have to be a physician to be on that team.

The national council is all physicians. Hospitals and administrators and boards, yes, can try to use their influence. When it comes down to deciding whether that patient needs three tests, or six tests, it is physician judgment.

Senator KENNEDY. I listened with great care to the Secretary, and there was nothing in his testimony whatsoever that would suggest that——

Mr. BROMBERG. Nothing except the legislation. By putting a 9-percent cap on, what happens is——

Senator KENNEDY. Are you suggesting that the administrator in Johns Hopkins tells doctors how many tests to perform, and whether they can provide treatment?

Mr. BROMBERG. I am saying, a little later under this bill, he is not going to have to worry about it as much, because a 9-percent ceiling on Johns Hopkins' average cost per day would be acceptable to all hospitals in this country.

Senator KENNEDY. Massachusetts General Hospital, a teaching hospital covering a whole range of categories, why are 22 percent able to comply——

Mr. BROMBERG. What this bill says is that every hospital, regardless of what it costs, are going to go up 9 percent. A $100 a day hospital gets $9, and Massachusetts General, Johns Hopkins, $500 a day hospitals, get $45.

Senator KENNEDY. With that you targeted in on one of the problems that we recognize as well, one that this legislation is going to deal with. But even with those inadequacies, it is going to save $40 billion.

Mr. BROMBERG. It is going to make it a lot easier for the already inefficient hospitals to meet the cap.

Senator KENNEDY. No one is saying this is not a perfect world that should not be changed. We are saving—with all those imperfections and inadequacies—we are saving $40 billion, and what we are interested in from the rest of your testimony is what your proposal is to help us save a similar amount.

Mr. BROMBERG. Let me refer to the example at the bottom of page 6 and the top of page 7.

What if the Government proposed a ceiling on the total revenue of grocery stores, but at the same time forced the stores to provide as much food as the consumers ordered?

The grocery store would have no control over the volume of food ordered or the cost of the food, and it could not raise prices in excess of the ceiling on gross income. That kind of plan probably would attract the support of housewives and even grocery store workers, provided their wage increases were exempt from the ceiling.

In the end, the only way the grocery store could survive would be to lower the quality of the product itself. We think this is an analogy.

We have given the example on pages 8 and 9 of commenting on the fat on this proposal, and we have some recommendations beginning on page 16.

We start to list 12 alternatives, which we hope will correct some of these inequities.

The first recommendation we have is endorsement of a bill introduced by Senator Talmadge, which has been worked on for several years to establish target rates for medicare and medicaid based on average costs of similar hospitals. That bill would treat hospitals fairly by providing incentives for those that are efficient and penalties for those shown to be out of line when compared with their peers.

The second and third suggestions we have, I would like——

Senator CHAFEE. Well, one of the problems with Senator Talmadge's bill is it puts it off for so long. What is the date? About 1981?

Senator KENNEDY. Three years.

Mr. BROMBERG. That is when the penalties take effect. There is a base year for the bill, and the publication of data starts in fiscal 1979—starting October 1978.

Senator CHAFEE. First of all, I want to acknowledge that I am delighted you are here today, because you people have had extensive experience in running hospitals with some incentive. There is nothing like the incentive for making profit that makes people try to keep their costs down.

However, I take it that your reimbursement is also based on your expenses, reimbursement by medicare and medicaid, and also Blue Cross. You have not had full thrust of incentives there.

But taking the Talmadge bill, suppose we said, all right, we begin that in October, is that physically possible if that bill should pass?

Mr. BROMBERG. In our testimony last year we recommended the Talmadge bill be accelerated, phased in more quickly. Another year has gone by.

Senator CHAFEE. Suppose we could wave a wand, and the bill would pass in July, when could that take effect?

Mr. BROMBERG. People at HEW say they do not have the data to do it now. We think perhaps it could be done much more quickly, even starting in January next year, or July 1 of next year. They tell us they do not have the accounting systems in place, or the data.

Senator CHAFEE. To make a comparison?

Mr. BROMBERG. You could do it, but one of the problems would be there might be some shifting in costs from routine to nonroutine. I think certainly within a year and a half that bill could be implemented, and perhaps the psychological impact of its coming, and perhaps using this as a base year would be one way of making sure that no one increased prices unnecessarily in the interim.

We would like to work on ways of accelerating it.

Senator CHAFEE. You mean calendar 1977?

Mr. BROMBERG. Or fiscal 1978.

Senator KENNEDY. As I understand it, the CBC has estimated it is $250 million by 1982. Is that your understanding?

Mr. BROMBERG. The $252 million has not been confirmed by the people who worked on the bill, to me, but even if it is true, they have recommended that we look into taking that bill across the board to nonmedicare and medicaid, and that would immediately triple that saving at a minimum, since medicare and medicaid are about 35 percent of the total.

Senator KENNEDY. You would be for expanding to include all the other——

Mr. BROMBERG. Depending on how it works, we would like to find a way.

Senator KENNEDY. In other words, you are not for it now?

Mr. BROMBERG. No, we have not seen the proposal, and we would like to work on it.

Senator KENNEDY. Whatever makes sense from medicare-medicaid would make sense, would it not, for the other?

Mr. BROMBERG. Provided charges instead of costs are used, that would be one test. Medicare and medicaid reimbursement is different from commercial insurance.

The general concept of taking hospitals by group, and seeing who is out of line and who is not, and that concept, looking at what the

average is, and putting a ceiling on the average, as opposed to on each hospital's previous experience.

The second and third recommendations relate to voluntary price guidelines. This basically would be in nonmedicare-medicaid area where we have recommended a combination of jaw boning, disclosure, review, and public finance.

The ICF Study referred to by the previous witness, of State programs, came to one other conclusion. It was that the State of Arizona had the most effective rate review program in the country by 2 percent. That program has no teeth in it, but it is a very effective program. It requires disclosure of all rate increases, justification statements, and public findings by the State bodies, as to whether it was warranted or not.

We think use of local and national publicity is a great weapon that can be used to moderate price increases on the charge side of the hospital structure.

The fourth recommendation we have been over about cost sharing.

Finally, we would require the abolition of phasing out of cost reimbursement——

Senator CHAFEE. Where is your cost sharing?

Mr. BROMBERG. Page 17, No. 4.

I think what we are saying here is the Government has promised access to a lot of health services which now, after 10 years experience, it finds it may have difficulty paying. If that is the case, and if it does not want to reduce benefits, and it wants to set a ceiling, at the very least it should not force the hospital not to be able to collect what it needs to exist, at least the patient should have to pay the difference, over and above the percentile or the ceiling.

The last recommendation on the cap side is the phaseout cost reimbursement, and require medicare and medicaid to move to prospective systems as quickly as possible, by soliciting and awarding contracts for prospective rate systems.

The ceiling on capital section of our testimony again zeroes in on the fact that we think——

Senator CHAFEE. Could you touch on that. I do not understand that, requiring the Secretary to solicit bids and award contracts for prospective payment systems to hospitals under the medicare program on a reasonable charge, or other basis.

You mean they would go to bid at which hospital is going to handle medicare patients?

Mr. BROMBERG. Let me give you an example.

For 6 years now Congress has authorized experiments. To my knowledge, there are only about five, or seven going on, which I think is very disappointing.

What we would like to see, for example, are bids of a nature where hospitals, either in groups, or individually, would come in and agree to service medicare and medicaid patients for agreed upon dollar amount. That could be determined by a formula, a percentage of average costs. It could be done by discount.

For example, you could agree to give medicare 5, 7, 8 percent discount, off what other patients are paying, or any other system of prospective reimbursement. Too little experimentation has been going on.

Blue Cross has done 26 experiments to 5 by HEW. They have been directed by Congress to do it. We need more movement away from cost reimbursement. We do not have the magic answer. We do not know which kind is best.

We know an agreed upon rate a year in advance is better than saying at the end of the year we will give you whatever your costs were.

Senator CHAFEE. Is this physically possible, in view of the fact that medicare and medicaid represent a substantial portion of the patient load of the hospitals, and so if the hospital acts when they award, you could not expect them to handle medicare population for that community?

Mr. BROMBERG. We are not suggesting all medicare-medicaid patients would have to go to one hospital. This would take away freedom of choice.

We are suggesting that where there are available hospitals that want to go on a prospective system, that the Federal Government should encourage that approach, use a negotiated rate.

Senator KENNEDY. Do you favor doctors having open staff privileges at different hospitals?

Mr. BROMBERG. I do know we have no official organization physician.

Senator KENNEDY. What is your personal view in light of your earlier point that it makes some sense?

You can be a little risky this morning. We are a nice friendly group and won't give you much trouble. [Laughter.]

Mr. BROMBERG. Our next suggestion concerns the ceiling on capital.

If there were not cost reimbursement, if the hospital had negotiated the charge in advance, we think there would have been a lot less duplication of services than in the future, and instead of talking about surplus hospital beds, and how to close them, normal market trends of bankruptcy in every other industry would have taken place.

The problem is, that with empty beds, it is subsidized. The prior witness said many of these empty beds are staffed, or partially staffed. They should not be. If management had an incentive not to staff them, they would not.

If you are getting your costs, whatever they are, back, why not keep them staffed? Why fire people? If you are getting $100 a day for full beds, and nothing for empty beds, you are not going to staff that bed necessarily.

I think elimination of cost reimbursement would not only help the revenue side, it would help duplication. You would not have open heart surgery in x number of hospitals underutilized, if it were not for the fact the costs were being reimbursed.

I think that first recommendation perhaps is the most important.

Senator KENNEDY. Why don't we go ahead and close them then? What does your operation or organization try to do to cut back?

Mr. BROMBERG. We try not to staff for them. The debt is there any way. The usual debt of the hospital is about 10 percent of operating costs. If 55 percent of your daily costs are wages, hopefully, if it is a permanently empty bed, you should have none of that involved—we do not.

Where hospitals operate in the South on charges, where Blue Cross pays charges, instead of in the North, where Blue Cross pays cost, we have incentives not to staff empty beds.

On the variable, 35 percent of hospital costs, that can be cut to very minimal amount. We would think well-managed hospitals should not have more than 15 percent of its cost of a full bed applied to an empty bed.

Yet the estimate we are reading about in the papers, is 50 percent.

Senator CHAFEE. Go through that statistic again. I did not understand you.

Mr. BROMBERG. If it costs $100 a day to operate a full bed in the hospital, we estimate that 55 percent, or $55 is wages, payroll, people, labor intensive industry, about 10 percent is debt, mortgage payment on equipment and building, and that the balance is variable services, supplies, products.

What we are saying is, if the bed is permanently empty, as opposed to that 20 percent you need for seasonal adjustment, there is no good management reason why the cost of sustaining that empty bed should be 50 percent of a full bed as we read in the papers.

We do not think it is in our hospitals. We think it is much closer to 10 to 15 percent. Just mortgage payment, and some minor variables.

Senator CHAFEE. What is a permanently empty bed?

Mr. BROMBERG. If you are running at 80-percent occupancy, you need the other 20 percent, but if you are running at 60 percent, there is probably 10 or 20 percent permanently or chronically empty.

Senator CHAFFEE. You have told us here how to run hospitals, and I am sure you have had considerable experience.

Has your experience shown you can run hospitals cheaper than nonprofit hospitals that are not run by you folks—in making true comparisons?

As you say, up in the beginning of your testimony, it is very hard to compare hospitals. One deals with intensive care for burns, and another deals with chronic long-term care, and so forth.

How does your outfit make out in running a hospital, comparatively speaking?

Mr. BROMBERG. I will let Mr. Miller answer the question. Mr. Miller's company, Hospital Corp. of America, is the biggest.

Mr. MILLER. There are many situations throughout the country where we have been able to offer management——

Senator CHAFEE. Would you speak into the microphone?

Mr. MILLER. There are many situations across the country where we have been able to offer management contract services to existing not-for-profit hospitals, and bring about substantial improvements in financial performance of hospitals, cost reductions.

However, to generalize that across the board would, I think, be somewhat inappropriate. Many hospitals, many not-for-profit hospitals, are doing excellent jobs, in our opinion.

As a corporation, we think we bring certain unique economies of scale to bear on the situation, such as central purchasing contracts, standard productivity ratios, and management systems.

But again it would be difficult to generalize that to the total population. There are many situations.

Mr. BROMBERG. I think the important point is whether we have done it or not, at least we are willing to try.

By endorsing the Talmadge approach, we are saying let us compete against the average and see if we are better or worse.

Senator CHAFEE. Are you saying that this bill would present hardships to hospitals you run?

Mr. MILLER. Yes, it would.

Mr. BROMBERG. More so than big, expensive hospitals. The small rural hospital would be hurt more by this bill, in our opinion, than the very expensive hospitals. The 9 percent would be a much lower figure.

Senator CHAFEE. We have had testimony that the increase in nonsupervisory wages is considerably less than 9 percent. Is that accurate?

Mr. BROMBERG. We did a survey, and we hope we will be able to keep it to 8.1 percent in the next year. What do we do if we negotiate 9 percent, and people on the other side of the table, representing the workers, say you might as well give us 15 percent or 20, that will be passed through. Salaries is one of the few things management can be tough about.

This is not part of the bill that would give us the most trouble. It is the ancillary part of it over which we have no control, that is what is growing. That is where doctors are ordering new tests, with new equipment. We cannot control that. We can control the hotel part of the hospital—food, dietary, bookkeeping, administration.

Senator CHAFEE. It is the laboratory costs that you cannot control?

Mr. BROMBERG. Things like that. That is right.

Senator KENNEDY. Of course, you have not had any incentive to hold down wages. You just pass those through, yet the hospitals have done a pretty good job.

Mr. BROMBERG. Geographically, in our industry, we are predominant in the Southeast and Southwest, where Blue Cross is not cost-reimbursement oriented, but charge-reimbursement oriented, and where commercial insurance companies have much greater market penetration than in the North and Northeast. That is not entirely by coincidence, but it is also where populations have boomed, in Florida and Texas.

Most of our hospitals are reimbursed on charges where there is a built-in incentive. Charges is most typical prospective rate there is. It is a negotiated rate in advance.

It may be able to change it during the year, but it is a negotiated rate. So we are located in areas where incentives do pay off.

Our management contracts seem to be coming in areas where hospitals are finding it much more difficult to meet the line in light of tougher regulations.

A few other recommendations on the capital side.

We were one of the organizations that supported the Planning Act when it was passed, and worked on by this committee. We would like to see it adequately funded.

We would also like to see a requirement that where certificate of need is about to be issued, competing applications be insisted upon, so competition is injected, and the most cost effective application is selected.

We would also point out that the capital ceiling in this bill does not exempt things like replacement of obsolete equipment, plant maintenance and expenditures mandated by law, such as installation of sprinkler systems, under the fire system laws.

Finally, we would urge that experiments on closing hospitals, and that use of funds for this purpose be geared primarily to closing the entire facility.

As we tried to point out before in our cost analysis, unless more money can be saved by closing the entire institution than by so closing a few beds within a hospital—we think again the Talmadge bill is a step in the right direction, where it says where a hospital wants to close, and where the planning agency thinks it should close, that some effort should be made to pay the cost of closing that facility.

Mr. Miller will just touch on a few of the management decisions which are affected by this bill.

Mr. MILLER. Mr. Chairman, I will keep these brief.

I have deleted several comments that I have submitted in writing, in previous discussions.

As health care manager, participating daily in these decisions affecting 28,000 employees, 6,000 physicians, and most importantly, 350,000 patients, who will be admitted to hospitals operated by Hospital Corp. of America this year, I would like to point out certain practical problems I foresee with S. 1391.

Ceiling on revenues proposed in title 1 of S. 1391 will force hospitals to postpone capital expenditures which may well be approved under the title 2 capital limitation provisions of the same bill.

Specifically, in order to stay in compliance with ceiling on revenues, many hospitals will be forced to postpone replacement of obsolete equipment, postpone modernization of antiquated physical plants, and postpone all new services, regardless of community needs and other approvals.

Revenue ceiling would also encourage hospitals to avoid financial hardships and redtape of appeal process by eliminating high cost, low profit services, and services requiring long length stay, again regardless of community need.

In addition, hospitals would in many cases be placed in financial situations under which they would be financially rewarded if they could find techniques to increase unnecessary short term, low cost admissions in order to lower average revenue for admission.

Mr. Chairman, as a constructive alternative, we submit that any ceiling imposed should be on average cost, or charges of similar hospitals, rather than on prior experience of each institution. This approach would apply basic concepts of the Talmadge bill, and would at least redirect economic incentives away from any inefficiency, and toward sound management practices.

We understand the need for Government to have better vehicle for predicting in advance its health care expenditures. However, we cannot accept a Federal ceiling on all Government and personal health care costs as a rational way to achieve that goal.

We have suggested a number of alternatives earlier, for containing health care costs, and we urge you to consider these proposals in lieu of S. 1391.

We thank you very much for the opportunity to present our views on this very important subject.

Senator KENNEDY. What do you account for the total expenditures per hospital admission. How much did you go up last year?

Mr. BROMBERG. Estimate about 13.5 percent to 14 percent total expenditure increase.

Senator KENNEDY. HEW tells us it is 21.

Mr. MILLER. I am not sure I understand.

Mr. BROMBERG. Was the question an increase in the total——

Senator KENNEDY. Expenditure per admission.

Mr. BROMBERG. We estimated ours was about 14 percent, I believe. I did not think the entire hospital industry was that high. I do not have that figure.

Senator KENNEDY. Well, we ought to get these figures and statistics so we can compare them.

Thank you very much. I will have to submit the other questions as we have two more panels, and we have to terminate at 1 o'clock.

Your commentary this morning was helpful and we will look forward to working with you.

Thank you.

Mr. BROMBERG. Thank you very much.

[The prepared statements of Mr. Bromberg and Mr. Miller follow:]

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STATEMENT OF

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AND

ANDREW W. MILLER, PRESIDENT-ELECT

FEDERATION OF AMERICAN HOSPITALS

BEFORE THE

SENATE SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

COMMITTEE ON HUMAN RESOURCES

ON S. 1391

THE HOSPITAL COST CONTAINMENT ACT

MAY 26, 1977

-ONE-

On behalf of the members of the Federation of American Hospitals, the national trade association of investor-owned hospitals, we appreciate this opportunity to present our views on S. 1391 the proposed Hospital Cost Containment Act and to discuss our recommendations for containing the rising cost of hospital care. I am Michael D. Bromberg, Director of the Federation. Accompanying me is Andrew W. Miller, President-Elect of our organization and Vice President, Administration, of Hospital Corporation of America, Inc. the world's largest hospital management company.

The Federation represents the nation's 1,050 investor-owned hospitals with over 111,000 beds, encompassing small rural hospitals as well as large urban and suburban medical centers. These facilities were all built or acquired with private capital, thus saving billions of dollars in public funds. In addition, our member hospital management companies now manage under contract over 165 additional hospitals, including teaching hospitals, public institutions, religious and other community non-profit hospitals.

Because of the investment of private risk capital and management of other hospitals under contract, our members are very conscious of cost containment.

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We therefore share with the Administration and the Congress a common desire to restrain inflation in the health delivery system.

Rising Costs

When Medicare and Medicaid were first enacted eleven years ago, and until quite recently, Congress perceived its role to be one of increasing and assuring access for the elderly and the disadvantaged to quality health care. That public policy decision triggered the demand-pull inflation which is a major reason for these hearings.

Since government has become the largest single purchaser of health care, the marketplace has become increasingly artificial as government control over both the supply and demand intensifies.

The hospital industry has been hit with severe inflationary pressures for the past ten years and in particular, following the expiration of the Economic Stabilization Program in early 1974. Those major pressures included catch-up wages in a labor intensive industry; escalation of prices for the goods and services purchased by hospitals, particularly in food, fuel and malpractice insurance; a rapidly changing medical technology in which new diagnostic and therapeutic techniques and expensive new equipment are centered in the hospital;inflated material costs for hospital

modernization and expansion programs; the increased costs of borrowing capital; increased costs of compliance with government regulations; and the Medicare-Medicaid retrospective cost reimbursement formula which provides no incentives for efficient management and fails to meet its fair share of the total financial requirements of hospitals, forcing institutions to shift additional costs to private patients.

This combination of demand-pull and cost-push inflation has created a hospital industry with an annual inflation rate well above the overall consumer price index.

Improved Quality

A hospital stay today is not comparable to a hospital stay five or ten years ago. The quality of the service is so different that cost comparisons are just not possible without major adjustments for such proven innovations as intensive and coronary care units, burn units, blood banks, cobalt therapy, nuclear medicine and a host of other techniques that are now standard in many hospitals to save and sustain life.

Duplication of these techniques and the expensive equipment needed to deliver that new technology should be avoided. Stronger planning laws have already been enacted, although not adequately financed, for that purpose.

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While we support planning laws designed to meet community needs, without duplicating expensive services, we believe that arbitrary rationing of medical advances and technology by government would not be in the public interest.

There is a clear conflict of interest when the major purchaser of services -- government -- sets a ceiling on the prices, the technology, and the quality involved in delivering those services.

If Congress votes to place a ceiling on hospital revenues and on hospital based technology, then Congress will be voting to establish itself as the moral judge of the dollar value of increased life spans, fewer fatal heart attacks, reduced infant mortality, significant survival rates for cancer patients, and every life saving device or technique.

Community health needs cannot be determined in advance by a government-mandated dollar ceiling. Rationing can be forced through that approach, but if Congress adopts that approach to resource allocation, it will be telling the American people that our values have changed from assuring that community health needs are met to reducing medical advances to a level set by the federal government based on the advice of economists instead of community representatives, consumers, or health professionals.

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Cost Containment

Controllable costs in a hospital (wages, administrative, hotel services) have been increasing at a much slower rate than those over which the hospital has little or no control (medical services, drugs, intensity of care, malpractice insurance, costs of regulation and patient mix). It is ironic that the proposed legislation under consideration today would place a stricter ceiling on non-controllable costs of the hospital.

There are positive steps which can be taken to encourage efficiencies in hospital management and a reduction of the inflation rates in health programs.

HEW has cited three reasons for soaring hospital costs:

-- Unrestrained demand because patients pay little or nothing at the time service is received for hospital care which is insured by third parties;
-- Lack of competition among hospitals; and
-- Cost reimbursement which encourages spending and provides no incentives for efficiency.

HEW has identified these three major reasons for high inflation rates but instead of addressing those underlying causes of inflation, HEW has opted for an arbitrary ceiling on revenues and capital -- a ceiling

imposed on top of the same system which lacks competition, encourages inefficiency, and produces unrestrained consumer demand.

In its haste to solve within a few months a budgetary problem which has been snowballing for twelve years, the Administration has developed a scheme which exacerbates all that is wrong with the health care payment system.

A hospital is "an institution providing medical and surgical care for treatment of the sick and the injured," according to the dictionary.

Hospitals provide services. They do not order them. They have no legal authority to decide which medical services to order and which to reject. Physicians have that authority.

We have taken the time to give this basic definition of a hospital because the Administration in proposing S. 1391 appears to misunderstand the proper role and authority of a hospital. This legislation would impose a ceiling on reimbursement to the hospital for costs incurred as the result of physician ordered services.

This leads hospitals into a Catch 22 position in which one law would require an institution to deliver a medical service while another law would penalize the institution if it delivered that service.

If the HEW plan were not so serious and so potentially dangerous to our nation's health, we would have to say it was absurd. What if the government proposed a ceiling on

the total revenue of grocery stores, but at the same time forced the stores to provide as much food as the consumers ordered? The grocery store would have no control over the volume of food ordered or the cost of the food and it could not raise prices in excess of the ceiling on gross income. That kind of plan probably would attract the support of housewives and even grocery store workers provided their wage increases were exempt from the ceiling. In the end, the only way the grocery store could survive would be to lower quality -- for example by selling only grade B meats and rotten apples.

Ceiling on Revenues

S. 1391 would place a 9% limit on increases in hospital revenues earned from inpatient services during the first year of implementation. This percentage would decrease in subsequent years. Exceptions would be made only for extraordinary changes in patient load, or for major increases in capital, facilities, equipment, or services, but only upon a showing that solvency is threatened. In addition, those wage increases above 9% granted to non-supervisory employees could be passed through. It is ironic that by limiting the pass through to high wage increases, the bill will encourage unionization of hospitals, above average wage settlements, and an inflationary ripple effect to maintain wage differentials among the various skill categories of an already labor

intensive industry.

A ceiling on revenues is price controls on a single industry. It amounts to nothing more than a more stringent version of the Phase IV hospital price control mechanism of the Economic Stabilization Program rejected by a prior Congress for sound economic, social, and medical reasons which remain valid today.

Aside from the inherent conflict of interest created by government purchasing services as well as unilaterally determining what price it will pay, a flat ceiling on revenues will merely serve to perpetuate existing inefficiencies. The ceiling would become the floor. By utilizing a basic formula which permits the same percentage increase to all providers, high-cost facilities would have an incentive to continue to operate inefficiently in order to garner a larger share of available funds. In contrast, lower-cost, more efficient hospitals would be penalized for their lower base period costs.

Secretary of HEW Joseph Califano in a recent interview stated that the Administration's proposal to contain hospital costs is "like a 350 pound man. There's a lot of fat that can be trimmed away." He failed to acknowledge the more important fact that the already trim hospital, the $100 a day institution would be limited to a $9 a day increase but the fat $350 a day

hospital would be entitled to a dollar increase 3½ times as large or $31.50.

Another crucial point which merits continued repetition is that a cap on revenues ignores physician -- not hospital -- control over such revenue determining factors as length of stay, number of services, and the frequency of admission. Penalizing the hospital for events beyond its control is unjustifiable.

Since about 90% of all expenditures at the time of delivery for hospital services are paid for by someone other than the patient, there is virtually no incentive to the consumer to show restraint in the medical market. Furthermore, there is no doubt that Congress itself has contributed in large part to the current budget crunch in Medicare and Medicaid by continually promising and providing increased benefits without concomitant increases in patient deductibles and coinsurance.

In addition, the Congress has failed to take into account the pressures that face institutional providers in meeting increased demands for services that are being paid for at less than actual cost. The only reason the system has not broken down entirely to date is that hospitals can -- unfairly but of necessity -- pass these increased costs on to private patients. The Administration proposal would end this only available source of relief and by so doing, force a reduction in

availability of services and quality of care.

If the crisis in health care costs is as severe as the Administration would have us believe, then it is a matter of concern -- and shared responsibility -- to all of us. That includes stimulating public awareness through increased out-of-pocket expenses, and government recognition that someone must pay for increased Medicare-Medicaid benefits.

Another critical issue ignored by the simplicity of a flat cap on revenues is the incontrovertible fact that such mandated ceilings are inequitable in the face of uncontrolled supply and service costs. Not even the most efficient hospitals -- when faced with a ceiling on income, uncontrollable outside costs and no means of shifting cost increases -- can hope to survive for long.

Aside from the dilemma that would be imposed by a restraint on revenue in the face of uncontrolled costs of supplies and services, S. 1391 fails to provide for cost increases engendered through compliance. Compliance with the provisions of S. 1391 would stimulate employment in the accounting industry. Attempts to meet these and other regulations would drive up hospital costs significantly. And without provision made for passing-through such costs -- as well as money spent on malpractice premiums, meeting

life safety code standards, and approved capital for life-sustaining improvements in medical technology -- how is a hospital to cope?

We would also emphasize that in our view a ceiling placed on the revenues of a single industry raises serious constitutional questions involving due process and equal protection of the law.

The ceiling on revenues proposed in S. 1391 could force the following actions by hospitals:

-- Postpone replacement of obsolete equipment;

-- Postpone modernization of antiquated physical plant;

-- Postpone all new services, regardless of need;

-- Eliminate services regardless of community need;

-- Eliminate high cost low profit services, regardless of need;

-- Eliminate services requiring long lengths of stay, regardless of need;

-- Postpone elective surgery; and

-- Increase unnecessary short-stay low-cost admissions.

S. 1391 also contains the following inequities:

-- It penalizes efficient hospitals which have lower costs;

-- It penalizes hospitals which exercised restraint in price increases prior to 1977 and rewards those which increased prices prior to 1977;

-- It ignores malpractice insurance, fuel, food and other uncontrollable cost increases;
-- It controls gross revenue rather than net revenue, thereby, penalizing hospitals with the higher bad debts arising from the provision of indigent care;
-- It could penalize hospitals for the medical judgment of physicians;
-- It restricts application of new medical technology;
-- It penalizes hospitals for treating high risk, intensive care patients;
-- It singles out one sector of one industry for price controls without controlling wages or supplies; and
-- It encourages unionization and higher wages by recognizing non-supervisory wage increases above 9% as the only pass through expense.

Based on the above list, we urge you to reject S. 1391 and consider alternative reforms designed to stimulate and reward efficiency and to penalize inefficiency while preserving quality in the delivery of hospital services.

Any ceiling imposed should be on the average costs or charges of similar hospitals rather than on the prior experience of each institution. This approach would apply the basic concept of the Talmadge bill and would

at least redirect economic incentives away from inefficiency toward sound management practices.

In addition, the cost of approved capital projects should be exempt and the exception procedure should be modified to assure a reasonable surplus of revenue over expenses and a reasonable return on investment.

Alternatives to the Proposed Ceiling on Revenues

The current system by which hospitals are reimbursed is one of the stated reasons for the development of the Administration proposal. Cost reimbursement in any industry is acknowledged to be inefficient and inflationary.

In its April 25th statement describing S. 1391, HEW characterized its 9% cap as a program which, "can be implemented and administered quickly and simply . . . and guarantees immediate savings to the Medicare and Medicaid programs, to private insurance and to the public." That statement in itself makes the program suspect.

It is true that the plan could be implemented hastily -- but the speed with which S. 1391 could be implemented is largely due to its arbitrary simplicity. An attempt to control an industry as vast and complex as hospital care in a hasty, simplistic manner is dangerous. The long-range impact is ignored, as

are basic principles of planning and management. Hospitals would be unable to accurately forecast volume by class of purchaser. The deadline of October 1st completely overlooks the time necessary to train and place adequate numbers of administrative personnel in both government and hospital positions.

And finally, S. 1391 would indeed guarantee "immediate" (which is not to say long-term) savings at the expense of the hospitals. But this only creates a new time-bomb; it doesn't defuse any already in existence.

There are several alternatives which we would like to propose. We believe that they address our mutual concerns in a responsible manner, taking into account the needs of all parties.

One approach which we favor would direct the Secretary to consider a number of prospective rate systems developed by providers, third party payors, and other interested parties and subject to federal guidelines, approve and authorize immediate implementation of those systems.

The Medicare-Medicaid Reimbursement Reform bill, introduced by Senator Talmadge, represents a major step in making those programs more cost efficient. By establishing target rates based on average routine costs, the proposal seeks to inject competition among similar facilities. It is quite important that the

maximum allowed percentage increase be applied to the average costs of similar hospitals, as opposed to the actual costs of each hospital, and the resulting dollar amount treated as a target for each hospital. Hospitals which restrain cost increases below the target level would be allowed to retain half of the savings, while hospitals whose cost increases substantially exceed the target would absorb the excess, unless they receive an exception.

We would recommend that where ceilings on reimbursement are imposed, the hospital should be permitted to charge the patient for the difference between the ceiling and its actual charges. That type of surcharge would encourage patients to consider taking a more active role in selecting a hospital and thereby inject another element of competition into the process.

Another innovative cost containment program is that presently in place in Florida. Under that program, which has been in effect since January 1, 1977, Blue Cross of Florida reviews proposed changes in rates in the 200 hospitals with Blue Cross contracts. The plan was designed with the cooperation of the hospitals themselves, and seeks to give them an incentive to contain costs without jeopardizing patient care. The screen is 80% of last year's hospital service charge component of the CPI. Hospitals which require rate

increases greater than the screen are required to apply to Blue Cross for approval, which means presenting a full budget outline and justification to the review body. Hospitals are motivated to work within this screen in order to avoid going through the bureaucratic red tape of obtaining an exception.

Another recommendation is to apply the President's general economic policy of jawboning to hospital rate increases in excess of an agreed upon percentage. The threat of adverse publicity from findings of local insurers and the President's Council on Wage-Price Stability would certainly create a climate in which most hospitals would attempt to hold down spending increases.

We recommend that Congress consider these alternatives to S. 1391:

(1) Passage of the Talmadge bill to establish Medicare and Medicaid target rates based on average costs of similar hospitals grouped by size, scope of service, and geographic location. Provide economic incentives for hospitals with below average costs and penalties for those significantly above that target. Once the concept of target rates for the Medicare and Medicaid programs has been demonstrated, then the law could be amended to mandate similar treatment by other cost reimbursers.

(2) Require all hospitals seeking charge increases in excess of 80% of the hospital service component of the CPI to disclose and justify their budgets to their local Blue Cross plan and commercial insurance companies.

(3) Establish a national guideline for hospital price increases and provide for review of increases above that level by the President's Council on Wage-Price Stability, utilizing publicity as a disincentive to unrestrained price increases.

(4) Require patient cost sharing by limiting government reimbursement to a percentile above which patients would have to pay the excess cost. By making public the names of those facilities with costs above the specified percentile, consumers would become more involved in the hospital selection process.

(5) Require the Secretary to solicit bids and award contracts for prospective payment systems to hospitals under the Medicare program on a reasonable charge or other basis.

Disclosure

The disclosure provisions of S. 1391 are intended to foster better public understanding of hospital costs -- an objective which we commend and share. We do not believe the details of a Medicare cost report released in that form will achieve the desired result.

Our recommendation would be to disclose the names and average per diem and per admission charges of those hospitals significantly above the average costs within their classification together with an explanation of such variance prepared by those institutions.

By placing the public spotlight on the highest cost institutions, we will be achieving two objectives -- public education and an incentive to the high cost institution to reduce costs in order to avoid adverse local and national publicity.

These objectives should be further assured by requiring patients admitted to those higher cost facilities to share in those additional costs.

Ceiling on Capital

S. 1391 authorizes the Secretary of HEW to establish annual ceilings on all capital expenditures by hospitals up to a maximum annual limit of $2.5 billion. This dramatic decrease in the availability of capital -- a 50% reduction in current spending -- amounts to a dangerous rationing of medical technology, hospital beds, and quality of patient care.

By giving such vast new authority to the Secretary, including the power to set annual capital limits for each state, Congress would be changing its basic comprehensive health planning policy set forth just a few years ago in Public Law 93-641. That law places

at the state and local level the authority and responsibility for determining community health needs. S. 1391 would replace that policy with arbitrary federal ceilings based on simple dollar limits and bed or occupancy formulae.

The Federation of American Hospitals supported P. L. 93-641 as a rational vehicle for community based decisions on needed health services. There is no way to make those important decisions by some magic formula or dollar limit. While factors such as beds per thousand within an HSA region can be useful to local planners, they must be flexible and considered along with many other factors such as transportation, projected population growth, scope of services, seasonal variations in occupancy for specific services, hospitals that are regional referal centers, etc. Those issues are best studied and debated at the local level, not left to the discretion of the Secretary of HEW who will be influenced more by federal budget constraints rather than by community health needs.

The strict dollar ceilings on capital do not recognize special needs for physical plant maintenance, replacement of obsolete equipment, and rural areas without access to modern technology. The capital limit will have an inflationary impact on construction and modernization programs by forcing

delays, thereby sweeping the problem under the rug today but producing substantially higher costs later.

The capital ceiling fails to recognize the structural modernization requirements of the Life-Safety Code and again places hospitals in the Catch 22 position of complying with one law requiring a capital expenditure to meet federal standards for participation in Medicare or Medicaid and another law which prohibits the hospital from making that capital expenditure.

Further, the recent signature by Secretary of HEW Califano of regulations mandating equal treatment for disabled persons is certain to require extensive and expensive capital outlays by many hospitals to conform. The proposed bill must be amended to accommodate such changes.

If cost reimbursement were abolished and reasonable charges were paid, hospitals would not consider unnecessary capital expenditures because they could not be economically sustained. Rationing would be achieved without government intervention.

Alternatives to Ceiling on Capital

Over-regulation of capital will block life saving innovation. Instead of that drastic approach of S. 1391, we offer the following alternatives for providing incentives designed to curb unnecessary capital expenditures in a less arbitrary manner.

(1) Adopt new hospital payment mechanisms which we have already discussed above. These systems would end cost reimbursement which encourages unnecessary spending and inflation in both the operations and capital budgets of hospitals.

(2) Fund P. L. 93-641 at adequate levels.

(3) Require certificate of need agencies to solicit competitive applications for needed services, equipment and facilities to stimulate competition and lower costs.

(4) Require certificate of need agencies to select the most cost-effective of the acceptable applications.

(5) Establish flexible federal guidelines for the certificate of need process developed by the National Council on Health Planning and Resources Development and not by the Secretary of HEW to assure that quality of care and availability of services are considered along with budgetary factors.

(6) Exempt replacement of equipment, plant maintenance, and expenditures mandated by law from any controls on capital.

(7) Authorize the use of government funds on a voluntary demonstration basis to purchase and close hospitals which are determined to be unneeded by appropriate health planning agencies and the institutions themselves. The closing of some empty beds

within an institution will save little or no money while the closing of an entire facility can have a significant impact. The Talmadge bill provides for an initial bed bank experiment but should be redirected along these lines.

Conclusion

The basic question raised by these hearings is whether government must ration health care by establishing a maximum national spending level for all health care. We urge you to answer that question in the negative and instead to choose the more flexible and less arbitrary course of providing economic incentives to health care providers and consumers to contain rising costs.

On March 10, 1977 at the Annual Meeting of the Federation of American Hospitals, Nobel prize winner for economics, Dr. Milton Friedman said in response to a question about the appropriate percentage of the GNP which should be spent on health care:

> *"I do not believe that anybody can give you a numerical answer to that question. I believe that the amount to be expended on health care should be that amount which the individuals of this country, separately, want to spend on health care rather than on other things . . . I think the only guide is -- do you have a product that the public wants to buy and pay for? The problem arises because of the use of compulsion to finance it. That is why the problem arises.*
>
> *"If the government is going to finance it, well then, it takes money from people, not because they want the service that they individually get, but because they are required to pay it through taxes. Then, it is completely a political football, as to what is the total amount that will be spent. I do not believe that there is any scientific basis for reaching a judgment."*

We understand the need for government to have a better vehicle for predicting in advance its health care expenditures. We cannot accept a federal ceiling on all government and personal hospital costs as a rational way to achieve that goal.

We have suggested a number of alternatives for containing rising hospital costs and urge you to consider these approaches in lieu of S. 1391.

Thank you for this opportunity to present our views on this important subject.

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SUMMARY OF TESTIMONY

ON S. 1391

May 26, 1977

Hospitals provide services. They do not order them. They have no legal authority to decide which medical services to order and which to reject. Physicians have that authority.

If the HEW plan were not so serious and so potentially dangerous to our nation's health, we would have to say it was absurd. What if the government proposed a ceiling on the total revenue of grocery stores, but at the same time forced the stores to provide as much food as the consumer ordered? The grocery store would have no control over the volume of food ordered or the cost of the food and it could not raise prices in excess of the ceiling on gross income. That kind of plan probably would attract the support of housewives and even grocery store workers provided their wage increases were exempt from the ceiling. In the end, the only way the grocery store could survive would be to lower quality -- for example by selling only grade B meats and rotten apples.

The Federation's opposition to S. 1391 centers around the following points:

-- S. 1391 provides no incentive for efficiency. The ceiling on revenues will become the floor.

-- It is a conflict of interest for the major purchaser of services (government) to unilaterally determine the price it will pay for those services.

-- Hospitals have no legal authority to control the volume of services ordered by physicians which a cap on revenues ignores.

-- The ceiling on revenues will force a reduction in the quality and scope of services offered. The continued existence of emergency rooms and obstetrical wards would be threatened.

-- The haste with which the plan is proposed to be implemented ignores the complexities and long-range impact of the issue:

  - Hospitals cannot accurately forecast revenues by class of purchaser until year's end.

  - The timing ignores basic principles of planning and management

  - An October 1st deadline ignores the necessity of training and putting in place necessary administrative personnel in both government and hospital positions.

-- A cap on revenues minus any controls on the cost of hospital supplies and services is completely unrealistic. If forced to absorb such costs, hospitals will have to cut services and reduce quality.

-- S. 1391 rewards inefficient, higher cost institutions because the percentage limit would be placed on a higher base.

-- If it weren't for the current inflationary system of cost reimbursement, the rationing of services through a ceiling on capital expenditures would be unnecessary.

-- Restraining capital expenditures as proposed fails to take into account future needs -- and the future inflated costs of meeting those increased needs.

-- The cost of implementing the proposal has not been calculated. Nor has its cost effectivenss been evaluated.

-- No provision has been made to allow hospitals to recover the added costs involved in complying with the proposal.

-- There is no provision made within the allowable increase limitation for such uncontrolled hospital costs as rising malpractice premiums and life-sustaining improvements in medical technology.

-- Controls on the revenues of a single industry raise serious constitutional questions involving due process and equal protection under the law.

Alternatives to Revenue Cap

We recommend that Congress consider these alternatives to S. 1391:

(1) Passage of the Talmadge bill to establish Medicare and Medicaid target rates based on average costs of similar hospitals grouped by size, scope of service, and geographic location. Provide economic incentives for hospitals with below average costs and penalties for those significantly above that target. Once the concept of target rates for the Medicare and Medicaid programs has been demonstrated, then the law could be amended to mandate similar treatment by other cost reimbursers.

(2) Require all hospitals seeking charge increases in excess of 80% of the hospital service component of the CPI to disclose and justify their budgets to their local Blue Cross plan and commercial insurance companies.

(3) Establish a national guideline for hospital price increases and provide for review of increases above that level by the President's Council on Wage-Price Stability, utilizing publicity as a disincentive to unrestrained price increases.

(4) Require patient cost sharing by limiting government reimbursement to a percentile above which patients would have to pay the excess cost. By making public the names of those facilities with costs above the specified percentile, consumers would become more involved in the hospital selection process.

(5) Require the Secretary to solicit bids and award contracts for prospective payment systems to hospitals under the Medicare program on a reasonable charge or other basis.

Alternatives to Ceiling on Capital

Over-regulation of capital will block life saving innovation. Instead of that drastic approach of S. 1391, we offer the following alternatives for providing incentives

designed to curb unnecessary capital expenditures in a less arbitrary manner:

(1) Adopt new hospital payment mechanisms which we have already discussed above. These systems would end cost reimbursement which encourages unnecessary spending and inflation in both the operations and capital budgets of hospitals.

(2) Fund P. L. 93-641 at adequate levels.

(3) Require certificate of need agencies to solicit competitive applications for needed services, equipment and facilities to stimulate competition and lower costs.

(4) Require certificate of need agencies to select the most cost-effective of the acceptable applications.

(5) Establish flexible federal guidelines for the certificate of need process developed by the National Council on Health Planning and Resources Development and not by the Secretary of HEW to assure that quality of care and availability of services are considered along with budgetary factors.

(6) Exempt replacement of equipment, plant maintenance, and expenditures mandated by law from any controls on capital.

(7) Authorize the use of government funds on a voluntary demonstration basis to purchase and close hospitals which are determined to be unneeded by appropriate health planning agencies and the institutions themselves. The closing of some empty beds within an institution will save little or no money while the closing of an entire facility can have a significant impact. The Talmadge bill provides for an initial bed bank experiment but should be redirected along these lines.

STATEMENT OF THE

HEALTH INSURANCE ASSOCIATION OF AMERICA

ON

HOSPITAL COST CONTAINMENT ACT OF 1977
(S. 1391)

Presented By

MORTON D. MILLER

Before The
SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
of the
COMMITTEE ON HUMAN RESOURCES
UNITED STATES SENATE

MAY 26, 1977

My name is Morton D. Miller. I am Vice Chairman of the Board of Directors of The Equitable Life Assurance Society of the United States. With me is Mr. Henry A. DiPrete, Second Vice President, the John Hancock Mutual Life Insurance Company. We appear today on behalf of the Health Insurance Association of America.

The companies we represent, which provide health insurance protection for over 100 million Americans, have long been intimately concerned with the costs of health care in this country. In that connection, we have lent our active support to community health planning, increased ambulatory care, alternative delivery systems, health education, Professional Service Review, and a better distribution of health manpower.

As was stated in our testimony of May 17, 1976 before this subcommittee, the rapid escalation of costs during the last several years which has spread across the full spectrum of health services -- doctor and dentist fees, drug and nursing home charges and especially the costs of hospital care -- has created a most worrisome situation. The health insurer's suggestions for reducing this problem were spelled out in some detail at that time.

Mr. Chairman, your subcommittee does not need a long recitation from us regarding the reasons for the health care cost escalation we have been experiencing or the magnitude of the problem. Suffice it to say that through the intervention of third party payments by government and private insurance plans, the American public has been shielded to a large extent from the full

impact of rising costs, most significantly with respect to hospital costs where third party financing exceeds 90% of total revenues. The prevalence of third party payments has tended to inhibit the normal operation of supply and demand in the health care field and, together with the rising expectations of the public, has been translated into an almost limitless demand for health care services.

Accordingly, we would like to express our wholehearted approval of the Administration's efforts to contain health care costs and, subject to some qualification, support for the recently announced hospital cost containment program set forth in S. 1391, The Hospital Cost Containment Act of 1977.

On the one hand, there are a number of good features in the Administration's proposal. In starting with hospital costs, it would focus on the largest single cost component, where the number of service units is manageable, and the rates of inflation most extreme. The proposed legislation avoids a major flaw in prior cost control measures which dealt with Medicare and Medicaid costs alone and had the effect of turning the savings flowing to the two governmental programs into increased costs for private patients. The limitations of the bill apply to a hospital's total revenues from all patients equally and not just to reimbursement by government under Medicare and Medicaid. It recognizes the importance of capital expenditures in the cost equation. Also, it would appear on the surface to be relatively easy to administer.

On the other hand, there are a number of disadvantages. Some hospitals are more cost effective and others less so. To impose the

same revenue limits on all will be unfair to some and overly generous to others. The pass-through of wage increases for non-supervisory personnel may well weaken the ability of the hospitals to bargain at arms length with their employees. Instead of a blanket provision, it might be preferable for the Secretary to be in a position to approve an exception in an area where wages are substandard. Furthermore, S. 1391 does nothing to redress the present longstanding imbalance between the lower reimbursement levels of Medicare and Medicaid and, to a lesser extent, Blue Cross and the disproportionately higher levels of hospital costs passed on to insurance company and self-pay patients. Such an inequity must be adjusted in the long run. Finally, S. 1391 is admittedly an interim or transitional program.

The President in presenting his proposal indicated that it "relied heavily on the initiatives of the private sector -- business, unions and insurers working with providers -- to pursue innovative techniques for reducing the cost of high quality care." We accept the challenge.

We believe S. 1391 can be strengthened to move more rapidly and effectively toward a long-term permanent solution for moderating hospital care costs. The National Health Care Act (S. 5 and H. R. 5) introduced by Senator McIntyre and Representative Burleson and supported by the health insurance companies of America, includes such a plan. It calls for a system of prospective review of hospital operating and capital budgets and the approval of rates for all payors to be carried out at the state level.

Such systems have been in operation in four states, Maryland, Connecticut, Washington and Massachusetts and have worked well. We are confident that a substantial reduction in the growth of hospital care costs can be achieved through the mechanism of prospective hospital rate approval and budget review conducted by the states under a federal mandate and guidelines.

In the two states with the most experience, Maryland and Connecticut, the State Rate Setting Commissions have saved residents $27 and $18 million a year, respectively. In order to illustrate the potential of extending this type of program, nationwide, we estimate there would have been savings in the order of $1 billion last year.

The experience to date suggests that to be successful such state prospective budget review and rate approval programs must:

1. Have an independent state commission which is solely responsible for reviewing the operating and capital budgets of the institutions and for setting their rates.
2. Establish rates applicable to all payors, as is the case now in Maryland.
3. Institute effective programs of utilization review.
4. Be closely coordinated with the planning agency responsible for certificate of need determination.

The best of prospective hospital rate approval and budget review processes would still not be fully effective operating alone. The functions of prospective rate review, certificate of need determination and utilization review must be carried out together. Given close liaison with the local planning agencies and involvement with utilization review, the State Rate Setting Commission can be truly responsive to local needs and conditions.

Turning to another aspect of our problem, excess bed capacity has clearly been a prime factor in the recent cost inflation. The Administration has estimated that we have about 100,000 more hospital beds than we need. Therefore, as part of the long-term control of health care costs, we would propose the following:

a) That the certificate of need process be strengthened to include all major capital expenditures, regardless of their ownership.

b) That consideration be given to studying the desirability of discontinuing the tax subsidies and loan guarantees which are now available for hospital related capital investment. Hospitals seeking funds would then have to turn to normal investment channels. The investors would become more selective in their lending and would have compelling reasons to be concerned over the management of their investments.

c) That clear provisions for decertifying unneeded beds be established under the Planning Act.

d) That funds be appropriated to assist in closing down excess beds or their conversion to other uses and for the retirement of outstanding debt.

We are persuaded that the combined efforts of state prospective budget review and rate approval when coupled with effective certificate of need determination and utilization review will succeed in effectively constraining the rise in hospital care costs over the long term.

We therefore would propose that S. 1391 be amended so that:

1. Hospitals in any state that has or institutes a prospective budget review and rate approval system and also has a certificate of need program, both of which meet federal guidelines, should be exempt from the revenue and capital ceiling provisions of Titles I and II of H. R. 6575;
2. The appropriation of modest funds be authorized to enable states to initiate prospective budget review and rate approval programs that comply with Federal guidelines;
3. The quality of care and utilization control requirements of P. L. 92-603 applicable to Medicare and Medicaid be extended to all patients;

4. The Planning Act (P. L. 93-641) be amended to authorize the decertification of unneeded hospital beds and services; and

5. The appropriation of funds in reasonable amounts be authorized to assist in closing down excess beds or their conversion to other uses.

Mr. Chairman, with your permission, I would like to submit for the record a more detailed exposition of what we would propose.

Thank you.

The full text of the HIAA statement follows:

Provisions of a System Offering a Permanent Equitable Solution to Containing Hospital Care Cost Increases

In order to moderate the rate of escalation in hospital costs under a permanent equitable reimbursement system, savings can be achieved in one or more of the following ways:

1. Providing incentives for improved efficiency in hospital departmental operations;
2. Restricting increases in capital expenditures to those projects which are consistent with community needs as determined by the appropriate planning agency;
3. Establishing incentives for merger, conversion and, where necessary, closure of under-utilized facilities and services;
4. Establishing incentives for utilization of inpatient and outpatient services only where medically necessary;

5. Establishing incentives for quality assurance which would discourage unnecessary treatment, and identify and eliminate physician practices which increase vulnerability to medical malpractice litigation.

6. Some combination of the above.

Consequently, the Congress must consider not only establishment of intelligent regulation of hospitals, but it must also strengthen the planning process.

Weaknesses of S. 1391

The bill in its present form has the following defects:

A. The proposed limitations on operating and capital costs are arbitrary and bear little relationship to an individual institution's actual budgetary needs. Hospital expenses increased 20% nationwide in fiscal 1976. The Connecticut Commission on Hospitals and Health Care's experience illustrates the flexibility in an annual budget review system permitting hospitals increases in total income averaging 13.5% in 1975, with the approved individual increases ranging from a low of 4% to a maximum of 24%.

B. It will freeze current inpatient utilization patterns at present levels at a time when there is an urgent need for intensified monitoring and evaluation by the medical staff of physical utilization practices. Hospital occupancy levels were running at about 75% nationwide in 1975. Recent studies have indicated that we have from 20% to 30% more acute care hospital beds than are medically necessary. We will not be able to achieve the economies resulting from reduced bed availability unless and until the existing utilization patterns are modified. Furthermore, the requirement of the present bill to maintain occupancy levels at 80% as the basis for approval of increases in capital expenditures will be counter-productive as it will stimulate increased utilization which will frequently not be medically justified.

C. Current price differentials between the amounts paid for hospital care by government and the private sector patients will be continued at the present percentage level but expanded in terms of absolute dollars. As a result of this practice, the private sector patient is already paying a subsidy of more than $2 billion per year for similar services.

D. The pass through for wage increases for non-supervisory personnel will provide little incentive for management of the institution to restrain union demands. We urge that such a significant piece of hospital costs not be exempt from control. Any wage pass throughs should be limited to hospitals which have demonstrated that their wages are below wage levels generally in their geographic area.

E. The absence of any requirements for justifying increases in out-patient revenue invites increased utilization of such services which may not be medically necessary.

F. No incentives are provided to promote merger or conversion of existing under-utilized facilities and services.

G. The bill provides little or no incentive for the establishment of new state regulatory commissions as a more sensitive and equitable permanent solution to the problem of rising hospital costs.

H. The bill does not provide adequate safeguards to assure that the program will in fact be a temporary measure, nor does it assure that more permanent solutions will be offered.

State Waivers with Respect to S. 1391
and with Respect to Any Permanent Solution

We strongly support the exemption of hospitals in states with existing hospital Cost Control Commissions from federal controls. We equally support the concept that where a state enacts legislation in the future which requires hospitals to submit their operating and capital expenditure budgets to review and approval by an

appropriately constituted state agency, it should be exempted from any temporary federal program such as S. 1391. This should, however, be done under federal guidelines.

The present bill recognizes that to be effective, hospital cost control legislation must focus on the total revenue of the institution. The dilemma with which we are currently faced is that we have failed to establish a process which permits separation and support for the factors which are legitimately inflating costs from those which are based on wasteful practices which may be corrected. Existing state commissions have recognized the need to resolve this issue and should be encouraged to continue their efforts in addressing the problem. This proposed modification in the current bill should serve to permit the development and comparison of additional experience under the federal "CAP" concept with state operated prospective hospital budget review systems.

In establishing the guidelines under which this state waiver would be granted, we have considered the experience of the state hospital cost control commissions now in place in Connecticut and Maryland drawing upon their best features and corrections for their weaknesses. It is significant that in both cases, the commissions have slowed down the cumulative rate of escalation in contrast with the national average by twelve points over a three year period in Connecticut, and seven points over a two year period in Maryland. It should be noted that a 1% reduction in the rate of escalation in hospital costs nationwide results in savings in excess of $500 million. The Maryland program is also unique in that it is the only state where the federal government has agreed to pay commission-approved rates under the Medicare program.

The present multimillion dollar subsidy on the private sector patient resulting from existing price differentials must gradually be eliminated. However, we realize that this cannot be achieved overnight and, therefore, a practical compromise on this point is necessary to bring the Medicare and Medicaid programs under any state operated budget review system.

Accordingly, the guidelines should be drawn so that, initially, the federal and state government would not pay amounts in excess of the federal "CAPS" for both operating and capital expenditures, if the state budget review and approval process permitted an aggregate statewide increase of a greater amount. Under such circumstances, the differences would continue to be absorbed, as it is currently, by the private sector patients, recognizing that the latter will benefit from a slowing down of the overall rate of escalation in hospital income.

We applaud the Administration for including limits on capital expenditures as well as on operating budgets. We feel, however, that the state exemption should also apply with respect to federal limitations on capital expenditures in those

instances where the state has enacted both Prospective Budget Review and Certificate of Need legislation and where the planning process, as contemplated by P.L. 93-641, is now in operation.

Objectives of the State Waiver Programs

Qualified state programs should incorporate the following objectives:

A. assure that a hospital's total costs are reasonably related to total services;

B. assure that aggregate rates are set in reasonable relationship to aggregate costs;

C. assure that rates are set equitably among all purchasers of care without undue discrimination;

D. assure the continued operation of financially stable, efficient and effective hospitals;

E. provide "positive" and "negative" incentives to contain the rate of increase in the cost to all payors of services rendered by all institutional health care providers without impairing the quality of care. Total costs, not just unit prices, should be contained;

F. set a mandatory prospective revenue basis applicable to all payors through a methodology which is, itself, efficient, not too costly, and does not unnecessarily restrict the institution's management prerogatives;

G. encourage the optimal use of health resources by phasing out under-utilized or inefficient institutional beds and services, and by reinforcing cost-consciousness in health planning, utilization review and the introduction of new technology;

H. encourage improved institutional management, budgeting and efficiency.

Guidelines to be Met to Qualify for the State Waiver

The guidelines for the program administered by the state should incorporate the following considerations:

1. The system should embrace all hospitals in the state and the care rendered to all patients, both the beneficiaries of governmental and private sector financed programs.

   Comment:

   To allow certain hospitals or certain classes of patients to be excluded from the process would destroy the effectiveness of the program.

2. Each state should establish a three to five member full-time commission appointed by the Governor for staggered terms, with a full term to be no less than four years. Members of the commission may not, during their tenure of office, be otherwise employed by the state, be employees or officials of a local government or a health care institution, nor may they engage in the delivery or financing of health services. The members of the commission should have at least a basic understanding of the delivery and financing of health services in the state, and an ability to bring to the affairs of the commission broad-gauged, highly qualified, effective direction. Alternatively, in lieu of a commission, states may establish a rate setting agency under the direction of a single full-time commissioner. In either case, there should be adequate full-time professional staff.

Comment:

The establishment of a full-time commission is predicated on the principle that effectiveness and equity of a hospital cost control program is in direct proportion to the knowledge, experience and effective direction provided by the commission members themselves. Consequently, the full-time commission approach will strengthen the commission's capabilities in addressing the more complex issues involved in budget evaluation.

3. There should be a policy board appointed by the Governor for staggered terms, with balanced representation from one-third consumers, one-third providers, and one-third purchasers of health care (i.e., prepayment plans, insurance carriers and state Medicaid program.) The policy board should be authorized to:

a. review and comment on regulations for approval of hospital rates and budgets;

b. review and comment on rules and regulations regarding uniform accounting and reporting;

c. review and recommend approval or disapproval of the commission's annual budget;

d. advise on the integration of the requirements of state rate regulations with other state health regulation, such as certification of need and federal requirements pertaining to the delivery of hospital services;

c. report to the commission, Governor, the General Assembly, and the Secretary of the Department of Health in the same manner as the national level advisory council reports to the Secretary of HEW and Congress on the program's effectiveness, recommended modifications and continuation;

f. review and recommend approval or disapproval of the regulations under which the commission itself functions.

The objective of both the full-time commission, with a full-time professional staff, and the policy board is to establish a desirable check and balance against domination of the activities of the commission either by the commission, itself, or staff, with the policy board serving as a check on both and also providing meaningful input into the work of the commission from individuals with unique knowledge and expertise in the health care field.

4. The commission should be charged with the coordination of both the state's certification of need law and the review of all operations of institutional services, including operating and capital expenses, and approval of capital budgets and gross operating revenues on an annual basis. If the administration of the certification of need and budget review programs are located in different state agencies, the close interrelationship between the programs required for the effectiveness of each program necessitates close coordination and cooperation.

More specifically, the evaluation of the financial impact of proposed new facilities and services by the rate review authority must be considered in the certification of need process. In addition, the effectiveness of any authority the certification of need agency has over new capital

expenditures or to promote relocation, merger and closure of facilities and services will depend in great part on fiscal sanctions through the budget review mechanism.

5. Institutions should be required to follow a uniform system of cost and revenue accounting as developed under Section 1533d of P. L. 93-641 or other system reviewed by the Policy Board as the basis for the commission's budget review and approval.

Comment:

In order for commission staff to appropriately analyze hospital budgets and rate requests on a comparable basis year-to-year and hospital-to-hospital, it is necessary to establish a system of uniform financial recordkeeping.

6. There should be a uniform definition of "Full Financial Requirements" which shall form the basis for equal payment for equal services by all patients. "Full Financial Requirements" shall include the cost of unreimbursed care for the indigent and bad debts on both an inpatient and outpatient basis.

Because of the wide discrepancy between the amounts paid by many state Medicaid programs and the private sector patient for the same services, the state legislation implementing this federal legislation should permit a state to avail itself of the same maximum allowable increase limitation which the federal government is to be allowed for its costs under Medicare and Medicaid. In other words, the state (as well as the federal government under Title XVIII and its participation under Title XIX) would be required to fund its share of Medicaid payments based on the rates approved by the program either under federal or state agency administration subject to a maximum allowable increase. Any excess would be charged to all nongovernmental patients by means of a surcharge on the approved rates for the following year.

Because of the assured financing, both short and long range, this definition would enable the hospital to increase the availability of outpatient services to the indigent and medically indigent population, particularly in the inner cities where care is now needed.

7. In evaluating increased capital expenditures, the commission should approve costs only for those facilities and services which have been approved by the appropriate planning agency.

8. In the evaluation of increased operating cost, the guidelines should define both comparative and normative standards of reasonableness to which the institution should adhere in supporting increases.

Comment:

In order to avoid arbitrary decisions and as a guide for hospitals in preparing budgets for analysis, some guidelines on reasonableness of increases should be established.

9. In supporting cost increases due to volume changes (e. g., utilization or intensity of services), the guidelines should require that the institution file with the state agency a quality assurance plan for all patients which provides for routine monitoring of the appropriateness of the confinement and the duration, and the quality of care rendered. This requirement will be satisfied by the extension of the PSRO program to all patients.

In addition, the system should clearly identify additional revenues generated by increased volume and establish a methodology for separating fixed and variable costs associated with such service volumes. The amount of reimbursement for the fixed cost component associated with the additional revenues should be used to reduce the hospital's financial requirements on the following year.

Comment:

The function of this guideline is multiple:

a. To maintain appropriate quality of care under the cost control system.

b. To reduce or eliminate any incentive under the system to increase the volume of services beyond the level currently budgeted as a means of increasing revenue.

c. To assure that the level of services previously experienced is appropriate.

d. To provide an incentive to the hospitals to change patterns of care with emphasis on the outpatient area, with any resultant decline in inpatient utilization to form a basis for interim rate increases.

e. To support the effective planning function by providing appropriate level utilization figures as the basis for the projection of needed facilities and services.

Utilization of acute care general hospitals throughout the United States ranges from a low of 527 inpatient days per thousand population in Alaska to a high of 2,018 inpatient days per thousand population in Washington, D. C., with a national average of 1,218 inpatient days. Furthermore, there is almost a direct correlation between bed availability and utilization, illustrating the fact that utilization patterns are currently influenced by bed availability.

In response to this issue, Congress enacted the Professional Standards Review Organization law in 1972 to assure that the beneficiaries of governmental programs will be admitted to hospitals and confined only for the period of time medically necessary, while receiving services which are consistent with professional standards of quality. In the interim, two major flaws have emerged in this concept. The first is the fact that the limitation of the law to federal programs, where the PSRO is effective, is leading to a double standard of quality and cost discriminating against the private sector patient. The second and more important consideration is that the

impact of the law will be severely limited, since the responsibility is generally being carried out as a medical staff function for each delegated hospital. The effect is to place the physician involved in the process in a conflict-of-interest position in determining whether his primary allegiance is to the PSRO or to the hospital where he serves his patients. If he chooses the former route, the resulting loss of revenue to the institution occurs when overall costs are escalating more rapidly than ever; thus, compounding the hospital's financial dilemma.

Requiring that concurrent utilization review and quality assurance be carried out as a medical staff function to support hospital cost increases due to volume changes (e. g., intensity of services or utilization) as the basis for the hospital to obtain future revenue increases eliminates the conflict of interest with which the medical staff is now faced, and serves as a positive incentive for objective performance in this area.

10. The guidelines should permit the state agency to adopt the option of either (a) requiring each institution to submit its budget and rates annually to review and approval; or (b) the establishment of at least a quadrennial review of all institutions plus a special review of those institutions which request increases in excess of a predetermined limit in any given year. The state agency must also have authority to reconcile a hospital's budgeted costs, revenues and volume of services with actual experience; that is, prospective budgets and retrospective financial reports should be prepared in a form which permits comparison.

Comment:

This guideline recognizes that one of the most effective means of obtaining accountability in hospital costs is through an annual budget review process. Review of rates alone does not provide an opportunity to review hospital costs at the most critical time, which is during the hospital budgeting process. If this opportunity for budget review is not utilized, the review authority faces

the problem of dealing only with the hospital rate structure after commitments based on the budget have already been made.

The use of an exception review process would permit the hospital to obtain modest revenue increases without the necessity of in-depth budget analysis. It would also enable the commission staff to control the volume of budget review in the early stages of implementation of the legislation.

11. The guidelines should permit the institution to petition the state agency for an emergency rate increase in the interim between budget reviews where costs have been inflated due to factors beyond the institution's control (e.g., reduction in expected occupancy levels, malpractice insurance, fuel costs, etc.)

Once an institution has submitted its budget to review and received approval, it should be encouraged to generate surpluses due to improved efficiency or productivity. The surpluses so earned should be disposed of on a basis consistent with management prerogatives. Expenditures of such surpluses should be accounted for in subsequent accounting periods and should not call into question the tax exempt status of hospitals.

12. The legislation should require the establishment of an appropriate administrative and judicial appeals process.

13. The legislation may make provision for a differential where the action of the patient, or a prepayment plan or insurance company on the patient's behalf, results in demonstrable savings to the institution. This point is illustrated by a patient paying the full bill at discharge, thereby reducing the hospital's normal credit collection and operating costs. The criteria for the differential should be established by the state agency depending upon the circumstances involved, and should be available without regard to third party sponsorship or lack thereof.

In the debate over whether controls on the system will be more effective if they are dominated by the federal or state process, we must keep in mind that the substantial investment of federal dollars in payment for services under the Medicare and Medicaid programs has resulted in the federal government being able to exert considerable leverage on the providers. The results to date, however, have confirmed the fact that federal controls have been largely simplistic, arbitrary and vulnerable to manipulation by the providers. In the ten years since the Medicare Program has been enacted, the beneficiaries of that program have been forced to pay an increasing proportion of their expenses out-of-pocket, while the rate of escalation in federal expenditures from year-to-year to support these programs has continued unabated.

We believe you should provide incentives for provider experimentation with the state control process to determine whether the private sector working with government can influence the establishment and help share and refine a state regulatory process which would produce a more reasonable response to the pressure for public accountability in the delivery of health care services. The fundamental issue to be tested is whether the federal or state process would be better balanced, objective and responsive to legitimate pressures for increased financing while improving the use of present resources by identifying and correcting wasteful practices. We encourage you to amend the bill before you to make this objective possible.

Financing

The present bill should be amended to provide one-time development grants to assist states in establishing budget review and approval agencies. Such grants should be on a graduated per capita scale, say 70 cents for each of the first 500,000 of the state's population; 50 cents for the second 500,000; 30 cents for the third 500,000; and 10 cents for each of the balance of the state's population. There should be some minimum grant per state, say $500,000.

The continuing operating costs of the agency would be financed by an assessment against the health care institutions in the state.

Federal Advisory Council on Hospital Cost Containment

We also propose that the bill be amended to create an advisory council which would assist the Administration and Congress in evaluating the experience under the competing reimbursement systems and would make recommendations for improvement in the programs as the experience unfolds.

There should be provisions for the appointment of an advisory council at the federal level composed of balanced input from providers, third-party purchasers and consumers active in the planning process. The advisory council will have the responsibility for monitoring the ongoing operation of the program and will be required to report annually to the Secretary of Health, Education, and Welfare and appropriate congressional committees on the program's effectiveness and recommendations for modifications, including the level at which the federal "CAP" should be set for the following year.

Included in such reports will be:

A. a measurement of the effectiveness of the program in reducing the escalation of hospital cost increases and the factors which have brought about such effectiveness;

B. an assessment of the program's impact on improved efficiency in departmental costs, the quality of institutional health care services, the utilization of such services, and support for the planning process; and

C. recommendations on modification and continuation of the program.

The advisory council will provide the opportunity for drawing on the wide variety of unique experiences and background of professionals concerned with the delivery and financing of health care, and offers the opportunity for meaningful input from concerned consumers in arriving at decisions which could ultimately affect the access to and quality of care rendered.

Additional Considerations

It has long been recognized that one of the fundamental reasons for spiraling hospital costs is an excess and maldistribution of hospital facilities. It has been estimated that as many as 30% of hospital beds in the United States are excess. Furthermore, the experience of the planning process to date has not indicated that the law as now administered will result in a significant reduction in this capacity. We would strongly urge the Congress to consider an amendment to Public Law 93-641 which would specifically authorize Health Systems Agencies to effect the merging or closure of excess facilities.

In this connection, the Congress should authorize the appropriation of up to $500 million dollars per year to assist in closing down excess beds for their conversion to other uses, and for the retirement of outstanding debt on such facilities.

Finally, it is our belief that both the present planning law and the professional standards review organization's efforts will be severely limited in their impact unless they are coordinated with prospective budget analysis. The proposed bill should spell out very clearly the need for interaction between these processes. The medical staffs, administration and governing boards of hospitals show an interest and concern for the institution's ability to obtain future revenue increases and to deliver high quality care. The bill, therefore, should establish common management objectives that can be achieved through the interaction, coordination and cooperation of regulators, planners and quality assurance experts.

Senator KENNEDY. Our next witnesses are Dr. Annis and Dr. Felch from the American Medical Association.

STATEMENT OF JERE W. ANNIS, M.D., AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY WILLIAM C. FELCH, M.D., AND HARRY N. PETERSON, DIRECTOR, DEPARTMENT OF LEGISLATION, AMA

Dr. ANNIS. I think we can keep this brief. I know you are faced with time constraints, and I would like the entire testimony submitted and then we can answer questions thereafter.

I am Jere W. Annis, M.D., a practicing physician in Lakeland, Fla. I am vice chairman of the board of trustees of the American Medical Association and am pleased to present on behalf of the association its views on S. 1391, the Hospital Cost Containment Act of 1977, introduced on behalf of the administration.

Participating with me in this presentation is William C. Felch, M.D., who is in medical practice in Rye, N.Y. Dr. Felch is a member of the AMA council on legislation. Accompanying us is Harry N. Peterson, director of our department of legislation.

At the beginning we want to express, on behalf of the AMA, appreciation for this opportunity to appear at this subcommittee hearing on the proposed legislation concerning cost constraints on hospitals. As you know, the American Medical Association is greatly 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.

We realize there is a great and severe problem.

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, insurance, 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.

I underline this last comment because it is no problem to reduce the cost if one does not care about what happens to the care.

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, 7 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 practitioners and providers 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 to 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. However, in our view this legislation would not be in the best interests of patients.

This is our prime concern. We do not think there is enough information present to draw up appropriate legislation at this time.

S. 1391, 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. Thus 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 2 years old—hospitals, and those institutions receiving at least 75 percent 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 nonsupervisory personnel.

Enforcement of the hospital cost containment revenue limit would be implemented through the disallowance by the medicare, medicaid, and maternal and child health care 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 percent of the excess—unless such amounts, based on the excess, were 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 S. 1391 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 percent as 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 10 times the amount otherwise recognizable as program payment for depreciation, interest on borrowed 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. Chairman, 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.

Senator KENNEDY. Do you have any information which indicates that the case has deteriorated in the places where we have put such a cap or limitation?

Dr. ANNIS. The cap has not been on here in this country. In countries where it has, yes. I would say an excellent example is in England; 3 or 4 months ago they built a new hospital, and they have such a cap——

Senator KENNEDY. Where is this?

Dr. ANNIS. This is High Wycombe, England, outside of London.

Senator KENNEDY. I am talking about the United States.

Dr. ANNIS. There is not a cap at the present time.

Senator KENNEDY. A number of States do have it now. Massachusetts has it, Maryland, Connecticut.

Dr. ANNIS. I am certainly not familiar.

Senator KENNEDY. Have you heard any reports to that effect from the medical societies up there?

Mr. PETERSON. May I raise a question as to how long the cap has been in existence?

Senator KENNEDY. About 1½ or 2 years.

Mr. PETERSON. The reason I raise the question is whether there has been sufficient time with respect to experience under the proposal.

Senator KENNEDY. Have you had any preliminary information; have you had any correspondence from any of the county medical societies, from the State medical societies?

Mr. PETERSON. If the information is available, we will be glad to forward it to you.

Senator KENNEDY. You do not have any knowledge at this time that either doctors or the county medical society or the State medical societies have brought information to your attention stating that there has been a deterioration?

Mr. PETERSON. The information may be available but we do not have it at the table at the moment.

Dr. ANNIS. Either that it has or has not.

Senator KENNEDY. I would imagine that if they had raised any complaint that you would be commenting on it to illustrate a point.

Dr. ANNIS. I would point out that in the United Kingdom they have four CAT scanners. The point has been made that we have too many in this country and are over-utilizing them. In the United Kingdom they are available, but it is awkward to get to them; you have to go 100 or 150, 200 miles and wait there before your turn comes, and that is the kind of thing one would anticipate with limits on capital expenditure.

Senator KENNEDY. We have 14 in the Greater Washington area, as I understand it. Do you think 14 is enough or do you think we ought to have 25?

Dr. ANNIS. I do not know. I have noticed in some of the Secretary's testimony that he contends that the great number of the tests done

on the CAT scanner machine are unnecessary and that they are just done for experience, and for one reason or another——

Senator KENNEDY. Perhaps to pay for them.

Dr. ANNIS. I think that it may be easier to say legislatively than it is professionally whether those things are deemed as necessary. But certainly the way in which the CAT scanning is utilized is far from its ultimate at this time.

Senator KENNEDY. Do you think we ought to try to develop some kind of assessment of new technology as well as a cost assessment? Don't you think that would be generally useful?

Dr. ANNIS. Yes; I do. I think it would be useful to do it. However, I would hesitate to allow it to restrict. That is like the FDA saying you cannot use this drug for a purpose other than in its label. That is the way we learn.

Senator KENNEDY. That is the way to learn, on a patient?

Let us proceed.

Dr. ANNIS. I was about to ask Dr. Felch to carry on with the rest of our presentation.

Dr. FELCH. Mr. Chairman, at this time we would like to comment in greater detail on the major provisions of S. 1391. I will try to make this detail as rapidly as possible.

Senator KENNEDY. We welcome your analysis. We have had a good deal of analysis this morning so we are eagerly awaiting your recommendations on how to deal with it.

Dr. FELCH. 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——

Senator KENNEDY. Do you support the Talmadge bill?

Dr. FELCH. We do have a position on the Talmadge bill. We have studied it. We think some of its provisions are perhaps more appropriate than the cap.

Senator KENNEDY. Senator Talmadge will be having hearings in early June. I just wonder what your position is going to be, if you would like to leak an important secret to us now.

Mr. PETERSON. Mr. Chairman, if I can elaborate on that. You are speaking of the Talmadge bill here with reference to comparable provisions for hospital containment costs?

Senator KENNEDY. That is correct.

Mr. PETERSON. The consideration under that bill is that we feel it does provide opportunities for incentives to hospitals, and as such feel that the program while it may have some weaknesses, is good as a limited experimental approach. We have some questions about categorizations, just how that would be ultimately achieved. That does have some inherent problems as well.

On the whole the concept of providing for average, routine operating costs with opportunities for efficiencies and incentives to reach these efficiencies we feel is an approach that merits consideration and should be tried.

We are recommending that that should be done on an experimental basis in geographically limited usage.

Dr. FELCH. I will first address the implicit issue found in section 2 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 2 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 a "permanent" proposal would be made "no later than" 6 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 consideration. This course would avoid the disruptive effects which are certain to occur under S. 1391 and its adverse effects upon health care. Such a course would be especially desirable since the permanent proposal is to "increase the efficiency"——

Senator KENNEDY. Did I hear you correctly? You are suggesting that we wait until we get the comprehensive in order to give examination to cost controls? On the other hand, we have just heard with regard to a rather limited program, the Talmadge bill. Evidently you feel that is so unpredictable that it ought to be done in a rather limited way. It seems you are arguing both sides of the issue.

On the one hand you are saying you are sufficiently unsure of the Talmadge proposal and you want to do it in an experimental limited way, but then on this limited proposal you say one of the reasons we should not do it is since we are going to have comprehensive, we ought to wait to consider the whole concept.

Dr. FELCH. This transitional proposal is an all-inclusive cap on virtually all hospitals in the country. It is certainly not an experimental or isolated program. It is all inclusive.

What we have long supported and would support here would be all kinds of experiments on prospective reimbursement, State rate-setting devices, a whole host of things, including Talmadge proposals. What we object to is an across-the-board imposition of this particular bill.

Senator KENNEDY. Do you support rate setting for radiologists and anesthesiologists?

Dr. ANNIS. He just said that support would be given a number of programs in the States——

Dr. FELCH. I was thinking about experiments taking place——

Senator KENNEDY. You do not support rate setting for physician fees?

Dr. FELCH. For physician fees, no.

Dr. ANNIS. As a matter of fact the FTC tells us that that is improper—that is restraint of trade.

Dr. FELCH. In any event, 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 subcommittee 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.

We will now turn to the more detailed provisions of S. 1391. 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 limitation 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.

Senator KENNEDY. Would you support the program if we limited it to 3 years?

Dr. FELCH. No. We believe that such limitation 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 limitation on hospitals which does not allow increases reflecting true cost increases could have the effect 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 nonprofit 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 effort on the public, hospitals 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 S. 1391 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 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-percent increase in gross inpatient revenues. This increase would be allowed for a particular hospital, however, only where the number of admissions increased by less than 2 percent or decreased by less than 6 percent—less than 10 percent for smaller hospitals—as compared to the base year.

On the other hand, if a hospital should exceed the increase limitation, the total allowable hospital inpatient revenues could increase only by one-half of the average revenue per admission for each admission over the increase limit. If the decrease limit were exceeded, one-half the average revenue per admission would be deducted from total revenue for each admission beyond the decrease limit.

For larger hospitals—those having more than 4,000 admissions in the base year—absolute limits in extra revenue would be established, and a 100-percent reduction from total revenue would be imposed for each decreased admission beyond 15 percent below admissions in the base year.

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—up to the allowed percentage—over the prior base year for no extra revenue, at one-half price for admissions above the allowable percentage increase, and—as to a large hospital—at no additional revenue beyond an absolute limit. Moreover it even runs the risk, at higher percentages, of a tax of 150 percent of excess inpatient revenues.

Senator KENNEDY. Do you have any suggestions on the formula for revenue increase?

Dr. FELCH. I think general ones——

Senator KENNEDY. If you have a different formula——

Dr. ANNIS. I think the point we are making is we do not have and no one has really presented a really sound formula for this.

Senator KENNEDY. I would welcome your suggestions on it.

Dr. ANNIS. You put me in a difficult position. There are also many illnesses for which I would like to give you cures, but unfortunately I cannot. I think bad medicine would be worse than no medicine at all.

Mr. PETERSON. I want to just mention again with respect to the activities of our Commission on Medical Care Costs, that we are expecting, and certainly anticipate that it will have, firm recommendations with respect to mechanisms, and we will be pleased of course to make these available. They will be available to this committee, and to the administration for its consideration as it develops the important permanent types of program.

So what we are recommending, rather than seeking a temporary program, is that the program should await the major considerations that are expected early next year.

Dr. FELCH. 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 admissions 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 or 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 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.

Moreover, 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 percent but which in fact could result in greater increased costs to the individual.

We also note that a 150-percent 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 be 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 result would impact adversely upon quality care of patients.

We also note that the bill would 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 or nonsupervisory personnel. Furthermore, the bill discriminates in its treatment and recognition of increases for supervisory and nonsupervisory personnel.

We believe that the administration's proposal for limitations on revenues of all hospitals should not be adopted.

As to the capital expenditure limitations, they 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. Chairman, 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 decisiomaking. Capital expenditures limitations as contemplated under the bill are unrealistic in that they attempt to state in advance the absolute 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 10 times the otherwise amount payable for depreciation, et cetera—to be taken from 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 S. 1391 should not be adopted.

At this time we will be pleased to respond to any questions which you may have.

Senator KENNEDY. On page 14 you indicate the bill discriminates in its treatment and recognition of increases for supervisory and nonsupervisory personnel.

Is that correct?

Dr. FELCH. Yes.

Senator KENNEDY. Since we know what nonsupervisory personnel are making, do you have any reservations about publishing what the supervisory personnel are making in hospitals?

Dr. ANNIS. No. I think the American Medical Association would have no objections to that, provided only that it is a reasonably accurate publication—not like the 65 percent error that was in a recent HEW publication.

Senator KENNEDY. Well, just asking the hospitals themselves to publish that, you do not have any hesitancy?

Dr. ANNIS. Of any hospital employee, no.

Dr. FELCH. I think disclosure ought to have some purpose. If it is to help the consumer ultimately——

Senator KENNEDY. Well, so we understand where the money is being expended. We have got 40 percent which is coming from the public sector, and it certainly seems that we are trying to find out how we could get control, how we could get some kind of cost containment, to understand how the money is flowing through the system.

I was interested on page 15 where you talk about competition and your concern about preventing competition. I am pleased to hear about the AMA promoting competition. What about the advertising of hospital rates so patients can choose between competing hospitals? Do you think that would be helpful in promoting competition, or physicians' fees for the same reason, so we know what the different hospitals are doing and what the physicians' fees are?

Dr. FELCH. I think it was you who indicated with an earlier witness that the admission to a hospital is to a considerable degree not determined by individual decisions of patients or providers. It depends really on where an emergency incident occurred. If you turn to that variety of admissions that are elective admissions, the person with a hernia, that is uncomfortable, that wants to get fixed sometime, can wait for some months—then he can choose to go to the Mayo Clinic or to the city instead of a country hospital, or adjacent hospital, because it is more convenient for his family, and in that situation I would think that understanding price differential would be beneficial.

Dr. ANNIS. I think it is an awful delicate subject. If the purpose of advertising rates, hospital physicians, or anything else, is to sell more services, you are going to defeat your objective—you do not want to get more utilization by having a "special" in a hospital for tonsillectomies on the weekend. That is the usual reason for advertising, is it not?

Senator KENNEDY. You mean people would go in even though they do not need their tonsils out, they could say, here is a bargain so I think that this weekend I will have my tonsils out, and they would go down and get it done, just because it is a good buy that weekend?

Dr. ANNIS. I had a patient recently who said he went so he could get out of going to work that day.

Senator KENNEDY. To get out of work?

Dr. ANNIS. He told me that was his reason for going to the doctor.

Senator KENNEDY. Hopefully the doctor did not take them out.

Dr. ANNIS. By the time he had seen the doctor the patient had missed work anyhow, you see.

If the purpose of advertising is, as it is in business certainly, to merchandise and sell more of a product, while unit price may come down, total amount expended is going to come up because utilization will increase.

Senator KENNEDY. It also has the purpose of giving information to the people.

Dr. ANNIS. If it can be confined to that.

Senator KENNEDY. It is all in the eye of the viewer, is it not?

Dr. ANNIS. It depends on whether you think it is a good idea for a patient to understand.

Senator KENNEDY. What do you think?

Dr. ANNIS. I think it would not help to advertise. I think information ought to be available to patients beforehand and know what the prices are at the various hospitals and know what the physician's services would be.

Senator KENNEDY. How about physicians' fees?

Dr. ANNIS. That is what I am speaking of, physician fees.

Mr. PETERSON. If I can elaborate on that.

The association has long recommended that physician fees should be available and should be discussed with the patient in advance of the services that are rendered. In addition, the association has not at any time advocated any prohibition against a disclosure through appropriate types of advertising, if you want to use that term, for indicating the fees of the physicians. The problem that can arise as was alluded to here is when any type of so-called advertising can amount to a solicitation, which may not be in the best interest of the patient, and this is the concern. Certainly the patient should have full disclosure and full knowledge of physician fees, and the association has never recommended anything to the contrary.

I want to indicate just in connection with what was mentioned here about potential advertising, I did recall seeing some advertising from a hospital in the Southwest part of the country in which they recommended some certain benefits that would occur. I think that patients would be eligible for some drawing, or whatever it was, if they went in on a weekend basis.

Senator KENNEDY. I think it was a trip to Hawaii.

Mr. PETERSON. I forget the exact prize.

Senator KENNEDY. That is why some suggested that the 9-percent limitation is too high. If they are able to advertise and to do things like that, you could turn that argument around and say if they have got that kind of fact in their budget, maybe they ought to screw it down a little bit tighter.

Mr. PETERSON. I cannot speak for that hospital.

Senator KENNEDY. What is your own impression about the general kind of fat in terms of hospital budgets? You people ought to be able to speak to that.

Dr. FELCH. I will speak anecdotally about my own community hospital. This notion of fat is foreign to me. We became cost conscious 4 or 5 years ago and cost conserving 2 years ago and have not hired new employees without getting special permission from a committee, have let old employees go by attrition, and failed to replace

them. I have asked each individual department within the hospital to come up with ways in which they could save 10 percent over the previous year. All of those management kinds of cost savings we have been doing.

Senator KENNEDY. Which hospital is that?

Dr. FELCH. It is called United Hospital in Port Chester, N.Y.

Senator KENNEDY. What have your increases been in total in say the last year or two?

Dr. FELCH. The rate has continued to increase. It has slowed a little bit. Our deficit has increased remarkably because the third-party reimbursement formulas have been so restrictive that despite the cost containment efforts, there is an end-of-year deficit. I also wanted to mention that in our hospital we have rather strict utilization review. We had medical audits on hysterectomies, tonsillectomies, all of the things that are often asserted to be unnecessary.

We are reviewing regularly and constantly.

Senator KENNEDY. We have heard what is wrong with the administration's proposal. Can you tell us what you are recommending?

Dr. ANNIS. To go back to the original statement, that is when we recommend no legislative action be taken at this time because we do not have the information to do it correctly, and that we look and continue to watch what the State experiments are coming up with.

Senator KENNEDY. When will you have a proposal?

Dr. ANNIS. I do not know. I cannot tell you. We will have a report from our committee in January——

Senatory KENNEDY. Are they going to make recommendations to us in the Congress on cost controls?

Dr. ANNIS. It will be made to the board of trustees of the American Medical Association. The commission that we establish will make these recommendations to us.

Senator KENNEDY. It is on cost control, is that the purpose of the study?

Dr. FELCH. Medical care costs.

Dr. ANNIS. Complete medical care costs. It is not looking at just hospitals, but all costs. One would hope it would have a good answer. But I think one has to be realistic. It may take longer than that to come up with the answer.

Senator KENNEDY. Do you have an interim report from that committee?

Dr. ANNIS. No.

Dr. FELCH. Its task forces are reviewing, for example, existing literature on cost containment devices. Do deductible and co-insurance really have any real impact? Do exerting caps by rate setting have any impact on cost savings? We do not yet know what their conclusions are. One of their processes is to review the existing literature.

Senator KENNEDY. We would be glad to instruct our staff to meet with that staff at the present time and see if they have got any recommendations or suggestions. Would there be any objection?

Dr. ANNIS. No, anything that we have would be welcome.

Senator KENNEDY. Well, thank you very much.

Dr. ANNIS. Thank you.

Senator KENNEDY. The final witness is Terrance Pitts, supervisor, Milwaukee County, Wis., National Association of Counties.

Mr. Pitts, we welcome you here, and look forward to your testimony.

STATEMENT OF TERRANCE PITTS, SUPERVISOR, MILWAUKEE COUNTY, WIS., NATIONAL ASSOCIATION OF COUNTIES, ACCOMPANIED BY MIKE GEMMELL, LEGISLATIVE REPRESENTATIVE

Mr. PITTS. Thank you, Mr. Chairman.

For the record, my name is Terrance Pitts. I am a supervisor, Milwaukee County, Wis., and chairman of the Health and Education Policy Steering Committee of the National Association of Counties (NACO) on whose behalf I am appearing today. With me is Mike Gemmell, NACO legislative representative.

The reasons for appearing today are outlined in the official statement. In the interest of time, I would like to just briefly state them. With your permission, I would like to include my full statement in the record.

Senator KENNEDY. It will be included in its entirety as if read. All the statements will be this morning.

Mr. PITTS. The National Association of Counties is going on record in support of the Hospital Cost Containment Act of 1977—S. 1391. Elected officials in county government are in support of the administration's attempt to bring the skyrocketing hospital costs under control.

After all, counties pay 10 percent of the $17 billion medicaid bill, not to mention the costs of medical care to the "unsponsored patients." These are people who do not have health insurance or Federal support for their medical care. This gap group includes the disabled but working person, intact families, the underinsured, the working poor, illegal and nonresident aliens, prisoners, transients, and migrants, among others.

In addition, we are concerned about the cost containment proposal because counties operate more than 10 percent of the hospitals in the country. In fact, over 45 percent of the 1,700 public general hospitals are county owned and operated. Many provide services to inner-city residents like our own Milwaukee County Medical Center.

We must point out that the current gaps—both uncovered people and uncovered services—are not addressed by medicare, medicaid, or the health care cost containment proposal under consideration today.

As a result, local governments will continue to be called upon to fill the gaps, Containment of costs will create even greater demands for public services to fill the gaps. Coupled with inflation of health care costs, this will compound the financial burden on counties and cities.

Although we support S. 1391, we feel that the following suggested amendments would strengthen the overall goal of the bill. That goal, as you know, is to constrain the rate of increase in total hospital inpatient costs by limiting the amount of revenue that may be received by hospitals from all sources.

First, the cost containment proposal must contain incentives to place higher priority on outpatient care, medicare, medicaid, and private insurance all provide greater coverage for inpatient care than for outpatient services.

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For example, in Cook County, Ill., and in Los Angeles County, Calif., the recovery rate is less—often close to zero. In many places, patients who could be inexpensively treated as outpatients are admitted to expensive hospital beds so that more of their costs will be recovered. Other patients do not receive early treatment and preventive services which could avoid expensive hospitalization.

Therefore, the proposal must contain payment mechanisms to allow medicare, medicaid, and other third-party payers to pay for outpatient services at reasonable cost to act as incentives for that type of care.

Second, the cost containment proposal must contain a provision that helps county and local governments pay for the costs incurred by their hospitals for treating unsponsored patients. We believe that increases in publicly provided services brought on by the cost control program should be partially or totally financed by the Federal Government.

The transfer of costs from Federal sources and private insurance to the local tax bill will not save on total costs, and will only place greater strain on local government revenue sources. The Federal Government must provide financial protection against any added demands for public services which result from a ceiling on private sector costs.

As such, we suggest that title II, section 1115, of the Social Security Act be amended by adding a new subsection. Briefly, the amendment would provide that the Secretary of HEW may waive the State plan requirement under medicaid and allow local governments to use their own appropriations earmarked for care to unsponsored patients as medicaid matching funds.

Third, we also request that local government appropriations above the 9 percent limit to the public general hospitals be exempted from the revenue limit. Most public hospitals have been operating on locally imposed cost control programs over the last few years. County hospitals have voluntarily closed beds in order to live within these self-imposed budget ceilings.

Therefore, if county governing boards allocate property tax revenues for their hospitals beyond the allowable limit, the added resources should be exempted from the cap. We call this "get well money," since it would attempt to raise the public hospitals to the same base that private hospitals have been operating from all these years without self-imposed revenue ceilings. This provision should apply to those hospitals that need additional funds to meet life safety codes.

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 proposal, therefore, must contain stronger language requiring private hospitals to at least maintain their present charity patient-load. The bill must insure that no hospital reduce its share of care to "unprofitable" patients.

Therefore, all hospitals should be required to:

First. Maintain their present patient mix in terms of insured and noninsured patients;

Two. Maintain their present bad debt ratio or charity load; and

Three. 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 might be dumped upon.

Section 126, as written, 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.

I am enclosing a resolution adopted last week by NACO's Health and Education Policy Steering Committee. Briefly, it states that NACO supports S. 1391 as a stopgap measure to control runaway and excessive hospital costs.

We urge Congress to pass S. 1391 with our amendments. This or similar legislation would lay the groundwork for national health insurance which we support.

We thank the members for giving us the opportunity to comment on this hospital cost restraint proposal. We are most willing to work with subcommittee staff in seeking enactment of a bill that conforms with the points raised by our testimony.

Thank you, Mr. Chairman.

Senator KENNEDY. Thank you very much for your testimony.

Maybe you could elaborate a little bit on the dumping possibilities from one hospital to another. How are we going to deal with that? Is this a problem?

Mr. PITTS. Certainly, if the public hospitals were not included in the bill automatically, that would be a dumping ground for the private sector to unload their charitable patients into the public sector.

There is one question, I am not really sure of the answer, and that is relative to the ability of the public hospitals to use increased local taxes and therefore complete their budgets annually. The question is whether or not that increase is really prohibited by the cost containment proposal.

If it is in fact not prohibited, that in and of itself may be a basis for allowing, or giving incentive to a private hospital to dump into a public hospital.

Senator KENNEDY. So you think county hospitals should be included?

Mr. PITTS. Yes; definitely.

Senator KENNEDY. Tell us a little bit about your own experience in the cost cutting that was involved in the Milwaukee County Hospital.

Mr. PITTS. Briefly, first of all, we have had consolidation of programs where consolidation would reduce expenditures without compromising quality of service, and when consolidation would not compromise Milwaukee County's capability to serve those dependent upon Milwaukee County, and the principal example was consolidation of Milwaukee County's long-term care programs for inpatients, such as rehabilitation, chronic disease, and tuberculosis.

Reduction on cost was due to elimination of over 70 physicians. Of course, there is also the other part of the point on that, there is strong

resistance from the unions of the civil service employees, and that creates a problem.

However, in the long run it has the effect of reducing the hospital's budget. The elimination of full-time positions, and replacement of those positions with hourly employees, in order to adjust the work force with functions involving peak periods of activity, and a long-term effort is underway to develop a management system which will reduce manual, clerical activity throughout the medical complex with a net substantial saving.

A product standardization committee meets regularly to assure that all items are purchased at the lowest price, but maintaining the standards that the committee has set.

The administration and professional staff have implemented an effective professions service review organization function assuring that all hospitalizations are necessary, and for only the duration that is required.

In addition, admissions to hospitals are scheduled and planned so that the patient care services can be organized to gain more efficient use of equipment and personnel, while at the same time helping to avoid prolongation of hospitalization.

So those are some of the things we have done.

As far as things we have done to conserve energy, we have planned to institute a computer control system whereby we could have automatic shutoff of lights, blowers, fans, heaters, and other automatic systems when they are not in use. This would be done by a computer control system.

In addition, at our plant, at our medical complex, we have been experimenting with burning solid waste. We usually get that from the city, and we include that as a fuel along with our coal.

So we have been working with that. However, there are, on the other hand, some uncontrollable costs. For instance, we have to purchase an electrostatic precipitator which removes solid materials from smoke that is being emitted into the air. That is going to cost $2.5 million.

That is more or less an unanticipated, uncontrollable expense, or cost that has to be borne by the hospital budget.

So these are some of the things, Mr. Chairman, that we have been able to achieve in cutting our hospital costs.

Senator KENNEDY. What have been the factors that have increased costs to you in the last year or two?

Mr. PITTS. I think generally the major thing has been increase in wages, salaries, and benefits paid our employees. That is generally always one of our big problems that increase our costs.

Of course, we have very little control over the increasing costs for supplies and commodities that we use in the hospital complex. Also, increased costs that are a direct result of the requirement to be in compliance with Federal laws and rules and regulations.

The reporting mechanisms under the Federal requirements have increased our personnel costs of admission requirements. Also, we have had increased costs due to development of new knowledge and new technologies and increased intensity of care provided has resulted in the need for more, and rarely not less, highly skilled personnel in many technical areas.

Of course, we also had increased costs incurred by hospitals as a result of promulgation of more stringent life and safety codes.

Senator KENNEDY. What is the percentage increase in the last year?

Mr. PITTS. I think it is comparable to the national average, approximately 15 percent annually.

Senator KENNEDY. Well, I want to thank you very much for your presence.

We have now completed 2 days of hearings on the Hospital Cost Containment Act.

We are going to have 2 more days of hearings, on June 16 and June 17. You have heard from a number of our witnesses on why cost control containment is so essential in terms of bringing into perspective the explosion of hospital costs in our society, and relating this to other services, particularly in the preventive health care area, health education, the whole range of different areas of need which are not being attended to, drug, alcohol control, mental health, immunization programs, a wide variety of different public health prevention programs.

We have heard some criticism of this proposal. I think some of the observations that have been made in terms of reservations were put forth by the administration, Secretary Califano. They do not come as very new criticisms. They recognize this as a temporary measure. But if implemented, according to the figures that we have been able to gain from the Congressional Budget Office, as well as the Secretary, savings of approximately $40 billion for 1981, 1982, will be gained and without it we are going to see that, plus other additional moneys expended.

I feel we have to deal in a comprehensive way with the whole issue of cost controls. We have talked about this. There is only one way and means of doing it, as I see it, and that is by a comprehensive program that relates to both expenditures with delivery system. That is what is absolutely essential.

Even as we hear comments on this more limited program, it just reaffirms my longstanding belief that unless we are going to deal with it in a comprehensive way, we are not going to be really taking the bull by the horns.

We must recognize that even a comprehensive program will take time to implement. However, we are still under an important mandate to at least temporarily deal with this explosion of costs.

It seems to me, that of the arguments that have been made today, the most important one is what it is going to mean in terms of the quality and cost of health care for our people.

Other than the rhetoric that has been explained in these committee hearings, I just have not been convinced that that case has been made in a very important way. We will continue in the course of our hearings to try and examine that and some of the other factors that have been raised.

We look forward to working with witnesses who have testified, as well as the others in June, to try and elicit from them constructive and positive recommendations about how we can deal with this.

Perhaps in an imperfect way, but nonetheless, in a way that is going to deal in a serious manner with a problem which is, I think, just crying for the attention of those of us who have some degree of responsibility in fashioning of public policy in the health area.

I want to thank you very much.

Mr. PITTS. Thank you.

[The prepared statement of Mr. Pitts follows:]

STATEMENT by

THE NATIONAL ASSOCIATION OF COUNTIES
1735 NEW YORK AVE., N.W., WASHINGTON, D.C. 20006 · (202) 785-9577

PRESENTED BY

THE HONORABLE TERRANCE PITTS

SUPERVISOR, MILWAUKEE COUNTY, WISCONSIN

BEFORE

THE COMMITTEE ON HUMAN RESOURCES

SUBCOMMITTEE ON HEALTH

UNITED STATES SENATE

ON

THE HOSPITAL COST CONTAINMENT ACT OF 1977

S. 1391

MAY 26, 1977

WASHINGTON, D.C.

STATEMENT OF THE HONORABLE TERRANCE PITTS, SUPERVISOR, MILWAUKEE COUNTY, WISCONSIN, ON BEHALF OF THE NATIONAL ASSOCIATION OF COUNTIES (NACo) BEFORE THE COMMITTEE ON HUMAN RESOURCES, SUBCOMMITTEE ON HEALTH, ON THE HOSPITAL COST CONTAINMENT ACT OF 1977 (S. 1391) MAY 26, 1977.

MR. CHAIRMAN, MEMBERS OF THE SUBCOMMITTEE, I AM TERRANCE PITTS, SUPERVISOR, MILWAUKEE COUNTY, WISCONSIN, AND CHAIRMAN OF THE HEALTH AND EDUCATION POLICY STEERING COMMITTEE OF THE NATIONAL ASSOCIATION OF COUNTIES (NACO)[1] ON WHOSE BEHALF I AM APPEARING TODAY. WITH ME IS MIKE GEMMELL, NACo LEGISLATIVE REPRESENTATIVE.

THE PURPOSE OF MY STATEMENT IS TO MAKE THE CONGRESS AND THE SUBCOMMITTEE AWARE OF THE KEY PROBLEMS FACING COUNTIES IN TERMS OF RISING HEALTH COSTS. WE WISH TO COMMEND THE CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE FOR CONDUCTING THESE HEARINGS ON THE RISING COSTS OF MEDICAL CARE AND THE MEANS TO CONTROL THOSE COSTS.

THE NATIONAL ASSOCIATION OF COUNTIES REPRESENTS OVER 1500 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.[2] TO CLEARLY SHOW THE MAGNITUDE OF THE FINANCIAL COMMITMENT COUNTIES

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[1]NACo is the only national organization representing county government in America. Its membership includes urban, suburban, and rural counties joined together for the common purpose 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 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.

[2]Over 75% of the 3000 counties are administratively responsible for providing community health services. Over 68% provide medical assistance, 60% provide mental health services, 30% operate hospitals (nearly half of public hospitals are county operated), 38% provide emergency medical services, and 26% 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, etc. 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.

MAKE TO HEALTH CARE IN THIS COUNTRY, WE ARE SUBMITTING FOR THE RECORD, THE RESULTS OF A SURVEY OF HEALTH EXPENDITURES IN 14 STATES. WE BELIEVE THIS PROVIDES REPRESENTATIVE EXAMPLES OF THE ROLE COUNTIES PLAY IN PROVIDING MEDICAL CARE.

MR. CHAIRMAN, I AM ALSO ATTACHING A RESOLUTION CONDITIONALLY SUPPORTING THE HEW COST CONTAINMENT PROPOSAL. THIS RESOLUTION WAS ADOPTED BY THE NACo HEALTH AND EDUCATION POLICY STEERING COMMITTEE AT OUR MEETING LAST WEEK IN MILWAUKEE.

THE NATIONAL ASSOCIATION OF COUNTIES GOES ON RECORD IN SUPPORT OF THE "HOSPITAL COST CONTAINMENT ACT OF 1977" (S.1391). WE, ELECTED OFFICIALS IN COUNTY GOVERNMENT, ARE IN SUPPORT OF THE ADMINISTRATION'S ATTEMPT TO BRING THE SKYROCKETTING HOSPITAL COSTS UNDER CONTROL. AFTERALL, COUNTIES PAY 10 PERCENT OF THE $17 BILLION MEDICAID BILL, NOT TO MENTION THE COSTS OF MEDICAL CARE TO THE "UNSPONSORED PATIENTS." IN ADDITION, COUNTIES OWN MORE THAN 10 PERCENT OF THE HOSPITALS (45 PERCENT OF THE PUBLIC GENERAL HOSPITALS) IN THIS COUNTRY

THE IMPACT OF COST CONTAINMENT WILL BE SUBSTANTIAL ON COUNTY GOVERNMENTS AND INSTITUTIONS. WHICH PROVIDE MEDICAL CARE TO INDIVIDUALS WHO CANNOT OBTAIN IT ELSEWHERE. THE POPULATION SERVED BY THESE 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, INTACT FAMILIES, THE UNDERINSURED, THE WORKING POOR, NON-RESIDENT ALIENS, PRISONERS, AND MIGRANTS, AMONG OTHERS.

WE MUST POINT OUT THAT THE CURRENT GAPS -- BOTH UNCOVERED PEOPLE AND UNCOVERED SERVICES - ARE NOT ADDRESSED BY THE PROPOSAL UNDER CONSIDERATION TODAY. AS A RESULT, LOCAL GOVERNMENTS WILL BE CALLED UPON TO FILL THE GAPS. CONTAINMENT OF COSTS FOR OTHER THAN GAP GROUPS WILL CREATE EVEN GREATER DEMANDS FOR SERVICES TO FILL THE GAPS. COUPLED WITH INFLATION OF HEALTH CARE COSTS, THIS WILL COMPOUND THE FINANCIAL BURDEN ON COUNTIES AND CITIES. SADDLED WITH A RIGID AND REGRESSIVE TAX BASE - THE PROPERTY TAX - LOCAL GOVERNMENTS ARE, THEREFORE, ON THE HORNS OF AN INCREASINGLY DIFFICULT AND DISCOURAGING DILEMMA.

THE RAPID ESCALATION OF HEALTH CARE COSTS IN THE PAST FEW YEARS HAS FORCED COUNTIES -- THE PROVIDERS OF LAST RESORT -- 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 GAP POPULATION; BUT, ARE LIMITED IN THEIR CAPACITY TO CONTROL COSTS OUTSIDE OF THEIR JURISDICTIONS. LOCAL GOVERNMENTS HAVE NO INFLUENCE IN ESTABLISHING ELIGIBILITY AND BENEFIT PACKAGES IN MOST STATES BUT MUST PAY FOR ALL NEEDED SERVICES WHICH THE FEDERAL AND STATE GOVERNMENT AND THIRD PARTY PAYORS CHOOSE NOT TO PAY FOR. WE BELIEVE THAT UNDER S. 1391 THIS SHARE OF HEALTH SERVICES IS LIKELY TO BE INCREASED.

THE ADMINISTRATION HAS ACKNOWLEDGED THAT THE PROPOSAL WILL ONLY BE A STOP-GAP SOLUTION WHICH WILL ONLY TREAT ONE RESULT OF BASIC HEALTH CARE ORGANIZATION DEFICIENCIES, i.e., THE HIGH COSTS OF HOSPITAL CARE. WE APPRECIATE THE POLITICAL REALITIES WHICH DICTATE THIS PARTICULAR SHORT TERM APPROACH, AT THIS TIME.

FOR THE SHORT RUN, SINCE HEALTH CARE COSTS TAKE AN INAPPROPRIATELY LARGE PORTION OF OUR NATIONAL RESOURCES, A CAP ON HOSPITAL COSTS IS ESSENTIAL. WE ENDORSE HEW SECRETARY CALIFANO'S EXPRESSED GOAL OF CONTAINING HOSPITAL COST INCREASES TO NINE PERCENT IN THE NEXT YEAR. THE RECOMMENDATIONS WHICH FOLLOW ARE INTENDED TO SUGGEST CHANGES IN THE PROPOSAL WHICH WILL PROTECT NEEDY PATIENTS WITHOUT INCREASING THE COSTS TO LOCAL GOVERNMENTS ABOVE THE PROPORTIONATE COSTS TO THE PRIVATE SECTOR OR NINE PERCENT -- WHICHEVER IS LESS.

MR. CHAIRMAN, ALTHOUGH WE SUPPORT S. 1391, WE THINK THAT THE FOLLOWING SUGGESTED AMENDMENTS WOULD STRENGTHEN THE OVERALL GOAL OF THE BILL. THAT GOAL, AS YOU KNOW, IS TO CONSTRAIN THE RATE OF INCREASE IN TOTAL HOSPITAL INPATIENT COSTS BY LIMITING THE AMOUNT OF REVENUE THAT MAY BE RECEIVED BY HOSPITALS FROM ALL SOURCES.

FIRST, THE COST CONTAINMENT PROPOSAL MUST CONTAIN INCENTIVES TO PLACE HIGHER

PRIORITY ON OUTPATIENT VERSUS INPATIENT CARE. AS YOU KNOW, MEDICARE, MEDICAID, AND PRIVATE INSURANCE ALL PROVIDE GREATER COVERAGE FOR INPATIENT CARE THAN FOR OUTPATIENT SERVICES. FOR EXAMPLE, IN COOK COUNTY, ILL., THE RECOVERY RATE IS ONLY 50 PERCENT FOR OUTPATIENT SERVICES. IN SOME OTHER COUNTIES, THE RECOVERY RATE IS LESS -- OFTEN CLOSE TO ZERO. IN MANY PLACES, PATIENTS WHO COULD BE INEXPENSIVELY TREATED AS OUTPATIENTS ARE ADMITTED TO EXPENSIVE HOSPITAL BEDS SO THAT MORE OF THEIR COSTS WILL BE COVERED. OTHER PATIENTS DO NOT RECEIVE EARLY TREATMENT AND PREVENTIVE SERVICES WHICH COULD AVOID EXPENSIVE HOSPITALIZATION.

FACILITIES AND PERSONNEL TO PROVIDE OUTPATIENT SERVICES ARE NOT AVAILABLE WHERE THEY ARE NEEDED. CAPITAL AND OPERATING SUPPORT FOR NEIGHBORHOOD HEALTH CENTERS AND SURGI-CENTERS WOULD MEAN THAT MORE PATIENTS COULD BE TREATED AT REMOTE SITES THAT ARE EASILY ACCESSIBLE TO PATIENTS, INSTEAD OF IN EXPENSIVE AND INCONVENIENT HOSPITAL EMERGENCY ROOMS AND CLINICS. THEREFORE, THE COST CONTAINMENT PROPOSAL NEEDS TO:

1. PROVIDE PAYMENT MECHANISMS IN TITLES XVIII AND XIX OF THE SOCIAL SECURITY ACT, AND OTHER THIRD-PARTY PAYORS FOR OUTPATIENT SERVICES AT REASONABLE COST, OR EVEN ABOVE COST, TO ACT AS AN INCENTIVE FOR OUTPATIENT RATHER THAN INPATIENT CARE; AND,
2. USE SAVINGS FROM THE CAP ON HOSPITAL COSTS TO SEED START-UP EFFORTS AND TO SUPPLY CAPITAL FOR NEIGHBORHOOD HEALTH CENTERS AND SURGI-CENTERS.

SECOND, THE COST CONTAINMENT PROPOSAL MUST CONTAIN A PROVISION THAT HELPS PUBLIC FACILITIES PAY FOR THE COSTS INCURRED FOR TREATING "UNSPONSORED" PATIENTS. WE BELIEVE THAT INCREASES IN PUBLICLY PROVIDED SERVICES BROUGHT ON BY THE COST CONTROL PROGRAM SHOULD BE PARTIALLY OR TOTALLY FINANCED BY THE FEDERAL GOVERNMENT.

THE UNDERINSURED AND UNSPONSORED PATIENTS NOW RECEIVE CARE THROUGH GENERAL REVENUE FUND SUBSIDIES OF LOCAL GOVERNMENTS OR IN THE DWINDLING MINORITY OF PRIVATE HOSPITALS WHICH CONTINUE TO PROVIDE CHARITY CARE. ANY PROGRAM WHICH PUTS A LIMIT ON ALLOWABLE COSTS WILL FORCE MORE PATIENTS INTO RELIANCE ON PUBLIC FUNDING.

THE TRANSFER OF COSTS FROM FEDERAL SOURCES AND PRIVATE INSURANCE TO LOCAL FUNDS WILL NOT SAVE ON TOTAL COSTS AND WILL ONLY PLACE GREATER STRAIN ON LOCAL GOVERNMENT REVENUE SOURCES. THE FEDERAL GOVERNMENT MUST PROVIDE FINANCIAL PROTECTIONS AGAINST ANY ADDED DEMANDS FOR PUBLIC SERVICES WHICH RESULT FROM A CEILING ON PRIVATE SECTOR COSTS.

AS SUCH, WE SUGGEST THAT TITLE XI, SECTION 1115, OF THE SOCIAL SECURITY ACT BE AMENDED BY ADDING A NEW SUBSECTION THAT STATES:

> (C) UNDER SUCH TERMS AND CONDITIONS AS THE SECRETARY MAY PRESCRIBE, HE MAY WAIVE ALL PLAN REQUIREMENTS UNDER TITLE XIX, SECTION 1902, WITH RESPECT TO FUNDS APPROPRIATED BY GENERAL PURPOSE LOCAL GOVERNMENTS FOR THE PURCHASE OF MEDICAL CARE TO THOSE INDIVIDUALS NOT RECEIVING AID OR ASSISTANCE UNDER TITLE XIX AND/OR WHO DO NOT MEET THE INCOME AND RESOURCES REQUIREMENTS OF THE APPROPRIATE STATE PLAN, OR THE SUPPLEMENTAL SECURITY INCOME PROGRAM UNDER TITLE XVI, AND THAT THE SECRETARY MAY CONSIDER SUCH FUNDS AS AN ALLOWABLE NON-FEDERAL SHARE OF THE EXPENDITURES INCURRED FOR SERVICES TO INDIVIDUALS NOT COVERED UNDER THE STATE PLAN OR TITLE XVI.
>
> (THIS AMENDMENT WOULD ALSO REQUIRE THAT THE $4 MILLION LIMITATION FOR SECTION 1115 BE CHANGED TO "...SUCH SUMS AS NECESSARY.")

THIRD, WE ALSO REQUEST THAT LOCAL GOVERNMENT APPROPRIATIONS ABOVE THE NINE PERCENT LIMIT TO THE PUBLIC GENERAL HOSPITALS BE EXEMPTED FROM THE REVENUE LIMIT. MOST PUBLIC HOSPITALS HAVE BEEN OPERATING ON LOCALLY IMPOSED COST CONTROL PROGRAMS OVER THE LAST FEW YEARS. COUNTY HOSPITALS HAVE VOLUNTARILY CLOSED BEDS IN ORDER TO LIVE WITHIN THESE SELF-IMPOSED BUDGET CEILINGS. THEREFORE, IF LOCAL GOVERNING BOARDS ALLOCATE PROPERTY TAX REVENUES FOR THEIR HOSPITALS BEYOND THE ALLOWABLE LIMIT, THE ADDED RESOURCES SHOULD BE EXEMPTED FROM THE CAP. WE CALL THIS "GET WELL MONEY" SINCE IT WOULD ATTEMPT TO RAISE THE PUBLIC HOSPITALS TO

THE SAME BASE THAT PRIVATE HOSPITALS HAVE BEEN OPERATING FROM ALL THESE YEARS WITHOUT SELF-IMPOSED REVENUE CEILINGS.

FOURTH, THE COST CONTAINMENT PROPOSAL MUST CONTAIN STRONGER LANGUAGE IN SECTION 126 REQUIRING HOSPITALS TO MAINTAIN THEIR CHARITY PATIENT LOAD. S. 1391 MUST GUARANTEE THAT NO HOSPITAL REDUCES ITS SHARE OF CARE TO "UNPROFITABLE" PATIENTS. ALL HOSPITALS, MR. CHAIRMAN, SHOULD BE REQUIRED TO:

1. MAINTAIN THEIR PATIENT MIX;
2. MAINTAIN THEIR BAD DEBT RATIO; AND,
3. MAINTAIN THEIR GROSS TO NET REVENUE RATIO.

ALLOWABLE COST REIMBURSEMENT FORMULAS CAN BE FACTORED BY THE ABOVE POINTS TO MONITOR HOSPITALS AND PENALIZE THOSE WHICH DUMP AND PROVIDE PROTECTION TO HOSPITALS WHICH ARE DUMPED UPON. THIS METHOD OF DUMPING CONTROL WOULD BE CONSISTENT WITH PRINCIPLES AND INCENTIVES OUTLINED IN SECRETARY CALIFANO'S ORIGINAL COST CONTAINMENT PROPOSAL ANNOUNCEMENT. IT WOULD ALSO PROVIDE PROTECTION TO PUBLIC GENERAL HOSPITALS. LASTLY, IT WOULD NOT REQUIRE NEW FUNDS, BUT WOULD LEAD TO REDISTRIBUTION UNDER THE CEILING IMPOSED BY THE PROGRAM.

SECTION 126, AS WRITTEN, CONTAINS NO REAL PROTECTION FOR PUBLIC AND OTHER HOSPITALS THAT PROVIDE CHARITY CARE AND WILL SURELY BE DUMPED UPON. ENFORCEMENT IS BASED ON INVESTIGATION BY LOCAL HEALTH SYSTEMS AGENCIES (HSAs) 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.

OUR PROPOSED AMENDMENTS TO THE BILL ARE NOT MEANT TO SUGGEST THAT WE ARE OPPOSED TO A HOSPITAL COST CONTROL PROGRAM. IN FACT, LAST YEAR, BEFORE THIS SUBCOMMITTEE ON HEALTH, WE SAID THAT "...THE ONLY WAY TO PUT A HALT TO RISING HEALTH CARE COSTS IS THROUGH THE ENACTMENT OF A PHASE FOUR TYPE PROGRAM THAT PLACES LIMITATION ON HOSPITAL RATES..."

IN SUMMARY, THE NATIONAL ASSOCIATION OF COUNTIES SUPPORTS THE GOALS AND PRINCIPLES OF THE "HOSPITAL COST CONTAINMENT ACT OF 1977." WE BELIEVE THAT IT IS A BASIC STEP IN THE EFFORT TO BRING UNDER CONTROL THE SKYROCKETTING COSTS OF MEDICAL CARE. THESE INCREASING COSTS ARE THREATENING TO BANKRUPT LOCAL GOVERNMENTS.

WE URGE CONGRESS TO PASS S. 1391, WITH OUR AMENDMENTS. THIS WOULD LAY THE GROUNDWORK FOR ENACTING A NATIONAL HEALTH INSURANCE PROGRAM.

NATIONAL HEALTH INSURANCE IS IN A COMA BROUGHT ON BY RUNAWAY INFLATION. IT WILL NEVER BE SERIOUSLY CONSIDERED UNTIL WE DO SOMETHING TO SOLVE THE PRESENT MEDICAL CARE COST DILEMMA.

CONGRESS, STATES, COUNTIES AND CITIES MUST COLLECTIVELY FACE AND RESPOND TO THE BASIC PROBLEMS OF HEALTH CARE IN THIS COUNTRY BEFORE NATIONAL HEALTH INSURANCE CAN BE ENACTED. THESE PROBLEMS ARE, BRIEFLY:

1. REDUCTION IN THE NUMBER OF UNNEEDED AND UNDERUTILIZED HOSPITAL BEDS;
2. PRESENT DISINCENTIVES FOR OUTPATIENT SERVICES;
3. LACK OF INCENTIVES FOR COST SAVINGS;
4. COSTS INCURRED TO MEET FEDERAL REGULATIONS;
5. LACK OF FUNDS FOR PUBLIC HOSPITALS TO COMPLY WITH LIFE AND SAFETY CODES; AND,
6. (MOST IMPORTANTLY) LACK OF INCENTIVES AND FUNDS TO PROVIDE PREVENTIVE AND PUBLIC HEALTH SERVICES.

WE THANK THE MEMBERS FOR GIVING US THE OPPORTUNITY TO COMMENT ON THIS HOSPITAL COST RESTRAINT PROPOSAL. WE ARE MOST WILLING TO WORK WITH YOUR STAFF IN SEEKING ENACTMENT OF A BILL THAT CONFORMS WITH THE POINTS RAISED BY OUR TESTIMONY.

THANK YOU.

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; and,

WHEREAS, counties pay 10 percent of the $17 billion national medicaid bill; and,

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; and,

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; and,

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; and,

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; and,

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 and,

WHEREAS, skyrocketting medical costs have forced counties to increase the proportion of scarce property tax dollars they allocate to health care; and,

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; and,

WHEREAS, NACo recognizes that the variety of problems affecting hospital costs makes a single approach inadequate and/or inequitable.

NACo URGES THAT:

-Congress pass the hospital cost containment bill as an initial approach to controlling health costs with the following amendments:

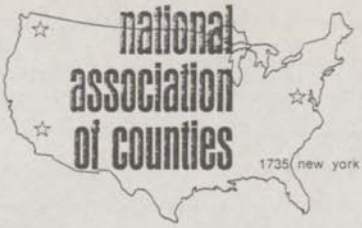
a) providing payment mechanisms in medicaid, medicare and other third party payors for outpatient care that are comparable to inpatient care;

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.

Health and Education Policy Steering Committee
May 20, 1977



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THE ROLE OF COUNTY GOVERNMENT IN MEDICAID:

A SURVEY OF SELECTED STATES

by

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NATIONAL ASSOCIATION OF COUNTIES
1735 New York Avenue, N.W.
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INTRODUCTION

This study by the National Association of Counties (NACo) demonstrates the financial and administrative commitment of county resources to the Medicaid program. Although the Medicaid program is generally considered to be a federal-state partnership, local county governments are required to provide substantial financial and administrative support. In five of the fifteen states surveyed for this study, county governments paid over 20 percent of the total Medicaid program or administrative costs for the fiscal year July 1, 1975 to June 30, 1976.

NACo maintains that the funding of the Medicaid program should be completely assumed by the federal government. This position is based upon three observations: 1) Medicaid plans vary from state to state; thus, the medically indigent residing in one state are commonly denied services available to those in other states; 2) counties must fill the gaps in services to the poor; thus, Medicaid programs which provide fewer services place a greater workload on county health agencies and hospitals; and 3) those states which require county support in Medicaid funding increase the burden on the major source of county revenue, the local property tax.

The purpose of this report is to demonstrate the burden the Medicaid program places on county government, to outline the major gaps in services to people, and to emphasize the need to address this problem in discussions concerning the reform of the Medicaid program. The escalating costs of the Medicaid program ($2 billion per year since 1974) have strained county budgets to the point where other mandated services areas are being jeopardized. Assumption of funding for the Medicaid program by the federal government would relieve counties of this burden, and enable them to maintain their efforts in other areas of responsibility including public health and medical care.

ACKNOWLEDGEMENTS

The data presented in this report were obtained from officials working in the agencies responsible for the individual state medical assistance plans. In many cases, more than

one official was consulted; however, the name of only the principal contact is provided for each state. The NACo staff wishes to express its appreciation to those state officals who provided the data necessary to complete this study.

METHODOLOGY

The survey was designed and directed by James Koppel of the NACo staff. John Clark authored the survey analysis.

Data for this report was obtained through personal interviews with officials of the departments responsible for administering the individual state medical assistance programs. Interviews were conducted between March and June, 1976. Where necessary, figures were projected to cover the fiscal year July 1, 1975 to June 30, 1976. The accuracy of the data, where available, was considered to be good. In some cases information could not be readily obtained from existing records, e.g., the number of state-operated skilled nursing and intermediate care facilities was in several cases unknown.

A total of fifteen states were interviewed, representing 47 percent of the country's Medicaid recipients (1973 figure). Geographical dispersion was obtained by selecting states located in the Northeast, South, Midwest, and West. Patterns in the provision of services, and participation in funding by the counties were identified.

Two types of costs were looked at for this report. Program costs were defined as costs for services provided. Administrative costs were defined as the costs associated with operating the Medicaid program, e.g., the costs of determining the eligibility of a recipient.

FINDINGS

Table 1 displays the states surveyed, the type of program operated (medically needy or SSI type), the optional services provided, and whether counties fund either the program or administrative costs of Medicaid.

Nine of the fifteen states operated a "medically needy" program, i.e., medical assistance was provided to poor persons other than those receiving AFDC or SSI. In seven of

these nine states, counties participated in funding the program costs of Medicaid. In three of these states counties also contributed to the administrative costs of the program.

Six of the fifteen states operate a "categorically needy" program, i.e., eligibility for medical assistance is based upon qualification for either AFDC or SSI assistance. In three of these states counties pay part of the administrative costs of the program. One state, Nevada, has property taxes earmarked for the Title XIX fund. In eleven of the fifteen states surveyed (or 73.3 percent), counties are required to financially support the Medicaid program. The other thirty-nine states are not required to financially participate in the Medicaid program. However, most counties in these states finance the bulk of medical services to medically needy persons that are not covered under Medicaid.

Opposite this requirement of financial support by the counties, the degree of county control over the program, i.e., as far as the setting of standards for eligibility and the setting of benefit levels was reviewed. (Data are presented on individual state survey sheets.) In all fifteen states, standards for eligibility were set by the state. In fourteen of fifteen cases, the level of benefits was likewise determined solely by the state, Nebraska being the exception. The costly process of determining the eligibility of potential recipients was assigned to the counties in all but three states.

Table 2 presents the program and administrative costs of Medicaid to county governments from July 1, 1975 to June 30, 1976. Table 3 displays the percentage of total (federal and state) Medicaid costs funded by county governments for the same period. For those states having the medically needy program, the counties generally (7 or 9 cases) were required to assist in funding Medicaid costs, ranging from 2.4 percent to 27.5 percent of total programs costs. Support of administrative costs ranged from 2.88 percent to 35.4 percent of total administrative costs.

Table 4 displays the per capita contribution by county governments to Medicaid program and administrative costs. These figures were obtained by dividing the contribution of each state's counties to program (and administrative) costs by the average monthly served population, multiplied by twelve. The highest per capita

contribution to program costs occurred in those states having the medically needy program. The highest per capita contribution to administrative costs was paid by Indiana counties ($13.17), and was nearly ten times the size of the next largest (New York at $1.34).

CUTBACKS

Between January 1, 1975 and January 15, 1976, five of the surveyed states (Ala., Md., N.H., N.J., Va.) reduced or eliminated mandatory or optional services to Medicaid recipients. Three more states (Ind., Neb., N.C.) plan to reduce or eliminate services in fiscal '77. The goal of reductions or eliminations in services provided under the states' Medicaid plans is cost control; the effects will surely be an increased burden on local governments, which are mandated to provide health services to their indigent populations.

States which have the medically needy program were slightly more likely to cut back on services than states with the more restricted SSI program (4 to 3).

County participation in Medicaid funding did not seem to prevent cutbacks in services. States in which counties funded Medicaid were as likely to cut back services as those states in which counties did not. Since county funding of Medicaid will continue, the ultimate losers in any cutback of services are the counties. The escalating costs of health care will require continued support by the counties at levels equal to or exceeding those of the past fiscal year. Meanwhile, those services to the poor that are no longer covered under Medicaid must be provided solely at county expense. A cutback in services or eligible population, while possibly serving the states' need for economy, only worsens the situation of the counties.

SUMMARY

This report has pointed out that the commitment of county governments to the Medicaid program is substantial. As health care costs increase, counties are being forced to rely on an already burdened property tax to support the health care of a small segment

of their population. While dedicated to the provision and availability of health care for all citizens, counties face the dilemma of sacrificing other necessary and mandated service responsibilities to the burgeoning fiscal requirements of the Medicaid program. Cutbacks in services and/or eligible population provide no relief to counties, which are traditionally the providers of last resort. The effective response requires the federalization of Medicaid.

TABLE I

SERVICES (Optional)

Program Type[1]	STATES PROVIDING SERVICE														
	AL	CA	CO	IN	MD	MN	NE	NV	NH	NJ	NY	NC	OH	VA	WI
	S	M	S	S	M	M	M	S	M	S	M	M	S	M	M
Clinic service		x		x	x	x	x	x	x	x	x	x	x	x	x
Prescribed drugs	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Dental services		x		x	x	x	x	x	x	x	x	x	x		x
Prosthetic devices	x	x	x	x	x	x	x	x	x	x	x		x		x
Eyeglasses	x	x		x	x	x	x	x	x	x	x	x	x	x	x
Pvt. Duty nursing				x		x	x	x	x		x		x		x
Physical Therapy		x	x	x	x	x	x	x	x	x	x		x	x	x
Preventive Rehab.		x		x		x	x	x	x	x	x	x	x		x
Emergency Hospital	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
SNFS patients under 21	x	x	x	x		x	x	x	x	x	x	x	x	x	x
Optometry	x	x		x	x	x	x	x	x	x	x	x	x	x	x
Podiatry		x	x	x	x	x	x	x	x	x	x	x	x	x	x
Chiropractors		x		x		x	x	x	x	x	x	x	x		x
LTC within ICF	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Mental illness in geriatric care (65)	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Participation in Funding[2]		B	A	A	P	B	P	3	P		B	B	A		

[1] M = Medically needy program
S = SSI eligibility program

[2] P - Counties contribute to program costs
A - Counties contribute to administrative costs
B - Counties contribute to program and administrative costs

[3] County property taxes exceeding $3.6 million are put into the state Title XIX fund

TABLE 2

Program and Administrative Costs to Counties

July 1, 1975 to June 30, 1976

Aggregated County Costs (State)	Program (dollars)	Administrative (dollars)
AL	--	--
CA	313,573,044 (covers both P & A)	
CO	--	151,660
IN	--	16,370,000 [1]
MD	4,457,511	--
MN	13,405,573	1,393,750
NE	13,228,000	--
NV	--	--
NH	3, 917,550	--
NJ	--	--
NY	754,000,000	18,694,000
NC	19,035,000 (covers both P & A)	
OH	--	1,100,000
VA	--	--
WI	--	--

[1] $5,004,000 was reimbursed from federal funds.

TABLE 3

Percentage of Total Medicaid Costs Funded by Counties
July 1, 1975 to June 30, 1976

State	Program Costs	Administrative Costs
AL	--	--
CA	15.0+	15.0+
CO	--	2.88
IN	--	35.4
MD	2.4	--
MN	4.4	25.0
NE	20.3	--
NV	--	--
NH	11.8	--
NJ	--	--
NY	27.5	24.0
NC	4.7*	4.7*
OH	--	10.0
VA	--	--
WI	--	--

+ 15% of the total program and administrative costs

* 4.7% of the total program and administrative costs

TABLE 4

Per Capita Contribution by Counties to Medicaid Program and Administrative Costs

July 1, 1975 to June 30, 1976

(Per Capita Dollar Amounts)

STATE	PROGRAM	ADMINISTRATIVE
AL	0	0
CA	P & A total - 21.78	
CO	--	.18
IN	--	13.17
MD	.89	--
MN	10.06	1.05
NE	32.89	--
NV	--	--
NH	14.67	--
NJ	--	--
NY	54.23	1.34
NC	P & A total - 9.70	
OH	--	.25
VA	--	--
WI	--	--

California and North Carolina reported program and administrative costs as one figure.

UPDATE--- OTHER STATES WHICH HAVE COUNTY CONTRIBUTIONS TO THE MEDICAID PROGRAM

Florida

I. Inpatient Hospital Care

The counties in Flordia pay 35% of the non-federal share for inpatient hospital care recipients beyond 12 days following admittance. This amounted to $4,306,546 in FY '76 (total expenditure: $45,871,447).

II. Skilled Nursing and Intermediate Care

The counties pay 35% of the non-federal share for recipients costing more than $170 a month. This cost can mot go above $55 a month per recipient. The FY '76 cost to counties in Florida was $8,651,433 (total expenditure: $73,900,070).

North Dakota------Richard W. Myatt-------701-224-2321

Federal	- 58%	--$13,763,364.62
State	- 35.7%	--$8,471,588,22
County	- 6.3%	--$1,494,986.16
	100 %	--$23,729,938.00

The counties also pay 50% of the administrative expenses which occur at the county level (eligibility determination, caseworkers, overhead costs, etc.)

Pennsylvania -------Mrs. Delaney-----717-787-4072

The counties paid 45% of the cost for county nursing care. There are 45 county nursing homes in Penn. and the total cost to these homes for F.Y.76 was $ 40 million of the $ 88 million total. Starting in F.Y.77 the state will begin to share the cost of the non-federal share.

	federal	state	local
F.Y.77---	55%	11.25%	33.75%
F.Y.78---	55%	22.5%	22.5%
F.Y.79---	55%	33.75%	11.25%
F.Y.80---	55%	40.5%	4.5%

Senator KENNEDY. We will recess on these set of hearings until June 16.

Thank you.

[Whereupon, at 1:09 p.m., the subcommittee recessed, subject to the call of the Chair.]

HOSPITAL COST CONTAINMENT ACT OF 1977

FRIDAY, JUNE 17, 1977

U.S. SENATE,
SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
OF THE COMMITTEE ON HUMAN RESOURCES,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:34 a.m., in room 4232 Dirksen Senate Office Building, Senator Edward M. Kennedy (chairman of the subcommittee), presiding.

Present: Senators Kennedy, Nelson, Javits, and Schweiker.

Committee staff present: Stuart Shapiro and Robert Wenger, professional staff members; David Winston and David Main, minority.

Senator KENNEDY. We will come to order.

This is a continuing hearing of the Senate Health Committee on the issue of the administration's cost control programs that have been developed by the Carter administration and directed toward hospitalization generally.

The Finance Committee has been holding hearings on the Talmadge proposal dealing only with the medicare and medicaid program which, in effect, deals with about half of the total of hospitalization programs.

The administration wanted to address this particular aspect of the growth of hospital costs in this country, which we have seen rise at a rate in excess of 31 percent in the last 2 years. It is one of the areas of the Consumer Price Index which has risen most rapidly. It is important that we get a handle on hospital costs, as well as on the growth of health-care costs generally. The Congressional Budget Office estimates that this country will be spending $250 billion by 1982. I am impressed but concerned by the fact that more and more is being expended in the medicaid-medicare area. It is putting important limitations on other areas of the health-care budget, primarily in the areas of health education, health prevention, the issues of drug and alcoholism control, reductions in child and maternal care, and reductions in immunization programs.

So the issues that we are reaching in terms of cost controls go far beyond just the dollars and cents which are involved, but are very much related to the issue of quality of health care and must be viewed in that particular way.

I would say that I do not think any of us are under the illusion that the proposal which has been advanced by President Carter and introduced as S. 1391 is an end-all. It is an interim measure. I would have serious reservations about its consequences over a significant period of time, but it is devised as a measure which, if implemented, according to the administration, will save the American consumer $42 billion by 1983.

Without effective cost-control programs, the American taxpayer ought to be prepared to pay much more in terms of dealing with the unnecessary hospital beds and unnecessary utilizations of drugs and surgery and many of the other areas of waste through hospital administration.

That is not an easily achievable goal, but it is one which we want to work on with those in the health professions to try to find out how we can best achieve it and do it.

[The complete text of Senator Kennedy's statement follows:]

OPENING STATEMENT OF SENATOR KENNEDY

Senator KENNEDY. Last year, Americans spent nearly $140 billion for health care—three times the amount we spent 10 years ago. At that current rate of increase, health spending will grow to more than $230 billion in 3 short years. Health care has become so expensive that Americans are now working more than 1 full month of every year just to pay for their health care—2 weeks' wages for hospital care alone.

The cost of this hospital care—which accounts for 40 cents of every dollar Americans spend on health care—has escalated even faster. Last year the Nation's total hospital bill jumped to $55.4 billion or more than $1,000 per family. Next year, without any control, the figure is predicted to increase dramatically to almost $64 billion.

We can no longer just sit back and watch health costs continue to escalate at past rates. For too long we have allowed hospitals to be reimbursed at whatever level they wanted. Their budgets have been open ended, and they have had no economic incentive to hold down costs. Ironically, our reimbursement system tends to encourage hospitals to add expensive new facilities, personnel and technologies. We've encouraged more hospital beds than are needed, and today the consumer is bearing the burden of paying for the costs of greatly underutilized facilities, services, and equipment. A recent study by the prestigious Institute of Medicine documented that this Nation as a whole has at least 100,000 more hospital beds than it needs. These beds which should be closed or used for other purposes are costing all of us well over $2 billion per year.

This open ended reimbursement has also encouraged the massive proliferation of expensive equipment in both hospitals and doctors' offices. The 1,000 CAT scanners now installed or on order have the capacity to scan over three million patients a year, and most often this expensive procedure has little efficacy and could have been avoided by a careful physical examination by the doctor. Today well over 500 hospitals now maintain expensive open heart surgery facilities yet in less than one-quarter of these institutions were 200 procedures performed annually. In most cases less than 100 cases were performed annually, and this goes on in the face of the guidelines of the American College of Thoracic Surgeons which state clearly that 200 procedures are needed to justify operation of a facility and maintain quality.

We're pouring so much money into hospitals right now for extra beds, for unneeded tests, for unnecessary surgery that we haven't had money to spend on basic preventive health care. It's more humane, and it would be a lot less expensive to prevent illness than to put some-

one into a hospital to cure them. Vital programs such as immunizing children have been overlooked for too long. Tragically, nearly 9 cents of every Federal dollar goes to the hospital industry while far less than 1 penny is spent on preventive care.

Today is the third in a series of hearings on S. 1391, "The Hospital Containment Act of 1977" and other potential solutions to the double digit increases in health care costs. I have indicated hundreds of times over the past 8 years, since I became Chairman of the Senate Health Subcommittee, that we need sweeping reform in the way we deliver health care in America. We've waited too long already for national health insurance, but even if it were signed into law tomorrow, it would require substantial lead time to implement. In the meantime we can no longer afford the 31 percent increases in hospital care of the past 2 years. A transitional cost containment program is needed. A program that is administratively simple, doesn't create a new expensive bureaucracy, and will result in significant savings. S. 1391 is not perfect—but it is a good starting point. Recent estimates by the Congressional Budget Office indicate that S. 1391, as drafted, would save over $40 billion in the next 5 years.

I am hopeful that the witnesses today, and at the hearing next Tuesday will discuss constructive alternatives for cost savings. The time for rhetoric is past. I plan to move forward with a transitional cost control bill that will have an impact on next year's budget. We can no longer continue to squander billions of dollars on unnecessary drugs, unnecessary hospitalization, unnecessary surgery, unnecessary technology while hundreds of thousands of children are not being immunized and millions of needy Americans can't get the basic care.

We have an impressive group of witnesses this morning. We look forward to hearing from them.

I would ask my colleague, Senator Schweiker, who is going to chair most of the hearing during the course of the morning, if he would like to make a comment.

Senator SCHWEIKER. Thank you, Mr. Chairman.

This subcommittee has now conducted several hearings on the administration's proposal for limiting the rapid rise of hospital costs and on the subject of hospital cost containment generally.

In my statement on the opening day of these hearings, I expressed strong reservations about the administration's proposal. I was, and still am, very concerned about the equity and the feasibility of the President's plan. While it would perhaps result in some short-term cost savings, it is, as the administration admits, a piecemeal and temporary approach to a long-term problem. It could result in the diminished quality of medical care across the country and cause enormous administration confusion.

There is no doubt, however, that medical costs, particularly hospital costs, are increasing at a rate which is totally unacceptable. The administration's bill is a laudable opening move toward dealing with this serious national problem. The time has now come for this subcommittee to identify viable alternatives to the more troublesome provisions of the Carter bill—alternatives which are workable but which serve the need to limit hospital costs, a goal that we all agree on.

I would like to express my appreciation for the constructive attitude of the witnesses who presented testimony at our previous hearings, and would further ask today's witnesses to address themselves in

particular to the questions raised in my statement and in the chairman's statement.

Thank you, Mr. Chairman.

Senator KENNEDY. Before hearing from our colleague, Senator McIntyre, Senator Nelson, do you have any comments?

Senator NELSON. Not at this time.

Thank you.

Senator KENNEDY. Senator McIntyre, we look forward to your testimony this morning. We welcome you here. We thank you for your appearance and ask you to proceed in whatever way you would like.

STATEMENT OF HON. THOMAS J. McINTYRE, A U.S. SENATOR FROM THE STATE OF NEW HAMPSHIRE

Senator MCINTYRE. Mr. Chairman and members of the subcommittee, I do appreciate the opportunity to appear here and address myself to the principal issue that I find in this cost-containment bill of 1977 known as S. 1391.

I do not believe, Mr. Chairman, it is necessary to dwell on statistics which clearly show the need to slow the rise in health-care costs. I for one applaud the President for facing up to a tough problem and highly sensitive political issue.

He has met it head-on by proposing to put a 9-percent ceiling, or cap, as we refer to it, on hospital revenue, thus directly attacking the single most inflationary item in the health-care picture.

But, Mr. Chairman, and members of the committee, while I admire the President's courage, I also believe that there is a better way to bring hospital costs under control than to set an arbitrary, across-the-board ceiling on revenues, a ceiling that applies to good hospitals and to bad hospitals; to efficient hospitals and inefficient hospitals; to hospitals with one set of problems in one part of the country and to those in another with a different set of problems.

As a member of the Armed Services Committee, I have never favored what I considered to be arbitrary, across-the-board budget cuts, because the same indiscriminate percentage reductions are applied to items that are needed and justified, as well as to those that are defective and wasteful.

This analogy holds for cutting hospital costs and revenue.

We need a system; we need a system that recognizes conscientious efforts to reduce costs as readily as it penalizes lack of effort.

Senator KENNEDY. The only difference, Senator, is that in the Armed Services Committee, you put a limitation on how much is going to be spent in terms of the Department of Defense and we do not in terms of health care. It is just open-ended. There is not a member of this committee or a member of the Budget Committee or member of the Appropriations Committee that can give you, more than a well informed estimate, about what we are going to be expending this year.

You can tell us within dollars and cents, perhaps with some exceptions for cost overruns, how much will be expended for every weapon system and what the budget is going to be.

Senator MCINTYRE. No, we cannot, Mr. Chairman; we have no more idea, as best as we try to control the cost in the military area—they pop out all over.

Take the C–5A, which was an overrun on an overrun: This year we will be appropriating $1 billion——

Senator KENNEDY. You have something to measure it by. You allocate a certain amount of money for the weapons systems.

Senator MCINTYRE. Initially we budget for it.

Senator KENNEDY. Well, we do not have a budget——

Senator MCINTYRE. We ought to, and that is why I am here.

Senator KENNEDY [continuing]. In terms of hospital costs, we do not have a budget. We do not say we spent x amount last year and spent y amount this year. We don't as you do on C–5A, or the MX, or the Minuteman III, say we are going to allocate so much to this, so much to that, and so much to this—we do not in terms of hospitals or hospitalization or hospital costs.

This is, I think, as I mentioned, what you tried to do in terms of arbitrariness as far as the Armed Services Committee; but what you are doing is reaching dollar figures in terms of each of these areas that will be targeted or appropriated.

Now, we do not do that in terms of hospitals.

Senator MCINTYRE. Perhaps I should continue. I think I address myself to that.

Senator KENNEDY. All right.

Senator MCINTYRE. So I feel that this analogy holds for cutting hospital costs and revenue.

We need a system that recognizes, as I say, conscientious efforts to reduce costs as readily as it penalizes lack of effort. We need to put a permanent, equitable effective cost-control system in place as soon as possible.

In the past 8 years, I have contended that the real, long term solution to hospital cost control lies in prospective budget review systems run by the States under the Federal guidelines. This approach has been an integral part of the National Health Care Act, which I first introduced in 1969, and have continued to introduce this bill every session thereafter.

My confidence in the effectiveness of prospective budget review systems has been bolstered to some extent by results of application in Maryland and Connecticut. Both States have enacted legislation requiring review of hospital budgets and prior approval of rates for private sector budgets.

Now, for the period July 1, 1974, to June 30, 1976, the Maryland Health Services Cost Review Commission was able to hold the rate of increase in Maryland hospital costs well below the national average.

Before the prospective budget review system was adopted, Maryland hospital costs were increasing at or above the national average.

It is estimated that the system has saved Maryland residents more than $55 million in hospital costs in that 2-year period.

In Connecticut, the estimate is that prospective budget review has saved State residents more than $30 million.

I was also pleased to learn in recent days that over 50 percent of New Hampshire hospitals are now utilizing prospective budgeting in the negotiation of contracts with the State's major carriers.

The president of the New Hampshire Hospital Association indicated to me that this approach has benefited the hospitals, the third-party carriers and, most importantly, the consumers in our State.

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In your home State of Massachusetts, I understand that a State commission is in its first full year of reviewing the budgets and charges pertaining to all patients and not just government patients.

I am told that the initial reaction has been very favorable; and I am interested in seeing the statistics on the system's ability to control costs.

Now, I recognize that we cannot expect a newly accredited commission to work at maximum efficiency during their first year of operation. But it seems to me, gentlemen, that if we encourage the creation of prospective review commissions now and maintain the President's proposed cap for the first year of operation, I believe we will have made a significant start toward long-term control.

It seems to me that the quickest way for the hospitals of a given State to get out from under what I am sure they consider an arbitrary and indiscriminate increased ceiling is to adopt prospective budget review systems that cut costs with a scalpel instead of a cleaver or meat ax.

I believe any hospital cost-control legislation should provide Federal funds to help States with costs of establishing the budget review agencies; contain Federal guidelines for composition of State budget commissions; require prospective review of both budgets and charges; require review and utilization controls that apply to all patients, not just Government patients; coordinate with reinforced health planning process; and include an appeals procedure for hospitals.

With these features, Mr. Chairman, the administration's proposal could become an effective means of stemming the inflationary spiral in health care costs, and at the same time set in place a system for effective, long-term cost control.

Such control legislation applying to all sectors of patient revenue would not only slow the rate of cost increases but would enhance the effectiveness of the health planning process.

The present existing duplication of facilities and services, the oversupply of acute beds can be effectively addressed only by the combined action of strong planning efforts and hospital control legislation, which includes operating and capital budget approval and rate review.

I thank you, Mr. Chairman.

Senator KENNEDY. Thank you for your statement.

I am in complete agreement with the prospective budgeting concept. The fact of the matter is that there are very few States at this time that have the mechanism to achieve it, probably only half a dozen. Of course, what is absolutely essential is that even in some of the States that have prospective budgeting, the boards that are doing that kind of budgeting have been controlled, strongly influenced by the hospitals themselves; and even with prospective budgeting, it really has made very little difference in some areas in terms of the cost of controls on it.

What is necessary is prospective budgeting, and boards that are going to be effective in carrying through the kind of savings you have identified here.

The mechanism is a plausible one, and one which I think has some validity, if it is implemented in such a way that it has some teeth in it.

Let me ask you this, until we are able to get to the point where the mechanism, which you support is really effective, would you support a temporary cap?

Senator McIntyre. I really think that in coming here, to impress the prospect of budget control, that I am looking downstream, and I am probably ducking the issue of the cap. I say here that I know we could not pass a law and put this into effect and expect to come up with a 9-percent cap, or even close to it.

What I am saying is, in the long term, address the problem as a whole. I do not know what you want to do with the cap. It is arbitrary as the devil, and it is very unpopular. I know you realize that because you must have heard testimony from hospital associations.

I do not want you to miss the ball game because of the inning.

I think what you ought to do is institute Federal guidelines; go strong on budget review—and I realize you have to be flexible as what might go well in Idaho might not look too good in Massachusetts.

I would hope the committee members, after all the testimony you are going to hear, would be able to support the 9 percent, or move it to a figure that is perhaps a little easier for hospitals to get under. Somehow or other we have got to begin to do something that rewards the efficient hospital and penalizes the inefficient; so I tentatively say that 9 percent seems to be pretty harsh. I hope you can hold it to that.

I say put a cap on at the same level, but let's get to the real problem and make these hospitals sit down initially, at the beginning of the year, and plan their rates and plan their charges and look at the census and work out somewhere or some way that we can reward the hospital that comes through the year with keeping the inflationary spiral under control.

While I may be ducking the issue that you have before you right now, I did want to tell you about prospective rates, because I think it is a long-term solution.

Senator Kennedy. Senator Schweiker?

Senator Schweiker. Senator McIntyre, I want to commend you for a very fine statement.

I mentioned in my opening remarks that I think we have to look for some alternative suggestions. I think you have come forth with a very constructive one.

I wonder if you would just elaborate on why you think a prospective budget review system would do the job and what characteristics make it work as well as you think it has.

Senator McIntyre. From what I know of hospitals—and I do not consider myself an expert—some of them are run in a pretty freewheeling manner.

I know when I grew up, my little town had a doctor who was your family physician, and he was the hospital. He said when; and if they wanted a new bed, they put it in.

If his patient wanted to say 34 days, she stayed. What I am saying is, the answer is to sit the hospital administrators down and talk about what their costs were last year and bring in the nursing system; what has the census been; what charges are you making for radiology, and to systematically try to plan for a target figure to contain the price and costs of those hospitals.

Of course, put a State cost commission in; put executive officers in charge of the State cost commission or rate commission; over and above him, perhaps, the Governor would have a council—make sure the rate commission not only has experts in this field, but make sure

they report to a council, perhaps, that includes providers, that includes consumers, and includes the hospitals themselves.

All I am asking for is some rational thinking at the beginning of the year as to how you are going to run this hospital, come the next year.

Senator SCHWEIKER. The other point that I find interesting in your statement—it is one I think I made to Secretary Califano—is that when a cap of this sort is used, the fat get fatter and the lean get leaner. The purpose of cost containment is to make everybody lean; not to reward the fat for being fat.

Now, I gather from your analogy to military spending and the across-the-board cut, that is close to what you are saying——

Senator MCINTYRE. I am saying that that 9-percent cap that the President has come up with is arbitrary, and I am sure you are finding it out in your testimony. But I give him credit for trying to tackle a tough problem.

You know, in desperation with the budget you see in the armed services, somebody says, why do we not cut it 10 percent across the board—it does not work very well.

As I indicated, and you know so well, the good hospital or good program is cut the same way that an inefficient hospital or inefficient program, or defense program, is cut——

Senator SCHWEIKER. If you have a hospital, for example, in New York that gets $1,600 per admission, and then you have a hospital, say, in New Hampshire that gets $1,000 per admission, and you give them both a 9-percent increase, are you not rewarding the hospital that up until that time, has done the poorest job?

Senator MCINTYRE. It could very well be.

One of the first things I learned as a young mayor of Laconia, N.H., was that a hospital runs 24 hours a day. When a customer is at the door, a broken arm because of a motorcycle, you cannot close the door. You have to let them in.

I do not pretend to be able to say initially—to tell you what to do with the hospital. You have to bring the cost of hospital care, which is the most inflationary part of the medical picture, under control; we have to bring in some sound budgeting and we have to try to enforce it.

Senator SCHWEIKER. That concludes my questioning Mr. Chairman.

Senator KENNEDY. Senator Nelson?

Senator NELSON. I want to commend you. I have been in politics all my life, and I have never heard any politician say he was ducking the issue.

Congratulations.

Senator MCINTYRE. I want to reemphasize the ball game is more important than the inning. You are trying to put a cap on something here. You have got a real tough problem. You have to get at the root of the problem, and that is in the prospective budget review.

Thank you, Mr. Chairman.

Senator KENNEDY. Thank you.

Senator NELSON. The next witness is Representative Joe Czerwinski, who is a member of the Wisconsin State Legislature, chairman of the committee on health and social services, appearing today on behalf of the Conference of State Legislatures.

The committee is very pleased to have you here today, Mr. Czerwinski. You have earned a reputation on that committee as an expert on the operation health programs in the State of Wisconsin.

It is nice to have you here this morning.

I will have to leave before you finish your testimony, but we are pleased to have you here today.

Senator KENNEDY. I want to join in welcoming you.

STATEMENT OF JOE CZERWINSKI, MEMBER, WISCONSIN STATE LEGISLATURE, AND CHAIRMAN, COMMITTEE ON HEALTH AND HUMAN RESOURCES, ACCOMPANIED BY DICK MERRITT, NATIONAL CONFERENCE OF STATE LEGISLATURES

Mr. CZERWINSKI. Thank you.

If you have to leave, I understand.

My name is Joe Czerwinski, and I am a member of the State legislature in Wisconsin.

Before I begin, I would like to introduce Mr. Dick Merritt, National Conference of State Legislatures.

I have a cold this morning, so I hope you will be able to hear me.

I want to thank you for the opportunity to testify before you today regarding the administration's hospital cost containment bill.

The thoughts I would like to share with you today are from experiences that I have gained as a State legislator and as a member of the National Conference of State Legislatures.

As a legislator, I am chairman of the committee on health and social services, and a nonlegislative body called medical education review committee.

The experiences and efforts which have taken place in those organizations prompt me to speak in less than enthusiastic fashion of the administration's cost containment proposal.

But while doing so, I would like to compliment the administration and Congress for their preparedness in approaching this difficult and complex subject.

I am sure statistics have been batted about in this committee, and we all recognize the excess costs of hospitalization and the alarming outpacing of these costs to all other cost indicators which we use.

The National Conference of State Legislatures has developed a position paper which I would like to present before you today.

The paper outlines areas of hospitalization costs, alternative proposals which they feel strongly that State government can effect and, finally, an overview of health cost containment proposals initiated in the State of Wisconsin.

The national conference in their position paper states that cost containment is still largely an art, not a science; flexibility and experimentation should be the key to the eventual discovery of a system or systems which function properly.

The assumption that the solution to cost inflation in hospitals lies in a single approach is a faulty one, and, if allowed to guide our policy, is likely to lead us to a system of rigidity and inequality.

NCSL is therefore concerned that the present bill fails to provide real incentives to States to develop alternative hospitals costs, within the parameters of reasonable revenue restraints.

Recognizing that development of strong regulatory controls of hospitals costs is still in its infancy, States should not be put in the position of having to demonstrate beyond reasonable doubt that they can do a better job than the Federal Government.

Rather, States should be encouraged to experiment with several approaches and combinations of approaches, in hospital cost controls within the context of minimum Federal criteria.

The NCSL is worried that S. 1393, as presently drafted, would set a precedent for precluding States from a meaningful participation in hospital reimbursement policy under the national health insurance program. They feel it is essential that the bill be amended to allow interested States some opportunity to develop alternative statewide hospital cost containment programs.

While I am here, I would like to share with you some of the things that the State of Wisconsin has done. I would like to share with you these things in a factual, personal, and individualized fashion, and share with you the effects that we believe the administration's proposal will have on the Wisconsin efforts in this area.

As of the day before yesterday, Wisconsin had the broadest——

Senator NELSON. May I ask a question, Mr. Chairman?

Senator KENNEDY. Yes.

Senator NELSON. I notice you skipped over some of your testimony, but I would like to have one point made clear.

On page 6, you stated:

> The National Conference of State Legislatures endorses a Federal initiative of interim restraints on increases in hospitals' revenues, applicable to each State until that State enacts and implements an effective hospital cost-containment program.

Is the National Conference of State Legislatures saying that they endorse a cap as proposed by the administration as an interim measure, pending the opportunity for individual States to develop programs that may be, as I read it, approved by the Federal Government?

Mr. CZERWINSKI. It is my understanding, Senator, that the national conference supports a cap until States can gear up and develop a cost containment package, Until that time, a cap would be supported by the National Conference of State Legislatures.

Senator NELSON. So what the National Conference is saying is that they support a cap, but States should be allowed to develop their own cost-control programs; and, if I read this correctly, the conference endorses the concept that if a State fails to maintain appropriate cost controls—according to the statement—the Department of HEW should monitor State systems and be prepared to assume functions if it is clear that a State is not performing effectively. Is that the position of the national conference?

Mr. CZERWINSKI. It is my understanding that is essentially correct, Senator.

Senator NELSON. We have a situation where the National Conference of State Legislatures is endorsing the cap, but suggesting that there be flexibility so the States may develop their own programs, under monitoring by HEW. I assume that if each individual State has a successful program, it would continue to monitor its own costs, but if it is not successful, the national conference endorses the concept that the Federal Government then would preempt the problem of cost controls in that particular State.

Is that a fair statement of what you are saying?

Mr. CZERWINSKI. I think that is a fair statement.

Senator KENNEDY. One point before leaving this provision. Section 117 of the administration's program, is the exemption for hospitals

in certain States. It has a triggering mechanism by which the States would be able to opt out.

It reads:

[Section 117 read by Senator Kennedy follows:]

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 12-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.

Senator KENNEDY. That is the provision, and I do not know whether you have specific recommendations you want to give to us today with regard to that section; or whether you find that to be satisfactory in carrying forward your earlier responses to Senator Nelson's questions?

Mr. CZERWINSKI. I think it would match some of the concerns of the national conference in looking at those States that have done very little.

However, Wisconsin has done a great deal, but we do not have a year's experience, as insisted upon in section 117.

The second thing is that I would hope the administration bill would spend more time in identifying what they believe a cost-containment program is. That cannot be only hospital cost containment—that can only be rate control; it has to be decertification and it has to be health planning.

I would hope if the administration is serious about 9 percent, that they treat the States the same way.

You will notice in the bill that the Federal Government's responsibility is to maintain 9 percent per hospital; yet, when they refer to the State's responsibility, if the State indeed wanted to take on that hospital cost containment program, its responsibility is an aggregate 9 percent throughout the State; so I think if the Federal Government and the administration is willing to take on that responsibility and the States the same, there should be hospital-by-hospital bases or aggregate bases for both entities of government.

Senator KENNEDY. If you have any other suggestions with regard to those particular provisions in terms of section 117, we would certainly welcome them.

What is the rate you established in Wisconsin under your certification program?

In Massachusetts, they set 10 percent as a goal.

Mr. CZERWINSKI. What we did on certificate of need is that anything over $100,000 for a single piece of equipment or $150,000 for two or more related pieces of equipment, need a certificate of need.

We have gone further than that, further than traditional certificate of need, which is prospective in nature; any new construction would have to be under the law.

In Wisconsin we have added two dramatic features to this certificate-of-need program:

(A) It includes physicians' offices. Any physician who would want to buy a CAT scanner or similar equipment would have to get a certificate of need——

Senator KENNEDY. You had the courage to take that position. In our initial planning bill before the committee, we had that provision in it and it was struck. We will have a chance to look at the planning bill next year. That was a courageous decision in terms of the pressures in your constituency.

Senator NELSON. May I ask—one point.

Senator KENNEDY. If I could just finish with this: I am interested in what you are responding to here, but I am also interested in an answer to the question I asked previously, and that is, have you established capping in Wisconsin in terms of hospitals?

Mr. CZERWINSKI. We have attempted to do that, sir. We have now in Wisconsin all the ingredients to begin a public-private cooperative rate review commission.

The problem is we have not received from the U.S. Attorney General a business approval form to let us go at it because of an antitrust problem.

Our Rate Review Committee will cover all third parties, whether it is public or private, and medicaid.

We need to get the approval of the U.S. Attorney General. Once he gives us the OK, we will be able to develop a cap for both private and public third-party payors.

I would like for the record to submit what we call our Wisconsin hospital rate review program and would be delighted to share it with you.

Until we are able to get the Attorney General's——

Senator KENNEDY. I am in the ambivalent position of being chairman of both this committee and of the Antitrust Committee where we want to get less planning and more competition in certain aspects of our economic system. In this area, we are urging more planning and better allocation of resources.

If there are any antitrust problems, I hope you will be in touch with us.

Senator Nelson had some questions.

Senator NELSON. I just had one question on hospital-by-hospital cost control, whether by individual percentage or statewide percentage.

Are you saying that you think the State could meet a 9-percent limitation, hospital by hospital, but that it would not be easy to do it on a statewide average basis? Is that what you are saying?

Mr. CZERWINSKI. I am not certain. All I am saying is I wish we would all play the same ball game.

If I had to make a decision today, I would probably support the aggregate position, only for purposes of medical education, where we may encourage hospital A to increase its expenditures for a particular service for the residency program, while decreasing hospital B, or consolidating different portions of hospitals.

Senator NELSON. Thank you.

Mr. CZERWINSKI. The other dramatic change we made in the certificate of need is that we can now decertify hospital services.

Senator KENNEDY. How many, if any, have you done?

Mr. CZERWINSKI. We passed the bill the day before yesterday.

We are able to decertify certain specialized services if these services are clearly, demonstrably not needed within a community or a particular hospital does not have the resources to continue those services.

Those specialized services are the heart catherization and the cardiac surgery, hemodialysis treatment, kidney transplant, high-risk maternal, high-risk fetal and high-risk neonatal patients, along with the CAT scanner.

That means if we find, as we have begun finding, a proliferation of CAT scanners, if we just had a certificate-of-need law, we could stop those people from purchasing those things in the future.

With this piece of legislation, if in fact there had been development of a number of these pieces of equipment and we found there were too many in a given community, we start taking them out. We expect that to save us a great deal of money.

Senator KENNEDY. You might submit for the record what your lawyers say about the constitutionality of that provision. I myself think it is an excellent suggestion.

After the hospital buys it, how do you require that they take it? I would think it is a constitutional issue. I hope you are able to resolve it because I think it makes a lot of sense as a concept.

Mr. CZERWINSKI. We did not allow any lawyers in on the negotiations.

But—and this is the problem we have with the administration's proposal—we think we meet the constitutional test because if we go to a hospital and say that their cardiac unit ought to be taken out, we have to guarantee that hospital that we will at least be sympathetic to their capital costs; if they are indebted for that cardiac unit, we would at least have to guarantee that they are not going to take the brunt of it economically.

Within the decertification portion, what we do is, we let the Rate Review Committee negotiate a room rate which would absorb those capital losses; and once that is satisfied, the new room rate will be renegotiated.

However, with a 9-percent ceiling, those negotiations may not be possible. The fiscal estimate that I have received just recently with regard to the decertification portion of our certificate-of-need bill, our Department tells us that on a yearly basis, the State of Wisconsin will be saving $15,931,000 a year, and that our projection for the next 10 years, through the decertification mechanism, is that Wisconsin will save $171,500,000.

[The following information was subsequently supplied for the hearing record:]

State of Wisconsin \ DEPARTMENT OF HEALTH & SOCIAL SERVICES

Division of Health
One West Wilson Street, Room 699
Madison, Wisconsin 53702
(608) 266-2020

June 15, 1977

Honorable Joseph C. Czerwinski
State Representative
State Capitol
Room 117 West
Madison, Wisconsin 53702

Dear Representative Czerwinski:

As requested by your office, we have prepared the enclosed estimates of cost savings anticipated as a result of decertification of specialized services under the pending certificate of need law. The following table summarizes the estimated savings:

Specialized Service	Annual Savings	10 Year Savings
Cardiac Surgery	$ 7,263,600	$ 79,899,600
Cardiac Catheterization Lab	2,450,000	26,950,000
Radiotherapy	4,040,000	44,440,000
Chronic Dialysis	277,200	3,049,200
Computed Tomography	1,560,000	17,160,000
TOTAL SAVINGS	$15,590,800	$171,498,800

Kidney transplant and maternal/fetal high risk services are not included because currently there are none we anticipate decertifying.

If we can be of further assistance to you, feel free to contact me.

Sincerely,

Ralph L. Andreano, Ph.D.
Administrator

RLA/WT:hew

Enclosures

CARDIAC SURGERY

	Annual Savings	10 Year Savings
A. Value of Capital Equipment, Facilities and Supportive Services - $948,000		
Capital Savings as a Result of Decertification	$663,600	$7,299,600
B. Annual Operating Costs - $8,000 per patient		
Savings as a Result of Decertification	$4,800,000	$52,800,000
C. Savings Per Operation - $3,000		
Number of Operations in Decertified Facilities - 600	$1,800,000	$19,800,000
Total Savings Cardiac Surgery	$7,263,600	$79,899,600

CARDIAC CATHETERIZATION LABORATORIES

	Annual Savings	10 Year Savings
A. Value of Capital Equipment, Facilities and Supportive Services - $500,000		
Capital Savings as a Result of Decertification	$350,000	$3,850,000
B. Annual Operating Costs - $300,000		
Savings as a Result of Decertification	$2,100,000	$23,100,000
Total Savings	$2,450,000	$26,950,000

COMPUTED TOMOGRAPHY

		Annual Savings	10 Year Savings
A.	Value of Capital Equipment, Facilities and Supportive Services - $600,000		
	Capital Savings as a Result of Decertification	$360,000	$3,960,000
B.	Annual Operating Costs: $100,000-$300,000	$1,200,000	$13,200,000
	Total Savings	$1,560,000	$17,160,000

RADIOTHERAPY

	Annual Savings	10 Year Savings
A. Value of Capital Equipment, Facilities and Supportive Services - $850,000		
Capital Savings as a Result of Decertification	$680,000	$7,480,000
B. Annual Operating Costs Savings as a Result of Decertification	$3,360,000	$36,960,000
Total Savings	$4,040,000	$44,440,000

CHRONIC DIALYSIS

	Annual Savings	10 Year Savings
A. Value of Capital Equipment, Facilities and Supportive Services - $8,000		
Capital Savings as a Result of Decertification	$7,200	$79,200
B. Annual Operating Costs - $30,000		
Savings as a Result of Decertification	$270,000	$2,970,000
Total Savings	$277,200	$3,049,200

Mr. CZERWINSKI. We are hopeful that this, along with our cost-containment package, which includes a number of separate pieces of legislation relating to medical assistance, and the direction by the legislature to have the Rate Review Committee develop alternative means of funding hospitals based upon services provided and length of stay; in other words, a lower rate for those days while recuperation is taking place than the day of surgery or the first day of testing which will have a great effect on hospital costs.

We are certain that Wisconsin can do well. With minimum effort in 1976 we held our hospital rates to 11.2 percent. That is without an effective Rate Review Commission. That was a private, voluntary rate review committee. It was 11.2 percent.

That other area I would like to just take a few minutes of your time on is talking about the formula itself.

I think that the formula could raise some problems, not only for hospitals, but indeed for those nonsalaried employees. If we are talking about a number of stationary costs, a number of uncontrolled costs, such as energy and food, the hospital, if it is fiscally responsible, will have a difficult time passing through the nonemployee pay increases.

The other problem I see with the formula is that the costs of new equipment or other costs within the bill, the formula does not permit adjustments for such costs, except for extraordinary changes in patient loads or major changes in facilities and services. Even if a facility has received approval for new equipment under a certificate-of-need program, there is no certainty that the facility could recoup the cost.

Second, I think the formula benefits the labor-intensive hospital. Those hospitals, I think, are rewarded, since they are given adjustments for the increased cost of labor. In no other area can we go above 9 percent.

If labor costs are 50 percent of a facility's costs, the wages rise 10 percent, the facility's allowable increase in revenue is 9.5 percent.

If the facility's labor costs are 75 percent of the total cost, and wages rise 10 percent, the allowable revenue would be 9.75 percent.

And finally I think although this may be a little extreme, that because we have that particular passthrough, it encourages hospitals to employ people rather than purchase equipment. Let me give you the only example I can think of:

If a physical therapy department needed a whirlpool, the hospital administration may decide not to purchase the whirlpool but simply hire another physical therapist. Those are possibilities. I do not run a hospital day to day, but I think there are other possibilities in this particular area.

That whirlpool is "other cost."

[The following information was subsequently supplied for the hearing record:]

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REPRESENTATIVE:
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CHAIRMAN:
Committee on Health and Social Services
Milwaukee Caucus

MEMBER:
Committee on Insurance and Banking
Wisconsin Clinical Cancer Committe
Wisconsin Emergency Medical Services Examining Council
National Legislative Conference
Council of State Governments

ISSUES RELATED TO THE REVENUE INCREASE FORMULA

The formula contained in the Act, while purporting to allow a full "pass-through" of increases in nonsupervisory employe wages, does not as a practical matter permit those increases to be granted.

For example, if a hospital's revenues were $1,000,000 for a calendar year, nonsupervisory employes' salaries and all other costs each represented 50% of the facility's costs and the federal formula is used, the following table lists possible situations that could occur.

Year	Allowable Revenues	Actual Costs	Employe Wages	Other Costs
1977	$1,000,000	$1,000,000	$500,000	$500,000
1978 [Example 1]	1,095,000	1,125,000	550,000 (10% increase)	575,000 (15% increas
1978 [Example 2]	1,090,000	1,100,000	525,000 (5% increase)	575,000 (15% increas

In the first example, because employe wages have increased by more than 9%, the facility is allowed a revenue increase of 9.5% [10% (employe wage increase) x 50% (% of facility costs of "employe wages") + 9% (federal limit) x 50% (% of facility costs of "other costs")].

In the second example, the facility is allowed a 9% revenue increase because employe wages have increased less than 9%.

In both cases the facility's costs exceed allowable revenues.

If the hospital enters into contracts for meals, supplies, etc., and those costs increase by more than 9% per year, it would not be fiscally

responsible for the facility to grant employe raises of 9% or more, since the facility's allowable revenue increase would not be able to cover the total cost increases.

The formula appears to raise two additional issues:

1. The costs of new equipment, etc., are "other costs." The formula does not permit adjustments for such costs except for "extraordinary changes in patient loads or major changes in facilities and services." Even if the facility has received approval for new equipment under a certificate of need program, there is no certainty that the facility will recoup its costs.

2. "Labor intensive" hospitals may be rewarded since hospitals are given a formula adjustment only for increases in labor costs of more than 9%, not for "other costs" increases of more than 9%. If labor costs are 50% of a facility's costs (as in the table) and wages rise 10%, the facility's allowable increase in revenue would be 9.5%. If the facility's labor costs are 75% of total costs and wages rise 10%, the allowable revenue increase would be 9.75%.

Even if the amortized cost of equipment and supplies to provide a service would cause a smaller rate increase than costs of employes used to provide that same service, the hospital is encouraged to emphasize personnel for services rather than equipment.

EFFECTS OF THE ACT ON STATE PROGRAMS

It is not clear from the federal Act whether a state program must achieve the federally-established limit (tentatively 9%) or if total revenues of each hospital in the state will be permitted to increase at the same rate as if the federal government were administering the program.

If the federal government administers the program, each hospital is treated individually without reference to other hospitals in the state. The formula in the federal Act may result in some hospitals being permitted 10% or greater increases and other hospitals being permitted 9% increases. The statewide total increases may exceed 9%.

If the state administers the program, SECTIONS 102 (f) and 117 appear to require that the aggregate increases of all hospitals in the state must not exceed the rate promulgated by the Secretary of Health, Education and Welfare (tentatively 9%). Thus, even if the state, through the use of the federal formula, determines that an individual hospital is entitled to increase revenues by more than 9%, it may have to restrict the hospital's revenues because the statewide average might exceed 9%.

Mr. CZERWINSKI. Finally, I would like to spend a few minutes on the other limitations that are produced within the administration's proposal; that is, limitation on new beds, construction.

The proposal states or uses these statistics on an HSA basis. Four beds per 1,000 or less than 80 percent occupancy. These areas have no ability to gain new construction or new beds.

We have used the HSA districts in Wisconsin but only for the purpose of submitting grants and drawing maps. The HSA's we find are not very relative or very realistic. So in the State of Wisconsin we have taken our seven HSA's and developed 73 acute-care service areas.

These acute-care service areas reflect patient habits and medical resources.

Using what I think is a more personalized or intelligent set of criteria, we find there is no relationship to the capital expenditure limitation developed within the Administration's proposal and the actual utilization or need within the State of Wisconsin by patients.

As a matter of fact, using the administration's proposal, there would only be one HSA in the State of Wisconsin which needs any beds. That is simply not very reflective of a rural State or a State that has obviously—going through the same throes as any other State in mal-distribution of beds.

Finally, this compounds our efforts in development of a sensible medical education program.

We have found through studies in the past or studies that we carry on continuously on the habits of physicians and habits of medical students, what is Wisconsin's best bet in distribution and retention of new doctors?—and we have found that we are able to obtain a larger percentage of our students through a decent and high-quality residency program. That helps us to do two things: It helps us retain new doctors in the State of Wisconsin. Just as importantly, it helps us get new doctors in places where they have not been in the past, the rural areas.

So, Wisconsin is on an energetic program of dispersing residency programs throughout the State of Wisconsin. We think that developing residency programs in rural areas will help our retention and keep those physicians within a close proximity of their residency program.

The problem, however, is that takes a great deal of juggling. It takes a great deal of consolidation and frankly a good deal of politics to develop a program which can be effective in medical education.

We have to consolidate different hospitals, different units in hospitals, different portions of hospitals. We have to find nurses from one place to another place. There are some hospitals where we encourage overutilization of while decreasing the dependency in other hospitals.

But what the administration's proposal does is take away a great deal of that enthusiasm because of the absolute caps; and although we would be able to work within those caps in the very immediate future, the dispersal of residency programs and the effort to use residency programs as a means of retention of Wisconsin physicians would not be long-lasting or effective.

[The following information was subsequently supplied for the hearing:]

EFFECTS ON MEDICAL EDUCATION AND PLANNING

One of the problems relating to the Health Hospital Cost Containment Act of 1977 is the provision relating to capital expenditure limitations. This provision provides that any health service area in which the number of hospital beds exceeds four per 1,000 population or in which the average hospital occupancy rate is less than 80%, no certificate of need would be allowed if it resulted in a net increase in beds in the area. In addition, no federal grants, loan guarantees or tax subsidies for construction of beds in excess of the existing number would be permitted.

Wisconsin, at present, has seven health service areas designated under P.L. 93-641. Using the criteria of four beds per 1,000, at present, only one of the seven health service areas has a deficiency in acute beds. That area, the northernmost area in Wisconsin, only needs seven beds in order to meet the four beds per 1,000 criteria.

However, Wisconsin has defined for the state 73 acute care service areas based on location and areas to be served by hospitals in the state. Of these (73 acute care service areas) in the state, 40 acute care service areas have excess beds, 28 have deficiencies in beds and four have met the standard of four beds per 1,000 population. [One acute service area is served by Michigan facilities.] It should also be noted that in the 40 acute care service areas having excess beds there are 3,667 excess beds, while in the 28 acute care service areas having deficiencies there are deficiencies of 1,321 beds. This latter method, which is a more sophiscated and more accurate way of determining needs for beds, would be preferable to using the health service area standard.

In addition, it should be noted that if the 80% occupancy rate is used, there are only three acute care service areas in the state which have an occupancy level of greater than 80%. However, since those three areas are within health service areas which exceed the four-bed per 1,000 standard, even these areas would not, it appears, be permitted to have new capital expenditure projects. It also appears that if a capital expenditure is permitted for new beds only in health service areas in which the occupancy is greater than 80% or the number of beds is less than 4% per 1,000 population, that capital expenditure project would be permitted in only one health service area in the state, although the state has identified 28 acute care service areas in the state which require beds.

Another factor to be considered is the effect of the legislation on the activities of the Medical Education Review Committee (MERC). The Medical Education Review Committee is presently engaged in determining which hospitals in the state are appropriate for the development of medical education programs for training of graduate medical students. In order to affect physician distribution and supply in the state, MERC has been involved in determining which specialties are in short supply in the state and in which areas there is a shortage of those specialties. The next step is the development of a state plan for affiliations between medical schools and hospitals for graduate

education. The Medical Education Review Committee is attempting to positively influence the development of these programs in the state.

The Carter Administration proposal does not exclude revenues needed to cover educational costs from the limit on revenue. Therefore, there is no incentive for the hospital to be willing to participate in an education program since the additional costs could not be recouped by increasing revenues. Therefore, the Carter Administration proposal prevents the MERC from carrying out its assigned task in two ways:

1. By applying a limit to all revenue increases, including the revenue increases necessary to meet increased educational costs.

2. By preventing the development of necessary beds or upgrading of beds through capital expenditures to provide the teaching opportunity for the training programs.

In addition, by placing a limitation on the total revenue increase of the hospital, the proposal ignores the fact that in order to provide an educational program the facility may have been encouraged by the state to increase utilization of that particular service by increasing average daily occupancy. For example, the activities of two or more hospitals in the area could be combined into one hospital with the result that the average daily occupancy of one facility increases, thus increasing the facility's revenues by more than the allowable limit. The more specialized the service provided as a teaching opportunity and the greater the expenses for the necessary support activities the greater the hospital's rate must be to cover the costs of the activity. Thus, rates and revenues associated with other services cannot be allowed to rise as needed since the facility's total revenues, including the educational activities, are subject to the limitation.

GAA:sem;kjw

Mr. CZERWINSKI. I have to apologize to the committee in that, as you can see, I have several documents before me. I have not been able to put them together in a cogent fashion.

Senator KENNEDY. I think it has been very helpful testimony.

Mr. CZERWINSKI. I would like to in the future, however, to have that opportunity to submit something.

Senator KENNEDY. I have no questions.

Senator Schweiker?

Senator SCHWEIKER. Thank you, Mr. Chairman.

On page 5 of your statement, near the bottom, you say:

> We feel that its major thrust——

referring to the Government Research Corporation's proposal——

> is highly preferable to the complicated and inflexible regulatory system that would likely evolve at the Federal level under the administration's program. Therefore, we highly recommend the document to the attention of this committee.

I gather what you are saying is that you feel State ratesetting programs should play a role here and that national arbitrary standards which rule out States like Wisconsin are something you would not support in the long run.

Is that a fair interpretation?

Mr. CZERWINSKI. Well, the National Conference takes perhaps a more sensible position. I would not favor any caps simply because of the progress that Wisconsin has made. It would take a lot of fun out of Government if we went through the throes of developing major cost-containment programs and successfully extending those only to have Federal Government come to us with a national cap.

The National Conference of State Legislatures believe they can live with the caps, but the legislation ought to include every encouragement to the 50 States to develop a ratemaking system and cost-containment package. Once that cost-containment package is in effect, through encouragement, that ought to be evidence of the State's good faith and future successes and the cap ought to be lifted.

Senator SCHWEIKER. Along similar lines on page 7, you say:

> Aside from enacting an interim program of restraints on increases in hospital revenues which would be waived for States operating effective ratesetting programs, Congress is also called upon to provide financial assistance to States for the initial startup costs of the Rate Setting Commission.

What kinds of startup costs did you find in Wisconsin? Were these heavy burdens on the State, or were they reasonable? What kind of assistance would the States need from the Federal Government?

Mr. CZERWINSKI. In terms of the certificate of decertification, we found that we would have to extend funds for 17 new State employees to carry that out intelligently.

Those employees would be hired over the next 365 days.

In terms of rate review, I am certain that all States would need assistance in developing the data base needed to make future decisions in any ratesetting responsibility.

So I think the encouragement that the National Conference of State Legislatures is talking about is financial. Initial startup costs in some efforts can be quite costly.

Senator SCHWEIKER. On page 14, you say:

> Our predominant concern with the administration's hospital cost-containment proposal is that instead of recognizing the advances the State of Wisconsin has managed to achieve in cost containment over the past few years, the proposal—

due to its excessively rigid criteria—would prevent Wisconsin from continuing to administer and operate its own program.

I wonder if you would expand on that? This is something that has concerned me about the Carter proposal.

Mr. CZERWINSKI. We spend a good deal of time in Wisconsin trying to approach this question. We have two medical schools in the State of Wisconsin. We try to address the question of physician retention.

In Milwaukee, where I come from, we are now in negotiations about closing down a hospital, a 320-bed hospital. As a matter of fact, we just built a wing on it 3 years ago, and we are trying to close it down; and I think we will.

But we are going to have to transfer, out of those 320 beds, 100 beds to another facility. That is new construction. I am not sure that under the 9-percent cap we would be able to make that kind of progress.

In certificate of need, we are looking forward to decreases in patient costs, yet having a 9-percent cap, I think, leads most hospitals simply to find that upper limit, that 9 percent, because there simply is no incentive to decrease their operations and, as a matter of fact, probably no incentive to decrease the number of employees.

Finally, in some of the fixed cost—and something which I would like to share with the committee—we tried to approach and affect fixed cost. For example, something like malpractice insurance—in Wisconsin we have done well and our malpractice rate is decreasing.

Under what we call the Wisconsin health care liability insurance program, the insurance coverage of $200,000 and $600,000, in 1975, the premium was $286 per bed per year. In 1977–78, it would be $229, a 20-percent reduction. The excess limits coverage per bed, in 1975–76, was $75 per bed. In 1977–78, it is $35 per bed.

We were able to make some successes, and we enjoyed the process. Giving us a cap and giving us a Federal proposal, although you ought to be complimented for striving to find an answer, really takes a great deal of the excitement out of finding those answers on a State level.

I think, as illustrated, the State of Wisconsin can find some of the answers, and I think in a number of other areas, the State of Wisconsin has that opportunity, to take that opportunity and treat it seriously; and I guess initially that is why I talked about rigidity in the Federal legislation.

Senator SCHWEIKER. I think we ought to crank the progress you have made into the system somewhere; and I think you have a commendable program. We have to be sensible and selective; and we will have to take programs like Wisconsin's into account.

Senator KENNEDY. We welcome Senator Javits. We just had some useful and worthwhile testimony from a representative of the Association of State Legislatures, who gave very interesting insights into what the State of Wisconsin is doing. They passed their certification of need the day before yesterday.

We have learned of some important steps that they have taken, and I think it will be helpful to us next year in the planning bill.

We want to thank you very much.

Mr. CZERWINSKI. Thank you very much for the opportunity.

[The prepared statements of Mr. Czerwinski of the National Conference of State Legislatures follow:]

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Council of State Governments

REMARKS BEFORE THE UNITED STATES
SENATE SUBCOMMITTEE ON HEALTH

June 17, 1977

My name is Joe Czerwinski; I am a State Representative from the State of Wisconsin. I want to thank you for the opportunity to testify before you today regarding HR-6575 and S-1393, the Administration's Hospital Cost Containment Bill. The thoughts that I would like to share with you today are from experiences that I've gained as a State Legislator and as a member of the National Conference of State Legislatures.

As a State Legislator I am Chairman of the Health and Social Services Committee and Chairman of a non-legislative body called the Medical Education Review Committee. The experiences and progressions which have taken place at these three organizational levels prompt me to speak in a less than supportive fashion of the Administration's Hospital Cost Containment proposal. But, while doing so, I would like to compliment Senator Kennedy, the

Administration and Congress for their preparedness in approaching this difficult and complex issue.

I'm sure that statistics have been batted about in this Committee and we all recognize the excessive costs of hospitalization and the alarming outpacing of these costs to all other indicators which we use.

The National Conference of State Legislatures has developed a position paper which I would like to present before you today. This paper outlines areas of hospitalization costs which they have identified, alternative proposals which they strongly believe State Government can have an effect on, and, finally, an overview of health care cost containment proposals initiated by the State of Wisconsin.

In the time I spend with you today I would like to expand upon this written summary and share with you in the most factual, personal and individualized fashion the effects of the Administration's proposal on efforts, successful efforts, taking place in the State of Wisconsin.

As of the day before yesterday, Wisconsin has the broadest and most far-reaching Certificate of Need law in the country. This law extends the traditional Certificate of Need concept to the lease, construction or purchase of a health care institution and institutions' substantial changes in provided health services; any change in the bed capacity; any expenditures over $100,000.00 for a single piece of equipment or $150,000.00 for two or more pieces of equipment; and, finally, anyone planning a capital expenditure would have to seek and receive a Certificate

of Need from the State Health Planning Office. The bill also encompasses two major and substantial initiatives not found in other traditional Certificate of Need proposals.

First, the Certificate of Need provisions cover independent practitioners, partnerships and other health care practitioners who expend more than $100,000.00 for a single piece of clinical equipment and more than $150,000.00 for two or more pieces of related equipment.

Secondly, the proposal provides statutory authority for the State Department of Health and Social Services to decertify certain specialized services if such services are clearly and demonstrably not needed by the community being served, or if the resources of the institution are incapable of maintaining that service. The specialized services subject to this provision of the law are as follows:

1. Heart catheterization studies or cardiac surgery;
2. Radiation therapy treatment of cancer and other diseases;
3. Hemodialysis treatment of acute or chronic renal insufficiency;
4. Kidney transplants;
5. The intensive care and management of high-risk maternal, high-risk fetal patients or high-risk neonatal patients; and
6. Computed tomography.

The traditional Certificate of Need portion of the Act plus those two incentives provide a substantial opportunity for State Government to effectuate further increases in hospitalization. It has been estimated that our anticipated cost savings as a result of decertification of specialized services will have an annual

savings of $15,591,000.00 and a projection for over the next 10 years is that the State of Wisconsin will save $171,500,000.00 by decertifying present hospital services. This effort to gain this piece of legislation is all but thwarted by the proposed Carter Administration hospital cost containment proposal. As I mentioned earlier, this proposal has become a reality in just the last 48 hours. This program, in cooperation with a State-run cost control program, can have a significant effect on hospital costs. Operated by itself, the program cannot be effective since there will be no ability to coordinate decertifications with rate adjustments necessary for the facility to recoup its capital expenditures and supply costs associated with a service which is no longer supported directly by patients using that service.

The hospital decertification concept in the Wisconsin law is adversely affected by the Carter Administration Proposal in the following manner. The State may decertify a hospital's specialty service and it will be necessary for the hospital to recover its capital costs and other costs associated with that service even though that portion of the facility is no longer being utilized. The closing of a service will result in decreased occupancy and since the hospital must amortize the costs of that specialty service over a decreased patient load, the necessary maintenance of rate or increase of rate would exceed the 9% limitation.

Under HR-6575's strict revenue limitations I envision a proliferation of diagnostic equipment in physicians' offices which would put undue pressure on that aspect of Wisconsin's bill which includes capital expenditure for independent practitioners.

Finally, HR-6575 compounds the difficulties by Wisconsin's Certificate of Need efforts in establishing and developing the individual hospital's mission. Because of the nature of the Wisconsin Bill and its heavy dependency on health planning, we feel that within the very near future we can eradicate duplication of services and develop an intelligent and coordinated hospital plan for the State of Wisconsin.

STATEMENT ON S 1391

THE HOSPITAL COST CONTAINMENT ACT OF 1977

BY

REPRESENTATIVE JOSEPH CZERWINSKI (WISCONSIN)

ON BEHALF OF

THE NATIONAL CONFERENCE OF STATE LEGISLATURES

BEFORE THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON HUMAN RESOURCES

U.S. SENATE

JUNE 17, 1977

THANK YOU, MR. CHAIRMAN, FOR THIS OPPORTUNITY TO APPEAR BEFORE YOUR COMMITTEE. MY NAME IS JOE CZERWINSKI AND I AM A STATE REPRESENTATIVE FROM WISCONSIN. I HAVE BEEN A MEMBER OF THE WISCONSIN LEGISLATURE FOR 9 YEARS AND FOR THE PAST 6 YEARS I HAVE HAD THE PRIVILEGE TO SERVE AS THE CHAIRMAN OF THE HEALTH AND SOCIAL SERVICES COMMITTEE.

IN ADDITION TO MY ROLE IN THE WISCONSIN LEGISLATURE I AM ALSO A MEMBER OF THE HUMAN RESOURCES COMMITTEE OF THE NATIONAL CONFERENCE OF STATE LEGISLATURES, AND IT IS ON BEHALF OF THE NCSL THAT I APPEAR BEFORE YOU TODAY. THE NCSL, AS I AM SURE YOU KNOW, IS THE OFFICIAL REPRESENTATIVE OF THE NATION'S 7,600 STATE LAWMAKERS.

THE RECOMMENDATIONS WHICH COMPRISE THE BULK OF MY TESTIMONY GREW OUT OF RECENT DISCUSSIONS CONDUCTED BY THE HUMAN RESOURCES COMMITTEE. THAT COMMITTEE IS COMPRISED OF CHAIRMEN AND RANKING MEMBERS OF HEALTH AND WELFARE RELATED COMMITTEES FROM PRACTICALLY EVERY STATE LEGISLATURE. THE POLICY RECOMMENDATIONS WERE THEN CONSIDERED BY OUR STATE-FEDERAL ASSEMBLY (SFA) AND WERE ADOPTED UNANIMOUSLY. THE SFA INCLUDES OVER FOUR HUNDRED STATE LEGISLATORS, REPRESENTING EVERY STATE AND BOTH POLITICAL PARTIES, AND HAS THE EXCLUSIVE AUTHORITY TO SPEAK ON BEHALF OF THE NATIONAL ORGANIZATION WITH RESPECT TO ISSUES AFFECTING STATE-FEDERAL RELATIONS.

THE HOSPITAL COST CONTAINMENT ACT

BROADLY SPEAKING, NCSL BELIEVES THAT THE ADMINISTRATION'S WILLINGNESS AND INITIATIVE TO ENACT AN INTERIM PROGRAM FOR RESTRAINING THE UNACCEPTABLE GROWTH IN HOSPITAL COSTS IS COMMENDABLE AND SHOULD

COMMAND THE UTMOST CONSIDERATION BY CONGRESS AND THE PUBLIC.

THE CONCERN FOR THE COSTS OF HEALTH CARE WHICH IS REFLECTED IN THE HOSPITAL COST CONTAINMENT ACT OF 1977 IS CLEARLY JUSTIFIED. HEALTH EXPENDITURES HAVE RISEN DRAMATICALLY IN RECENT YEARS. SINCE 1960, THE PROPORTION OF GNP ACCOUNTED FOR BY HEALTH EXPENDITURES HAS INCREASED BY 65 PERCENT. CURRENTLY MORE THAN $1 OF EVERY $12 OF GOODS AND SERVICES PRODUCED IN THE COUNTRY GOES FOR HEALTH CARE, WHICH EQUATES TO $638 PER CAPITA PER YEAR. HOSPITAL COSTS, ALTHOUGH NOT THE ONLY SOURCE OF THE PROBLEM, ARE A MAJOR CONTRIBUTOR TO THE ESCALATION IN EXPENDITURES. IN THE LAST DECADE (1966-1976) THE AVERAGE COST PER PATIENT DAY HAS INCREASED 3.6 TIMES. OF COURSE, ALL PRICES WERE RISING DURING THIS PERIOD, BUT EVEN WHEN THE EFFECT OF GENERAL PRICE INFLATION IS ELIMINATED, AVERAGE COSTS PER PATIENT DAY STILL ROSE BY 2.6 TIMES IN THE MOST RECENT TEN YEAR PERIOD. SINCE HOSPITAL COSTS ARE THE MOST RAPIDLY RISING COMPONENT OF HEALTH CARE COSTS AND SINCE THEY ACCOUNT FOR 45 PERCENT OF PERSONAL HEALTH EXPENDITURES, COST CONTAINMENT IN THE HOSPITAL SECTOR DESERVES HIGH PRIORITY. SUCH EMPHASIS IS PARTICULARLY DESIRABLE BECAUSE HOSPITAL CARE IS THE MOST EXPENSIVE FORM OF CARE, SO THAT POLICIES WHICH ENCOURAGE ECONOMIZING ON HOSPITAL SERVICES AND SUBSTITUTION OF OTHER FORMS OF CARE WILL ALMOST CERTAINLY REDUCE COSTS OF TREATMENT.

RISING HOSPITAL COSTS HAVE BEEN A MAJOR CONCERN TO MOST STATES FOR A NUMBER OF YEARS, AND SEVERAL OF THE THIRD-PARTY PAYERS--PARTICULARLY MEDICAID AND BLUE CROSS/BLUE SHIELD--HAVE INITIATED PROGRAMS WHICH AIM AT RESTRAINING HOSPITAL COSTS. HOWEVER, WHAT THAT EXPERIENCE CONFIRMS IS THAT POLICIES PROMOTED BY DIFFERENT PAYERS ACTING ALONE CAN HAVE ONLY A LIMITED IMPACT ON CONTROLLING

HOSPITAL COSTS FOR THE WHOLE SYSTEM. IF THE REIMBURSEMENT SYSTEM IS TO PROVIDE THE LEVER FOR CONTROLLING COSTS, A UNIFORM POLICY WHICH APPLIES TO ALL HOSPITAL PAYERS IS HIGHLY DESIRABLE. THE APPROACH CONTAINED IN S1391 THUS CONSTITUTES A MAJOR IMPROVEMENT OVER THE CURRENT HOSPITAL REIMBURSEMENT STRUCTURE BECAUSE THE APPROACH APPLIES TO ALL PAYERS.

THE PRESENT PIECEMEAL REIMBURSEMENT STRUCTURE IS AN INEQUITABLE AND INEFFECTIVE APPROACH TO HOSPITAL COSTS CONTAIMENT, AS WELL AS BEING A DISRUPTIVE INFLUENCE ON HOSPITAL PLANNING AND FINANCING. REFORMS WHICH APPLY TO THE REIMBURSEMENT POLICIES OF ONLY A SINGLE PAYER (E.G., MEDICAID) PROVIDE STRONG INCENTIVES FOR HOSPITALS WHICH ARE BEING SQUEEZED BY THAT PAYER'S POLICIES TO EITHER OPT OUT OF THE PROGRAM OR TO PASS ON THE COSTS TO OTHER PURCHASERS. IN SUCH CIRCUMSTANCES COSTS ARE SHIFTED FROM PAYERS WHO HAVE IMPOSED REIMBURSEMENT CONSTRAINTS (E.G. MEDICAID) TO OTHER PAYERS WHO DO NOT OR CANNOT CONTROL THEIR LEVEL OF REIMBURSEMENT (E.G. PRIVATE INSURERS AND PATIENTS WITHOUT INSURANCE.) THE RESULT IS THAT TOTAL HOSPITAL COSTS ARE NOT EFFECTIVELY CONTROLLED, PRIVATE PAYERS REALIZE AN INEQUITABLE FISCAL BURDEN, AND THOSE HOSPITALS WHICH HAVE A HIGH PROPORTION OF MEDICAID PATIENTS BEAR THE BRUNT OF COST CONTAINMENT EFFORTS. FURTHERMORE, HOSPITALS MAY INCREASINGLY VIEW MEDICAID ADMISSION AS UNDESIRABLE, WITH THE LONG-RUN RESULT THAT MEDICAID ADMISSIONS ARE SHIFTED TO A FEW HOSPITALS. SINCE THOSE HOSPTIALS WOULD THEN FACE INCREASINGLY TIGHTER COST CONSTRAINTS RELATIVE TO OTHER HOSPITALS, THE RESULT MIGHT VERY WELL BE A DISCERNABLY DIFFERENT HOSPITAL DELIVERY SYSTEM FOR MEDICAID PATIENTS. FURTHERMORE, THE PRESENT FRAGMENTED REIMBURSEMENT STRUCTURE

IS A DISRUPTIVE INFLUENCE ON HOSPITAL ADMINISTRATION AND PLANNING BECAUSE HOSPITALS FACE INCONSISTENT INCENTIVES FROM THE VARIOUS THIRD-PARTY PAYERS. UNDER THE PROPOSAL, HOSPITALS WOULD FACE MORE EQUITABLE, UNIFORM CONSTRAINTS ON REVENUE GROWTH FROM ALL PAYERS, AND BY DEFINITION, TOTAL HOSPITAL REVENUE GROWTH WOULD BE MORE EFFECTIVELY CONSTRAINED.

THE CLEAR STRATEGY OF THE ADMINISTRATION BY THE INTRODUCTION OF THIS BILL IS TO PROVIDE SOMETHING OF A "DULL MEAT AX" APPROACH TO CONTAINING HOSPITAL COSTS UNTIL A MORE SOPHISTICATED COST CONTROL SYSTEM CAN BE PUT IN PLACE. THERE IS NO DISPUTE THAT A SENSIBLE COST CONTROL STRATEGY OR SYSTEM MUST PRECEDE THE IMPLEMENTATION OF A NATIONAL HEALTH INSURANCE PROGRAM. SUBSTANTIAL DISAGREEMENT IS LIKELY TO OCCUR, HOWEVER, OVER WHAT KIND OF COST CONTROL SYSTEM WILL PROVE EFFECTIVE AND WHAT LEVEL OF GOVERNMENT SHOULD BE RESPONSIBLE FOR ADMINISTERING AND OPERATING THE SYSTEM.

GIVEN THE FACT THAT COST CONTAINMENT IS STILL LARGELY AN ART, NOT A SCIENCE, FLEXIBILITY AND EXPERIMENTATION SHOULD BE KEY TO THE EVENTUAL DISCOVERY OF A SYSTEM OR SYSTEMS THAT WILL FUNCTION PROPERLY. THE ASSUMPTION THAT THE SOLUTION TO COST INFLATION IN THE HOSPITAL SECTOR LIES IN A SINGLE APPROACH IS A FAULTY ONE AND, IF ALLOWED TO GUIDE OUR POLICY, IS LIKELY TO LEAD US INTO A SYSTEM OF EXTREME RIGIDITY AND INEQUITY. THE NCSL IS THEREFORE CONCERNED THAT THE PRESENT BILL FAILS TO PROVIDE REAL INCENTIVES FOR STATES TO DEVELOP ALTERNATIVE HOSPITAL COST CONTROL PROGRAMS WITHIN THE PARAMETERS OF REASONABLE REVENUE RESTRAINTS. RECOGNIZING THAT THE DEVELOPMENT OF SOUND REGULATORY CONTROLS ON HOSPITAL COSTS IS STILL IN ITS INFANCY, STATES SHOULD

NOT BE PUT IN THE POSITION OF HAVING TO DEMONSTRATE "BEYOND A REASONABLE DOUBT" THEY CAN DO A BETTER JOB THAN THE FEDERAL GOVERNMENT. RATHER, STATES SHOULD BE ENCOURAGED TO EXPERIMENT WITH SEVERAL APPROACHES OF COMBINATIONS OF APPROACHES TO HOSPITAL COST CONTROL WITHIN THE CONTEXT OF MINIMUM FEDERAL CRITERIA. WE ARE WORRIED THAT S1391 AS PRESENTLY DRAFTED WOULD SET A PRECEDENT FOR PRECLUDING STATES FROM MEANINGFUL PARTICIPATION IN HOSPITAL REIMBURSEMENT POLICY UNDER A NATIONAL HEALTH INSURANCE PROGRAM. IT IS ESSENTIAL, THEREFORE, THAT THE BILL BE AMENDED TO ALLOW INTERESTED STATES SOME OPPORTUNITY TO DEVELOP ALTERNATIVE STATEWIDE HOSPITAL COST CONTAINMENT PROGRAMS.

AN ALTERNATIVE PROPOSAL

IN ARRIVING AT AN ALTERNATIVE PROPOSAL--OR PERHAPS AN AMENDED VERSION--TO WHAT THE ADMINISTRATION HAS DEVELOPED, NCSL WISHES TO ACKNOWLEDGE IT HAS BORROWED SOME IDEAS FROM AN EXCELLENT REPORT ENTITLED, "A PROPOSAL FOR STATE RATE-SETTING: LONG RANGE CONTROLS ON THE COST ON INSTITUTIONAL HEALTH SERVICES." THIS MODEL STATE RATE SETTING PROPOSAL IS THE PRODUCT OF THE GOVERNMENT RESEARCH CORPORATION, A PRIVATE, NON-PROFIT ORGANIZATION ENGAGED IN RESEARCH AND POLICY ANALYSIS. WHILE NCSL DOES NOT EMBRACE EVERY SPECIFIC RECOMMENDATION EMBODIED IN THE DOCUMENT, WE FEEL THAT ITS MAJOR THRUST, NAMELY, THE ENCOURAGEMENT OF STATE RATE-SETTING PROGRAMS, IS HIGHLY PREFERABLE TO THE COMPLICATED AND INFLEXIBLE REGULATORY SYSTEM THAT WOULD LIKELY EVOLVE AT THE FEDERAL LEVEL UNDER THE ADMINISTRATION'S PROGRAM. THEREFORE, WE HIGHLY RECOMMEND THE DOCUMENT TO THE ATTENTION OF THIS COMMITTEE.

THE NATIONAL CONFERENCE OF STATE LEGISLATURES ENDORSES A FEDERAL INITIATIVE OF INTERIM RESTRAINTS ON INCREASES IN HOSPITALS' REVENUES, APPLICABLE TO EACH STATE UNTIL THAT STATE ENACTS AND IMPLEMENTS AN EFFECTIVE HOSPITAL COST CONTAINMENT PROGRAM. ONCE THE STATE PROGRAM BECOMES OPERATIVE, THE DEPARTMENT OF HEW SHOULD MONITOR THE STATE SYSTEM AND BE PREPARED TO ASSUME THE FUNCTIONS IF IT IS CLEAR THE STATE IS NOT PERFORMING EFFECTIVELY.

WE WOULD SUGGEST THAT AN EFFECTIVE STATE HOSPITAL COST CONTAINMENT SYSTEM SHOULD HAVE THE FOLLOWING CHARACTERISTICS:

- BUDGET AND RATE REVIEW AND APPROVAL SHOULD BE MANDATORY FOR ALL INSTITUTIONAL HEALTH CARE PROVIDERS AND SHALL APPLY TO THE RATES CHARGED TO ALL PAYORS;

- THE BUDGET AND RATE REVIEW AUTHORITY SHOULD BE EITHER AN INDEPENDENT COMMISSION OR AN AGENCY LOCATED WITHIN AN APPROPRIATE DEPARTMENT OF THE STATE;

- THE COMMISSION OR AGENCY SHOULD BE ORGANIZATIONALLY RELATED TO OTHER STATE AGENCIES IN SUCH A WAY AS TO FACILITATE COORDINATION OF THE VARIOUS TYPES OF HEALTH CARE REGULATION.

- THE COMMISSION OR AGENCY SHOULD PUBLISH A SET OF UNIFORM DEFINITIONS FOR ALL CATEGORIES OF COST RECOGNIZED AS SUBJECT TO REIMBURSEMENT, AND FOR RECOGNIZED CATEGORIES OF REVENUE ADJUSTMENTS:

- WHILE A UNIFORM FINANCIAL REPORTING SYSTEM SHALL BE REQUIRED OF ALL INSTITUTIONAL HEALTH CARE PROVIDERS, EACH STATE COMMISSION OR AGENCY WOULD DETERMINE ITS OWN NEEDS AND ISSUE APPROPRIATE REGULATIONS WITH RESPECT TO UNIFORM BUDGETING, ACCOUNTING AND COST ALLOCATION FOR INSTITUTIONAL PROVIDERS WITHIN ITS JURISDICTION.

- THE COMMISSION OR AGENCY SHOULD HAVE DISCRETION TO PRESCRIBE ONE OR MORE BASES OF PAYMENT FOR USE BY INSTITUTIONAL PROVIDERS. HOWEVER, INSTITUTIONS WOULD BE PROHIBITED FROM CHARGING DIFFERENT PAYORS ACCORDING TO DIFFERENT BASES OF PAYMENT.

- THE COMMISSION OR AGENCY SHOULD BE SERVED BY AN ADVISORY COMMITTEE TO CONSULT ON TECHNICAL ISSUES. THE ADVISORY COMMITTEE'S MAKE-UP SHOULD BE A BALANCE BETWEEN CONSUMER REPRESENTATIVES AND HEALTH INDUSTRY SPOKESMAN. WHILE THE ADVISORY COMMITTEE WOULD ASSIST THE AGENCY OR COMMISSION IN SUCH ACTIVITIES AS DESIGNING AND EVALUATING REPORTING PROCEDURES AND GUIDELINES, IT COULD SERVE AN EQUALLY SIGNIFICANT ROLE IN FORGING A COMMUNICATIONS LINK AND SENSE OF PARTNERSHIP BETWEEN ALL CONCERNED PARTIES.

ASIDE FROM ENACTING AN INTERIM PROGRAM OF RESTRAINTS ON INCREASES IN HOSPITAL REVENUES WHICH WOULD BE WAIVED FOR STATES OPERATING EFFECTIVE RATE SETTING PROGRAMS, CONGRESS IS ALSO CALLED UPON TO PROVIDE FINANCIAL ASSISTANCE TO STATES FOR THE INITIAL START-UP COSTS OF THE RATE-SETTING COMMISSIONS. CONSIDERATION OF STATE REQUESTS FOR MEDICARE AND MEDICAID PARTICIPATION IN THE RATE SETTING SYSTEMS SHOULD BE GIVEN THE MOST EXPEDITIOUS CONSIDERATION BY THE DEPARTMENT OF HEW. HEW SHOULD EXERCISE A MONITORING FUNCTION TO ENSURE THAT THE STATE COMMISSIONS ARE PERFORMING SATISFACTORILY. A NATIONAL POLICY REVIEW BOARD SHOULD BE CREATED TO ESTABLISH GUIDELINES BY WHICH THE PERFORMANCE OF THE STATE SYSTEMS WILL BE MEASURED.

AS A FINAL RECOMMENDATION, A SPECIAL PROVISION SHOULD EXIST TO PERMIT STATE RATE REVIEW COMMISSIONS TO BE ELIGIBLE FOR EXEMPTION FROM FEDERAL CONTROLS WHERE THE STATE PROGRAM DEMONSTRATES A STRONG POTENTIAL FOR CONTAINING COSTS. WE WOULD BE HAPPY TO WORK WITH THE COMMITTEE AND ITS STAFF IN THE DEVELOPMENT OF APPROPRIATE CRITERIA FOR SUCH AN EXEMPTION.

THE WISCONSIN EXPERIENCE

IN THE FEW MOMENTS I HAVE LEFT, I WOULD LIKE TO PROVIDE A BRIEF REVIEW OF THE EXPERIENCE THE STATE OF WISCONSIN HAS HAD WITH HOSPITAL COST CONTAINMENT.

IN 1972, THE WISCONSIN HOSPITAL ASSOCIATION AND BLUE CROSS OF WISCONSIN ESTABLISHED THE WISCONSIN HOSPITAL RATE REVIEW PROGRAM TO REVIEW AND APPROVE NON-GOVERNMENT INCREASES IN HOSPITAL RATES. THIS PROGRAM WAS INITIALLY ESTABLISHED ON AN "EXPERIMENTAL" BASIS AND BECAME PERMANENT IN OCTOBER, 1975. THROUGH THE ENACTMENT OF ENABLING LEGISLATION BY THE WISCONSIN LEGISLATURE THE STATE OF WISCONSIN, THE WISCONSIN HOSPITAL ASSOCIATION, AND BLUE CROSS OF WISCONSIN SUBSEQUENTLY SIGNED AN AGREEMENT ESTABLISHING THE STATE'S RATE REVIEW PROGRAM. THIS AGREEMENT WAS THEN TRANSMITTED TO THE

DEPARTMENT OF HEW FOR APPROVAL SINCE IT INCLUDED TITLE XIX OF THE SOCIAL SECURITY ACT. JUST TWO MONTHS AGO, THE STATE RECEIVED FEDERAL APPROVAL FROM HEW BUT IS PRESENTLY AWAITING THE NECESSARY BUSINESS REVIEW CLEARANCE FROM THE U.S. DEPARTMENT OF JUSTICE.

THE FEDERAL AUTHORIZATION TO SET TITLE XIX RATES OF REIMBURSEMENT PROSPECTIVELY IS OUTLINED IN SECTION 222 of P.L. 92-603. FEDERAL REGULATIONS PROVIDE THAT ANY PLAN, TO BE ACCEPTABLE TO THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, MUST INCLUDE THE FOLLOWING CRITERIA:

1. INCENTIVES FOR EFFICIENCY AND ECONOMY;
2. REIMBURSEMENT ON A REASONABLE COST BASIS;
3. REIMBURSEMENT NOT TO EXCEED THAT WHICH WOULD BE PRODUCED THROUGH THE APPLICATION OF THE TITLE XVIII STANDARDS AND PRINCIPLES OF REIMBURSEMENT;
4. ASSURANCE OF ADEQUATE PARTICIPATION OF HOSPITAL SERVICES OF HIGH QUALITY TO TITLE XIX RECIPIENTS; and,
5. ADEQUATE DOCUMENTATION FOR EVALUATION OF EXPERIENCE UNDER THE STATE'S APPROVED REIMBURSEMENT PLAN.

OUR PROGRAM IS DESIGNED TO ADDRESS EACH ONE OF THESE CRITERIA IN A MANNER THAT IS EQUITABLE TO TITLE XIX RECIPIENTS, HOSPITALS, NON-GOVERNMENTAL PAYORS, AND THE STATE OF WISCONSIN MEDICAL ASSISTANCE PROGRAM.

PURPOSE AND OBJECTIVES

IN AN INFLATIONARY ECONOMY WITH INCREASING DEMAND FOR SCARCE RESOURCES, IT IS RECOGNIZED THAT THE RISING COST OF HEALTH CARE IS A CONCERN FACED BY HEALTH CARE PROVIDERS, THIRD PARTY PAYORS, CONSUMERS, AND GOVERNMENTALLY-FINANCED HEALTH CARE PROGRAMS. THE INCREASE IN

THE COSTS OF PROVIDING HEALTH CARE IS A RESULT OF MANY FACTORS INCLUDING INCREASED UTILIZATION OF SERVICES ON THE PART OF HEALTH CONSUMERS, INCREASED TECHNOLOGY OF MEDICAL CARE, INCREASED USAGE OF MEDICAL SERVICES PER PATIENT, AND THE INCREASED PER-UNIT COST OF RENDERING HEALTH CARE. OUR PROPOSAL IS INTENDED TO ADDRESS THE LAST OF THESE COMPONENTS (INCREASE IN PER-UNIT COST) FOR ONE ELEMENT OF HEALTH CARE HOSPITALIZATION. CONTROL OF THE OTHER VARIABLES CANNOT BE OBTAINED THROUGH ANY HOSPITAL RATE REVIEW AND CONTROL MECHANISM.

THE FOLLOWING GENERAL OBJECTIVES HAVE BEEN IDENTIFIED TO MEET THIS NEED OF CONTROLLING THE PER-UNIT COST OF HOSPITALIZATION AND, AT THE SAME TIME, TO MAINTAIN THE EXCELLENT CALIBER OF HEALTH CARE THAT WISCONSIN RESIDENTS HAVE COME TO EXPECT:

1. PROMOTE HOSPITAL COST CONTAINMENT WHILE MAINTAINING OR IMPROVING THE QUALITY OF CARE.
2. ESTABLISH A SYSTEM IN WHICH HOSPITALS ARE HELD TO PROSPECTIVELY DETERMINED RATES IN A 12 MONTH PERIOD, EXCEPT WHEN A HOSPITAL CAN DEMONSTRATE EXTENUATING CIRCUMSTANCES.
3. ENCOURAGE EFFICIENCY IN HOSPITAL SERVICE DELIVERY BY RELATING PAYMENT TO HEALTH PLANNING APPROVAL OF NEW PROGRAMS, SERVICES, AND FACILITIES AND TO CONSIDER HEALTH PLANNING FINDINGS BASED ON PERIODIC REVIEW OF INSTITUTIONAL SERVICES.
4. ESTABLISH A MECHANISM FOR ASSURING GREATER PREDICTABILITY OF HOSPITAL COST PER UNIT OF SERVICE.
5. DEVELOP AN ADMINISTRATIVE PROCESS WHICH PROVIDES FAIR REVIEW OF HOSPITAL COSTS AND AN INDEPENDENT APPEALS PROCESS.
6. DEVELOP A UNIFORM REPORTING SYSTEM FOR PROSPECTIVE PAYMENT.
7. ENCOURAGE APPROPRIATE UTILIZATION OF SERVICES AND FACILITIES AND DISCOURAGE UTILIZATION NOT FELT TO BE EFFICIENT.
8. FOSTER INNOVATIVE HEALTH CARE DELIVERY PATTERNS AND MECHANISMS.

9. PROVIDE FOR A SYSTEM WHICH INSURES HOSPITAL FINANCIAL VIABILITY AND, AT THE SAME TIME, EQUITY AMONG PAYORS.

10. TO ENGAGE IN SUCH OTHER ACTIVITIES RELATED TO THE COST OF HEALTH CARE, STUDIES, ETC. AS MAY BE IN THE INTEREST OF THE PUBLIC TO BE SERVED.

IN SETTING CHARGES EQUITABLY AMONG PAYORS, THE PROGRAM WILL RECOGNIZE THAT COSTS INCURRED BY THE INSTITUTIONS MAY DIFFER AMONG PURCHASERS. ADDITIONALLY, THERE SHALL BE REASONABLE LIMITATIONS ON AN INSTITUTION'S REIMBURSABLE FINANCIAL REQUIREMENTS REFLECTING THE CONCERNS OF THE PUBLIC AND THE RATE THEY ARE REQUIRED TO PAY, AS WELL AS TO ASSURE EQUITY AMONG HOSPITALS.

IN MEETING THE OBJECTIVES OUTLINED ABOVE, THE PROGRAM WILL REVIEW ALL CHARGE INCREASES OF WISCONSIN HOSPITALS. THIS WILL BE ACCOMPLISHED USING A RATE REVIEW COMMITTEE WHICH WILL MEET ON A REGULAR BASIS AND DETERMINE FOR EACH HOSPITAL WHETHER INCREASES ARE REASONABLE AND CONSISTENT WITH ALL ELEMENTS OF THIS PROGRAM AND ANY RATE REVIEW STANDARDS WHICH MAY BE DEVELOPED. THE RATE REVIEW COMMITTEE WILL BE STAFFED BY BLUE CROSS OF WISCONSIN WHICH WILL ENSURE THAT ALL DATA ARE PRESENTED IN A MANNER WHICH IS EQUITABLE TO ALL PARTIES AND GIVES THE COMMITTEE SUFFICIENT INFORMATION WITH WHICH TO MAKE AN OBJECTIVE DECISION.

THE HOSPITAL, IN SUBMITTING DATA FOR AN INCREASE, HAS A RESPONSIBILITY TO PROVIDE ALL DATA AND INFORMATION WHICH MAY BE REQUIRED AND TO HAVE CERTAIN RIGHTS WHICH MUST BE ADDRESSED THROUGHOUT THE PROCESS. IF THE HOSPITAL IS DISSATISFIED WITH A DECISION OF THE RATE REVIEW COMMITTEE AND FEELS THE TERMS OF THE RATE REVIEW

DOCUMENT WERE NOT FOLLOWED, AN INDEPENDENT APPEALS PROCESS EXISTS.

TO AID THE RATE REVIEW COMMITTEE IN DETERMINING REASONABLENESS, STANDARDS WILL BE DEVELOPED BY A STANDARDS DEVELOPMENT COMMITTEE STAFFED BY THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES. THE STANDARDS WILL RECEIVE INPUT FROM ANY INTERESTED PARTIES PRIOR TO BEING FINALIZED AND WILL INCLUDE CERTAIN SAFEGUARDS TO ENSURE THAT THEY ARE EQUITABLY APPLIED TO HOSPITALS.

IN DETERMINING ALLOWABLE LEVELS OF CHARGES, THE PROGRAM WILL ADDRESS THE REASONABLE FULL FINANCIAL REQUIREMENTS OF THE HOSPITAL. FOR NON-GOVERNMENTAL PAYORS, THE AHA STATEMENT ON FINANCIAL REQUIREMENTS (AS MODIFIED) WILL BE UTILIZED TO ESTABLISH THE ALLOWABLE LEVEL OF PAYMENT FOR EACH HOSPITAL. FOR GOVERNMENT PAYORS (INITIALLY TITLE XIX) THE LEVEL OF PAYMENT WILL BE THE MAXIMUM LEVEL ACCEPTED BY THE RATE REVIEW COMMITTEE NOT TO EXCEED THAT PERMITTED BY FEDERAL LAW.

THROUGHOUT ALL PHASES OF THE PROGRAM, PUBLIC ACCOUNTABILITY WILL BE MAINTAINED AND ALL RATE REVIEW MEETINGS WILL BE OPEN TO ANY INTERESTED PARTIES INCLUDING THE PRESS. TO MAINTAIN A CLOSE RELATIONSHIP WITH HEALTH PLANNING, ALL PROJECTS REVIEWABLE UNDER SECTION 1122 OF THE SOCIAL SECURITY ACT MUST RECEIVE THE APPROVAL OF THE STATE HEALTH PLANNING AND DEVELOPMENT AGENCY BEFORE RECEIVING PAYMENT. ALSO, A CLOSE RELATIONSHIP BETWEEN THE PROGRAM AND HEALTH PLANNING WILL BE MAINTAINED TO ENSURE THAT BOTH THE RATE REVIEW AND PLANNING PROCESSES BENEFIT FROM THEIR COLLECTIVE EXPERTISE.

IN ADDITION, THE WISCONSIN LEGISLATURE IS PRESENTLY DEBATING ONE OF THE MOST FAR-REACHING CERTIFICATE-OF-NEED PROPOSALS INTRODUCED IN ANY STATE. THE WISCONSIN PROPOSAL EXCEEDS MINIMUM FEDERAL REQUIREMENTS IN SEVERAL AREAS AND WOULD ATTEMPT TO REGULATE ONE MAJOR AREA OF CONCERN WHICH IS NOT EVEN TOUCHED UPON BY FEDERAL LAW OR REGULATIONS, NAMELY, DECERTIFICATION OF SPECIALIZED HOSPITAL SERVICES. IF THIS PROPOSAL IS ENACTED, THE WISCONSIN STATE DEPARTMENT OF HEALTH AND SOCIAL SERVICES WOULD HAVE THE AUTHORITY TO DECERTIFY A SPECIALIZED SERVICE IF THE SERVICE IS CLEARLY AND DEMONSTRATABLY NOT NEEDED BY THE COMMUNITY BEING SERVED OR THE RESOURCES OF THE INSTITUTION ARE INCAPABLE OF MAINTAINING THE SERVICE. SPECIALIZED SERVICES, UNDER THE BILL, INCLUDE THE SPECIALIZED FACILITIES, EQUIPMENT AND STAFF NECESSARY:

1. TO PERFORM HEART CATHETERIZATION STUDIES OR CARDIAC SURGERY;
2. TO PERFORM RADIATION THERAPY TREATMENT OF CANCER AND OTHER DISEASES;
3. FOR HEMODIALYSIS TREATMENT OF ACUTE OR CHRONIC RENAL INSUFFICIENCY;
4. TO PERFORM KIDNEY TRANSPLANTS;
5. FOR THE INTENSIVE CARE AND MANAGEMENT OF HIGH RISK MATERNAL, HIGH RISK FETAL PATIENTS OR HIGH RISK NEONATAL PATIENTS; AND,
6. TO PERFORM COMPUTERIZED TOMOGRAPHY.

FOLLOWING THE INITIAL CERTIFICATION REVIEW, EACH SERVICE MUST BE REVIEWED EVERY THREE TO FIVE YEARS THEREAFTER. HOSPITALS OPERATING SPECIALIZED SERVICES WITHOUT A CERTIFICATE FACE A FINE UP TO $1,000 PER DAY.

ONCE FULLY IMPLEMENTED BY THE STATE OF WISCONSIN, BLUE CROSS, AND THE WISCONSIN HOSPITAL ASSOCIATION, THE PROGRAM SHOULD BE ABLE TO MEET ITS OBJECTIVES AND PROTECT THE RIGHTS OF WISCONSIN HOSPITALS AND THE PATIENTS THEY SERVE. THE PROGRAM, TO MEET CHANGING NEEDS, WILL BE FLEXIBLE AND IT IS EXPECTED THAT THE PARTICIPANT ORGANIZATIONS WILL REGULARLY EVALUATE IT TO ENSURE THAT IT IS APPROPRIATE TO MEET THE NEEDS OF WISCONSIN. IF CHANGES ARE FELT TO BE NEEDED, THE PARTICIPANT ORGANIZATIONS MAY CHANGE THE RATE REVIEW DOCUMENT IF ALL THREE ORGANIZATIONS AGREE.

FOR THE RECORD, MR. CHAIRMAN, I WOULD LIKE TO PROVIDE, AS A SUPPLEMENT TO MY STATEMENT, A MORE DETAILED DESCRIPTION OF THE PROPOSED WISCONSIN RATE REVIEW PROGRAM. THE MORE DETAILED ACCOUNT PROVIDES A SUMMARY OF THE RATE REVIEW PROCESS ITSELF, INCLUDING THE PROCEDURES FOR REVIEW, THE MAKE-UP OF THE RATE REVIEW COMMITTEE, THE DECISION-MAKING PROCESS AND THE MANNER BY WHICH PUBLIC ACCOUNTABILITY IS MAINTAINED. MOREOVER, THE DOCUMENT DESCRIBES THE PROCESS BY WHICH STANDARDS ARE DEVELOPED AND GIVES A THOROUGH ACCOUNT OF THE SPECIFIC ELEMENTS THAT COMPRISE THE RATE FOR NON-GOVERNMENTAL PAYORS. FINALLY, AN ANALYSIS OF THE RATE DETERMINATION PROCESS FOR TITLE XIX IS PROVIDED, AS WELL AS A DESCRIPTION OF THE WAY HOSPITAL CATEGORIZATIONS ARE ARRIVED AT.

IN CONLUSION, MR. CHAIRMAN, I WISH TO CONVEY THAT THE STATE OF WISCONSIN TAKES PRIDE IN THE INITIATIVES IT HAS TAKEN TOWARD BRINGING THE ESCALATION IN HOSPITAL COSTS TO WITHIN ACCEPTABLE BOUNDARIES. THE EFFORT TO DATE IS THE RESULT OF COUNTLESS MAN HOURS OF DISCUSSIONS AND NEGOTIATIONS BETWEEN THE STATE, BLUE CROSS OF WISCONSIN, AND THE WISCONSIN HOSPITAL ASSOCIATION. WE FEEL WE HAVE MADE TREMENDOUS PROGRESS IN ACCOMMODATING THE VARYING NEEDS AND

CONCERNS OF THESE PARTIES.

OUR PREDOMINATE CONCERN WITH THE ADMINISTRATION'S HOSPITAL COST CONTAINMENT PROPOSAL IS THAT INSTEAD OF RECOGNIZING THE ADVANCES THE STATE OF WISCONSIN HAS MANAGED TO ACHIEVE IN COST CONTAINMENT OVER THE PAST FEW YEARS, THE PROPOSAL--DUE TO ITS EXCESSIVELY RIGID CRITERIA--WOULD PREVENT WISCONSIN FROM CONTINUING TO ADMINISTER AND OPERATE ITS OWN PROGRAM. THAT WOULD BE THE CASE PRIMARILY BECAUSE OF THE CONDITION THAT IN ORDER TO QUALIFY FOR A WAIVER, THE STATE'S HOSPITAL COST CONTAINMENT PROGRAM MUST HAVE BEEN IN EFFECT FOR A LEAST ONE YEAR PRIOR TO THE REQUESTED WAIVER AND THE PROGRAM MUST HAVE INCLUDED ALL PAYORS (EXCEPT FOR MEDICARE). THE GOOD WILL AND COOPERATION WE HAVE MANAGED TO DEVELOP AMONG THE PARTIES CONCERNED WOULD, I FEEL, BE JEOPARDIZED BY AN INTERRUPTION OF FEDERAL ADMINISTRATION.

THE FACT THAT STATES DIFFER SUBSTANTIALLY IN THEIR POLITICAL, ECONOMIC AND SOCIAL MAKE-UP HAS GROWN TO THE LEVEL OF A TRUISM. YET, THE FACT REVEALS WHY THERE IS LIKELY TO BE A VARIETY OF STATE RESPONSES TO THE ADMINISTRATION'S INITIATIVE. SOME STATES WILL WILLINGLY STEP ASIDE AND WELCOME FEDERAL ADMINISTRATION; OTHERS THAT HAVE BEEN REGULATING THE HOSPITAL INDUSTRY FOR SOME TIME WILL INSIST THEY CAN DO A BETTER JOB THAN THE FEDERAL GOVERNMENT. HOWEVER, THERE REMAINS A HOST OF STATES -- LIKE MY OWN--THAT FALL SOMEWHERE IN BETWEEN THOSE TWO POLES AND THEY CAN BEST BE CHARACTERIZED AS CERTAINLY NOT HAVING THE FINAL SOLUTION TO CONTAINING HOSPITAL COSTS BUT BELIEVING THAT THE STATE LEVEL IS THE MOST APPROPRIATE LEVEL FROM WHICH TO EXPERIMENT AND EVALUATE THIS PARTICULAR KIND OF PUBLIC POLICY ISSUE.

THE CASE FOR STATE PARTICIPATION RESTS NOT ONLY ON THE ARGUMENT THAT STATES ARE GOOD EXPERIMENTAL "TESTING GROUNDS"; MANY OTHER ARGUMENTS ARE JUST AS COMPELLING:

- THE PROTECTION OF THE CITIZENRY'S HEALTH HAS TRADITIONALLY BEEN WITHIN THE RECOGNIZED POLICE POWERS OF THE STATE;
- STATES SHALL CONTINUE TO MAKE LARGE CONTRIBUTIONS TO THE HEALTH CARE SYSTEM THROUGH MEDICAID AND AS PURCHASERS OF HEALTH CARE FOR STATE EMPLOYEES, THEREFORE, THEY HAVE A FINANCIAL STAKE IN THE SUCCESS OF THE PROGRAM.
- STATES ARE IN THE BEST POSITION TO VIEW INDIVIDUAL HOSPITALS' NEEDS, PRIORITIES, BUDGETS, AND OPERATIONS IN THE CONTEXT OF STATEWIDE NEEDS, PRIORITIES AND RESOURCES FOR HEALTH CARE.
- STATES CAN MOST EASILY ASSURE THE COORDINATION OF RATE REVIEW AND OTHER FORMS OF REGULATION, SUCH AS, CERTIFICATE OF NEED REVIEW.

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MR. CHAIRMAN, THIS COMPLETES MY TESTIMONY. ONCE AGAIN I WANT TO EXPRESS MY GRATITUDE FOR THE INVITATION TO APPEAR BEFORE YOU TODAY AND REPRESENT SOME OF THE BROAD CONCERNS THAT HAVE BEEN IDENTIFIED BY MY STATE LEGISLATIVE COLLEAGUES FROM AROUND THE COUNTRY. GOVERNMENT MUST DO MORE TO STEM THE TIDE OF COST INFLATION IN THE HOSPITAL SECTOR AND, TO THAT END, THE ADMINISTRATION'S PROPOSAL OFFERS A USEFUL STARTING POINT FOR DISCUSSION. OUR CONCERN IS THAT GOVERNMENT IS TOO OFTEN SYNONOMOUS WITH NATIONAL GOVERNMENT AND THE LEGITIMATE CONCERNS AND INTERESTS OF OTHER LEVELS OF GOVERNMENT, NAMELY STATE AND LOCAL, MAY GO UNRECOGNIZED. WE SINCERELY HOPE THIS IS NOT ONE OF THOSE INSTANCES.

Senator KENNEDY. We have our next panel, Professor Olson, from Maryland; the Commissioner of Health from the State of New Jersey, Dr. Finley; and Dr. Whalen, commissioner, New York State Department of Health.

Dr. Finley, Senator Williams wanted me to extend a special and warm welcome to you. He wanted to be here, but was unable to at the last moment. He wanted to make sure that you were extended a very warm welcome to the committee.

Professor Olson, we will start with you.

STATEMENT OF MANCUR OLSON, MARYLAND HEALTH SERVICES COST REVIEW COMMISSION, JEANNE E. FINLEY, M.D., NEW JERSEY STATE COMMISSIONER OF HEALTH; AND ROBERT P. WHALEN, M.D., COMMISSIONER, NEW YORK STATE DEPARTMENT OF HEALTH, A PANEL

Mr. OLSON. My name is Mancur Olson. I am vice chairman of the Maryland Health Services Cost Review Commission and a professor of economics at the University of Maryland.

Dr. Harold Cohen, executive director of our staff, is with me today, as is Dr. Jack Cook, our director of rate review. They prepared the testimony that has been given to your committee.

Mr. Chairman, our most important point is that we wholeheartedly favor the two most fundamental features of the bill at issue.

Specifically, we are enthusiastic about the rate design with its limitation or cap in terms of admissions. This is something we proposed initially in Maryland and we believe it is very important, indeed.

A second extremely fundamental feature of the bill, about which we are enthusiastic, is the limitation on capital expenditures by State. We believe the present control system is not working and that this is necessary.

There are, though, some needed improvements in the bill, on which we would like to focus.

First, we would like to emphasize the need for prospective setting of rates, even in hospitals which can increase their costs less than the 9-percent cap. The way it is now, as the bill is drafted, a hospital has no incentive to keep its costs from rising less than the permitted 9 percent. That is at least true in most States because of their retrospective rate reimbursement systems. Indeed, a hospital has an incentive to make its costs rise at least by 9 percent, thereby putting itself perhaps in a better position for rate increases later on.

So we suggest a hospital be able to keep over the long run some part or all of the money saved if it comes in with costs rising less than 9 percent. We believe this will have a wholesome effect on incentives in the system and on the rate of cost increases in the future.

A second factor that we think very much needs change is the provision that allows the pass-through of wage increases obtained through collective bargaining. Since in most States, the more a hospital spends, the more it gets, under the bill as written now, there would not be true collective bargaining in the sense of a two-sided bargain between the hospital and the union. The hospital would have no incentive to keep the wages down because they would be passed through; in most

cases it would be automatically reimbursed for most of those wage increases.

So to my mind, the passthrough provision as it stands now is unfortunate. Indeed, it is even unfair to labor; because most labor unions in other industries will have to pay higher health insurance costs and negotiate higher health-insurance costs if this passthrough provision is allowed.

We also find through our own studies of Baltimore and of Washington that on the whole, hospital workers are paid about a fifth more than comparable workers in other lines of industry.

Senator KENNEDY. If they were not and we have other material which shows they are being paid less in terms of comparability then would your opinion be any different?

Mr. OLSON. Could I, first say that some of the information that suggests that hospital workers are paid less than nonagricultural workers in the economy at large is misleading because it neglects the fact that the higher-skilled people in hospitals for the most part are doctors' and their incomes, sometimes princely incomes, are not included in hospital totals, thus leading to misleading impressions.

Senator KENNEDY. We had an analysis submitted to us in an earlier hearing in which various different categories in both the private and public sector, ranging from dishwashers to computer operators were studied. I would welcome you taking a look at the material submitted to us. If you have different figures or different information with regard to Maryland, I wish you would submit it to us.

Mr. OLSON. That is right. I hope you would accept for the record, Senator, the four exhibits we have, one of which shows our calculations for Baltimore and Washington.

Senator KENNEDY. Fine.

[The material referred to may be found in the files of the subcommittee.]

Mr. OLSON. In those cities—and I realize there are some where wages of hospital workers are at the moment lower on average than those of comparable workers in other industries—I would say a key consideration is whether the hospitals have been getting enough labor.

If the situation is one that has been persisting a long while and the hospitals are not under staffed, then that calls into question the seriousness of the problem. How could hospitals get labor in the long run if they paid less than everyone else? Moreover we propose in our testimony an appeals procedure which would allow those States which have cost increases due to appropriate increases in wages to have an opportunity to appeal, and that would take care of these cases, in my judgment.

The next matter we would like to propose you consider for amendment in the bill is the language which seems to leave open the possibility that a hospital could lease certain services, such as, say, radiological services to a physician and then perhaps not come under the cap in the act. We think this is very dangerous and believe that the law ought to be amended in such a way that it is quite clear a hospital cannot come out from under any provisions in any department by leasing services from a physician.

Senator KENNEDY. If we did not address that, it would open the way, to a real escape valve in terms of the thrust of the legislation. You may not agree with the legislation and its concept, but if you do

agree with it, this could provide an extremely important loophole, would it not?

Mr. OLSON. I think you are absolutely right, Senator.

Since we do agree with the main concept of the bill, we think this is particularly important. Our experience in Maryland shows already efforts to get out from under the control of our Cost Review Commission by leasing services in some hospitals to physicians. This matter will finally be resolved in the courts or State Legislature of Maryland. Everything we have learned there suggests this is an urgent problem, and we wish you a lot of luck in trying to deal with it.

I would like to turn to one other aspect of the bill you asked us to testify about, and that is the question of the proper measurement of the price increases that should be taken into account in determining the cap on hospital costs per admission.

We believe it is possible to use a better measure of inflation than the GNP inflator that has been proposed. We have in Maryland worked out—and one of the exhibits I referred to shows—an index of the prices that Maryland hospitals have to pay for the particular mix of services that they need. This could also be calculated for the Nation at large. Similar indexes have also been calculated in some other States. So it would be better, we would argue, to use a measure of the prices of those services that hospitals actually buy in putting together the measure of inflation used in the act.

However, there has been some confusion about aspects of this.

It has been suggested, for example, by the American Hospital Association, that the fact that food and utility costs have risen faster than prices in general suggests that the GNP deflator is too low. In fact, hospitals spend smaller percentages of their money on food and utilities than other parts of the economy; so this argument taken by itself would argue for a lower measure of inflation than that provided by the GNP deflator.

The more general point, though, is that specific services that hospitals need to buy are the services that should be used for the deflator and it would be easy for the Secretary of HEW to work out a better index than the GNP deflator.

Senator KENNEDY. I think this point is important because this was at the heart of the testimony from the American Hospital Association. It indicated that in terms of food, energy, and other factors, that the hospital inflator was generally higher than the National Index on it.

You are indicating to us that this is not so.

Mr. OLSON. Not precisely that.

Senator KENNEDY. Are you familiar with their testimony?

Mr. OLSON. I was in Asia at the time that particular testimony was given. I want to make the following distinction, which I think is quite relevant, sir, to the question you have.

That is, I am not arguing that there is nothing that hospitals buy that is not increasing faster in price than the average of prices throughout the economy. There are many things that hospitals buy, especially supplies needed uniquely by the hospital sector, that are increasing very rapidly indeed and one of the reasons these prices are increasing disproportionately rapidly is cost reimbursement—the-more-you-spend-the-more-you-get system—under which hospital costs have been met in the past.

So that is one of the reasons why one needs a special index geared to hospital costs. It happens, though, that some of the arguments made in favor of such an index are simply incorrect. They emphasize things like food and utilities, which hospitals use in smaller proportions than other parts of the economy; and that by itself would argue in the opposite direction from what the hospital association did.

Our appendix 3 develops an estimate of a prospective factor cost increase of 7½ percent in the State of Maryland. This is faster than the rate at which the GNP deflator is rising. What we are arguing, is that 7½ percent is the rate in Maryland at which the prices of the things hospitals have to buy are increasing.

Senator KENNEDY. I understand generally what you are including, but what do you omit?

Mr. OLSON. There is nothing that we exclude.

Senator KENNEDY. In the 7½ percent?

Mr. OLSON. You see, it is not that we are excluding things that others do not exclude; it is that we are giving a lower weight or relative importance to some things than the GNP inflator does; that is to say, there are some things like food and utilities which hospitals spend a smaller percentage of their money on than does, say, the average consumer. Therefore, the disproportionate increase in the price of food and utilities would make a hospital cost index less than a GNP deflator. There are, of course, other factors going in the other direction, and these on balance make our index rise faster than the GNP deflator.

Senator KENNEDY. In layman's language, you are saying that if a hospital did not do any more in terms of tests or did not do any more in terms of treatment than they did a year ago, that in Maryland x hospital's costs would go up 7½ percent?

Mr. OLSON. Precisely. That is exactly right. You put it very lucidly.

Senator KENNEDY. I surprise myself sometimes with the profoundness of my understanding. [Laughter.]

Mr. OLSON. I would like to go on to one other important matter, and that is the need for stringent procedures in controlling new capital expenditures. That feature of the bill we like very well.

However, that too needs some amendment, we believe.

First, it is very important, we think, that those States which close down hospitals, should be able to spend more on new hospitals than they would otherwise have been allowed to spend. The closing down of old facilities may eliminate particularly high-cost facilities and it may reduce excess capacity, which under the system adds to hospital costs.

Further, we think a State ought to be allowed to come up with an economic impact statement on new facilities that it would plan to build which, if it showed that costs in the future of operations would be lower because of these new facilities, than the new facilities could be built, even if they put the State above the limit that would otherwise exist.

However, it would be part of the system that the reimbursement under title 1, would then have to be lowered for that State by the amount that that State had projected that its costs would fall because of the new facilities.

Senator KENNEDY. What you have suggested here seems to me to make eminently sound sense. The flexibility does not exist in the current legislation.

Mr. OLSON. That is right.

Senator KENNEDY. Can you still carry forward the thrust of the legislation with the kind of flexibility you described here?

Mr. OLSON. Indeed. We believe every one of the suggestions that we proposed are not only consistent with the thrust of the legislation, but would carry that thrust further.

Senator JAVITS. Would you yield for a minute?

I just learned this morning of the experience in New York City. We have closed a number of hospitals, four or five of them——

Dr. WHALEN. In the last 2 years, Senator, it is 20.

Senator JAVITS. I am speaking of municipal hospitals.

They have been deprived; they have been paralyzed because of an inability to have that flexibility to transfer other units of the same system. That is actual case history from the city officials.

Senator KENNEDY. Dr. Whalen, do you have a reaction to this suggestion in terms of New York?

Dr. WHALEN. Yes.

I think one of the problems that New York City and other urban areas may well have is not a question of the addition of beds, but outdated physical plants in a good number of areas, largely in the ancillary areas of laboratory and X-ray, and certainly in many of our outpatient departments.

So—although I fully agree—that we should not be building more acute-care beds, I do feel that we would have in New York City particularly a need for some modernization, particularly in the ancillary areas. So I think that flexibility should be there.

Senator KENNEDY. Dr. Finley, do you agree?

Dr. FINLEY. I agree, and I will speak to that.

Senator KENNEDY. The members of this committee have been attempting to change the old Hill-Burton formula, and we faced some problems in that.

You have got some other points, but we want to see if you can summarize those and get your point across.

Mr. OLSON. Our only remaining point that must be made is that we think the appeals procedure is too stringent. We would like to see the appeals allowed in cases where hospital costs have risen because of facilities that were approved but not put in operation before this act is passed.

We would also like to see the appeals for reasons of insolvency and in cases where costs arise for reasons out of the hospital's control.

We think it extremely important that the insurance companies, and others that pay for hospital care, should be allowed to be heard in hearings and should be allowed to appeal also. There should be in the appeals procedure voices which come from the payers. That would work in the direction of keeping down hospital costs.

Finally, we believe that additional States should be allowed to operate their State systems under the act in the interest particularly of experimentation; and we believe, as you yourself have argued, I gather, that the States that have regulation should be allowed a bit

extra to make up for the fact that the exceptions procedure would not apply to them.

Thank you very much for the opportunity to testify.

Senator KENNEDY. Are you suggesting that if under the appeals procedure you permit a hearing, which is for the hospitals to come forward to justify the expansion of these facilities, that you think there also ought to be permitted at that particular hearing either insurance groups or other groups to present a divergent opinion?

Mr. OLSON. Precisely.

Our experience suggests that is very important. We find when we set rates in Maryland that the third party payors, most especially Blue Cross, are on the side normally of keeping down the cost, make our task more nearly feasible. One of the problems of rate review commissions, which I think are often oversold, is the fact that, again and again, they tend to fall under the control of the industry that is supposed to be regulated.

Now, one of the ways to lessen the chance of this is to take the payors, who are major organized groups in most cases, and make sure that they are a very important part of the process that puts pressure on whoever sets rates or handles the appeals.

We want to give everyone a chance, and we will include the statements in their entirety. We will ask you to highlight.

Dr. FINLEY. I intend to.

In written testimony I have a complete description of the New Jersey program. I do not intend to go through that before you.

I think like the fellow states that I am here with and really trying to do a successful job of hospital containment, in general concept we support 1391. It is an idea whose time has come and at the same time we recognize it in the bill as transitional; much of your questioning goes to that point; and as a transitional bill, I think we all have to support it.

We do in New Jersey, both from lessons we have learned and mistakes we have made, have some suggestions to make for strengthening the bill, and some of these are similar to suggestions you have already heard.

The most important suggestion we have to make would be to find some way through amendment to account for the absense of any method for dealing with the issue of the reasonableness of the base period.

Senator Schweiker was asking questions earlier about whether or not a cap, a pure cap over the previous year's revenues might not be unfair to hospitals with really depressing financial problems, deficit problems, and equally fattening and unfair in another to hospitals that make profits. There are hospitals that do make profits.

We agree that is a problem with a pure cap. It is a problem that you might find some courts questioning as arbitrary and capricious. We have some suggestions to make for dealing with that.

The Talmadge amendments to the Social Security Act do suggest a method for approaching this problem; a similar approach is currently in use in New Jersey.

The Talmadge bill does propose to compare the reasonableness of the base period expenditures of various groups of hospitals. The methodology is limited because it addresses only routine costs, but it is

preferred to a statute that does not even attempt to deal with case period costs.

We recognize that no really accurate nationwide review of base period hospital costs is possible at the present time because of the inadequacy of the data base. However, we do propose that consideration be given to the comparing of gross hospital expenditures per bed by type of hospital, adjusting for regional price differences. Differences above a certain level might be disallowed before the cap increase is applied. That is one kind of amendment that I think could be dealt with.

We have some suggestions to make about section 112(b)(1)(B) of the bill which provides for so-called intensity increases.

Senator KENNEDY. Can that be done in short term?

Dr. FINLEY. We are trying to find suggestions, realizing that transitional legislation needs to be implemented in the short term, during which time a more sufficient data base can be developed; and we were trying to find that which would be readily available to HEW, which in a quick and dirty fashion could be used to assess reasonableness of base period costs.

Yes; we feel one suggestion we have made could be implemented in a short time.

Senator KENNEDY. We might—submit some questions to you on that at a later time.

Dr. FINLEY. I am going to be quite critical of the provision for so-called intensity increases.

As far as I am concerned, intensity, if properly defined, is the application of more units of service to the same number of patients. There is no evidence from studies undertaken in this country, Canada, or Britain, that such increased resource use leads to any improvements in the health status of patients. Might it not be a good idea to simply eliminate this increase in a transitional program and only include it in a long-run program where it can be carefully monitored?

Or S. 1391 might be amended to allow for intensity increases only where regionalized planning, buttressed by the certificate-of-need process, has designated one particular hospital as a tertiary center—for example, for cardiac surgery, or neonatal intensive care.

In the State of New Jersey, we have gone a long way toward developing regionalization standards for certificates-of-need. We have covered most of our specialty services now; there are criteria for staffing, criteria for equipment, location and numbers of procedures to be conducted. Certificates-of-need may not be granted and/or the reimbursement mechanism will not apply to existing services that do not meet those criteria. This is the only situation in which I would find the so-called intensity increase allowances acceptable, where there is some kind of rational process that has approved the increased intensity.

Perhaps it is difficult to deal with the question of unnecessary admissions under cap legislation, but we question section 113. Previous levels of admission are used as the base for establishing reimbursement. The Congress might wish to consider relating the activities of PSRO's more closely to the cost containment bill, so that some expenditures could be disallowed where some unacceptable level of unnecessary admissions is found.

Senator SCHWEIKER. Would you elaborate further on the problems you see in section 113?

Dr. FINLEY. All the way through we are talking about a gross approach to the base, whether it was base revenues, which you and I have already spoken about, or whether it was last year's admissions, whether or not they were necessary.

When they approach this, is this shotgun? You are giving some people the opportunity to add 9 percent to their revenues whether or not they are found to be admittedly unnecessary. We have not had to add a 9-percent factor in New Jersey to keep our hospitals open, viable, and high quality.

We came in last year at an average 8 percent in reimbursements with a much more sophisticated system for budget review and cost related rate setting. So without dealing with the unnecessary admission, or without dealing with the reasonableness of base year's expenditures, I agree with you on the questions you have asked; you are inviting several institutions to go on and do the things they should not do——

Senator KENNEDY. Are you saying gross revenue just went up 8 percent?

Dr. FINLEY. No; we have a cost-related reimbursement system. Using this system, the across-the-board average of the rates over the last year's rates for payers that we cover will go up no more than 8 percent in the New Jersey hospitals. We had a 9-percent goal. We have come in under our goal.

I have two different recommendations to make, to get to the subject you were talking with Maryland regarding capital expenditure allowances. These are slightly different versions, but elaborate on what Dr. Olson was saying. Section 114(c) does not reduce the revenue base for the inpatient charges of the hospital if a service is removed after being found inappropriate under section 1523(a)(6) ofthe Health Planning and Resources Development Act of 1974—Public Law 93–641.

It is reasonable to allow a period of time for changing the use of a facility, and therefore provide reimbursement for fixed expenses incurred by the plant space being used, though inappropriately. But there seems no reason to pay the hospital revenues attributable to variable costs. The hospital cannot change fixed costs associated with the building, necessary maintenance and heat. It can change staffing levels, supply purchases and other similar expenditures quickly. Other sections of the act which permit changes in revenue based on volume changes in the hospital assume that half of the hospital's revenues relate to fixed cost and the other half relate to variable cost. It seems reasonable to apply this relationship to section 114(c) and reduce the revenue base by the amount of inappropriate variable costs.

Section 115 provides for exceptions to the cap to be determined by the Secretary of Health, Education; and Welfare. It seems likely from our experience with the effects of capital acquisition, for example, that this will be a considerable workload in itself. Some increases in expert staff will be required to handle this problem. In particular, section 115(a)(2) may create a considerable problem for the Secretary. Use of the accounting ratio of current assets to liabilities as a means of defining the solvency of a hospital leads to strong incentives for hospitals to manipulate their financial positions.

There are already consulting firms working across the country to advise hospitals on how to "beat" reimbursement programs. You can rest assured that this will be an elementary problem to such experts, and the Secretary will be deluged with cries of insolvency.

Mr. William Welsh of AFSCME in his testimony to the House committees presented reasons why nonsupervisory wage increases should be a mandatory "passthrough." Section 124 makes this provision and we agree there should be an element of mandatory passthrough. However, at least in some parts of New Jersey, particularly the New York metropolitan area, and in some other eastern seaboard States, the level of nonsupervisory wages for many categories of workers have caught up and in some instances surpassed prevailing payment rates for similar jobs in the community. Therefore, a mandatory increase for all nonsupervisory wages does not seem appropriate. We feel that these wage increases can be defined in two categories, which should be given special consideration:

(a) For those nonsupervisory workers receiving below the federally established minimum wage, any increases to that wage level should be a mandatory passthrough. This requirement should be written into the statute.

(b) We also feel that the Secretary should be very flexible in his administration of the act and carefully consider exceptions for wage increases which allow nonsupervisory workers to attain the "lower-level budget" provision of the U.S. Department of Labor.

It is particularly important to recognize, however, that deserved increases for the lowest-paid workers do not have to be reflected in the grant of identical increases to the highest paid workerss.

Our experience has been that hospitals, even when only a small proportion of the work force is unionized, argue that identical increases should be given to all once a settlement is reached for low-income employees. Such a position does not seem particularly reasonable.

On the other hand, it is necessary that management have flexibility in determining hospital staffing patterns and in the appropriate salary structure to obtain that goal. For this reason, it is preferable to review a total hospital budget, not divided into wage, and other expenditure categories. At management's discretion, some wage increases can be granted in addition to those collectively bargained, if appropriate reductions are made in cost centers that are proven to be high.

Section 126 proposes that any change in the admission policy of a hospital which may avoid the purposes of the act be subject to sanction. We strongly support the intent. However, the trigger is a written complaint to a health systems agency. This mechanism is totally inadequate.

Again, we agree with Mr. Welsh of AFSCME that there should be detailed public disclosure by hospitals for the information of consumers, including HSA boards. This disclosure should include information about total costs, charges, patient admissions by type of payer. We feel that consumers need to be given the right to initiate complaints.

The records of the New Jersey Department of Health are subject to full disclosure. We also receive many complaints from consumers. Such State agencies are needed to play a significant role in assisting the enforcement of this section.

Senator KENNEDY. Even if we do all the points you mentioned, do you have any specific recommendations to deal with the dumping issue?

Dr. FINLEY. Are you talking now about the absence of programs in the States, the absence of such programs as we have in New Jersey to police this, making the assumption that many States do not have this kind of program?

Senator KENNEDY. Yes. What ought we be doing.

What minimum standards should we establish? The States might reach different ways of dealing with it.

Do you have any recommendations other than the publication?

Dr. FINLEY. This is not too positive. I think we are merely saying that HSA's per se, having really no regulatory or enforcement authority, are not the appropriate mechanism. They ought to be in on it in terms of public education and public outcry. I think you are going to need to hunt for a mechanism which has more regulatory authority. In our case, that is the State Health Department. I have no good suggestion about the States that did not have such agencies.

Senator KENNEDY. Do they have sanctions in New Jersey?

Dr. FINLEY. We are in the process through the statutory mechanism. Naturally, our problem started as many do with the denial of beds, nursing home beds, to medicaid patients. I have the licensure authority over all manner of health care facilities in the State health department. We first researched with legal assistance, the department's use of the licensure mechanism. We asked could we deny the license where care was denied. Since our reimbursement rate, which we fix for medicaid is comparable to the Blue Cross reimbursement rate in New Jersey, nobody can protest that the denial of care is based on a poor rate.

The attorney general in the State found that our licensure mechanism, at least under existing manual standards, was not sufficient. But corrective legislation is now before the State legislature which will make it a condition of licensure to (*a*) refuse to deny beds to needy or medicaid patients and (*b*) require in a sense that licensed facilities take a certain number of indigent patients.

Since your committee will also be looking at title 16 of Public Law 93–641, then you will be looking at Hill-Burton concepts, I suppose that some of the wise people on your staff could look at the possibility of sliding in Hill-Buron regulations for free care, and relating that to whatever antidumping enforcement mechanisms you might propose.

Senator KENNEDY. You can slide it in, but it has been a rather meaningless term over the history of this issue.

Dr. FINLEY. It is somewhat meaningless in terms of the amounts of money translated into the total number of patients received, there is no question about it. But slide it in as a concept and see what you can do to strengthen it. I am trying to think of mechanisms to insure that revenue requested hospitals to not deny care to the indigent.

Senator KENNEDY. If you do, it is going to be something we are going to have to deal with.

Dr. FINLEY. We are agreeing that under the proposed statute, HSA's will have written complaints, and go to newspapers and say the hospital is "bad." Everybody knows this is not going to insure the absence of a dumping system or assure the care of the needy. This section is very deficient.

For the sake of New Jersey, I do need to speak to our problems, and I think the problems of most of the Northeastern States with older capital plants, about the formula proposed in section 1504. This relates to the allocation of limited capital disbursements.

We strongly support the nationwide cap on capital expenditures built into the statute. However, the formula proposed in section 1504(a)(2) creates major problems for those States with older hospitals of which New Jersey is one.

We have no need for new beds, and indeed should be reducing the number of beds. We do, however, have large numbers of beds in deteriorated facilities which need rehabilitation and renovation. While this section provides for the Secretary to develop a formula based on more than population, it does not require him to do so in a timely fashion. It is our view that the formula should be initially mandated to at least include a measure of the plant asset value per bed. We suggest the addition of the ratio of beds, divided by asset value of fixed plant.

This formula will provide more funds to those areas which have deteriorated physical plants, but will not underwrite the acquisition of more and more costly technology where it is unnecessary.

The supply ceiling of 4 beds per 1,000 proposed in section 1504(b)(2) is a start in the right direction. But all studies dealing with appropriate provision of health care suggest that a much lower number is appropriate.

We feel that the committee should seriously consider reducing the required supply ceiling to either 3 or 3.5 beds per 1,000 population.

Section 1504(b)(3) promulgates an occupancy standard of 80 percent for hospital-use levels. In New Jersey, we have established a requirement of 90-percent occupancy for medical/surgical beds and 75-percent occupancy for obstetric and pediatric beds.

Since the majority of beds fall into the first category and since the underuse of beds falls significantly into the latter two categories, such occupancy standards are more likely to apportion resources more rationally.

Major urban hospitals, in New Jersey and elsewhere, have problems with respect to these sections of the legislation. We feel we must speak in their behalf. They must accept a disproportionately high load of medically indigent patients so that, under standard medicare and medicaid cost reimbursement formulae, they suffer. They also tend to have the deteriorated plant and thus have diffculty retaining physicians and other staff while they are deprived by the restrictions on their revenue from making capital improvements.

Some provision needs to be made for special consideration to those hospitals for provisions of care to the indigent patients. It is important also to insure that the capital formula will not restrict the ability of major urban hospitals to renovate and improve their plant and equipment.

The New Jersey Department of Health supports S. 1391 because the Nation cannot wait any longer to make some uniform first steps to contain health-care costs. Those of us in States with pioneer pro-programs know it can work without depriving the population of needed care of high quality.

Within our State, where we have come to know intimately the problems of each of our institutions, we have been able to maintain

average hospital rates for protected payors at or under the approximate 9-percent increase proposed in the administration's legislation. At the same time, we have been able to help hospitals with special problems.

Therefore, it is essential that the administration's proposal, hopefully with some of the feasible improvement we have suggested, be recognized as it is labeled: transitional.

In the long run, we have to be talking about delivering health care, rather than solely hospital care. We have to allocate our capital and operating resources in such a way that we do not encourage ever-increasing expenditures for hospitals while preventive and primary care remain the orphans.

In our experience, after the first 2 years, a cost-based reimbursement program with reasonable restrictions will have effectively identified many areas where hospitals are not as efficient as they should be.

We have even found a few industry, particularly business-like trustees, who welcome the technical and management assistance of our budget review. Then it is possible to move away from a pure cost-based system to methods of payment which will provide incentives to hospitals to move in the desired direction.

It is also crucial that the health-planning functions in DHEW be integrated with the cost and quality control activities. When these are well linked, as they are in New Jersey, societal decisions about what and where to expand—or contract—are made rationally and with a true knowledge of economic impact on all payors.

Cost containment is not a matter of "cut and paste," snip here and tighten there. It is truly a matter of informed consent to spend resources for planned and needed services, properly located. Without the marriage of planning and cost containment, we will ever more experience the "balloon effect"—squeeze in here—and the inflation pops out on the other side. That is the summary we have for strengthening the bill.

For the future, we would like to stress particularly the need to find both in the organization and the administration of HEW, and in future legislation when you take on extending the life of 93–641, that planning and fiscal management, ratesetting, investment in hospital capital plant, and so forth, all be administratively well integrated.

We are fortunate in New Jersey not to have to suffer the separate Price Commission problem. We have planning, quality control, licensure, certification, and the health economic service—budget review and ratesetting—in one agency.

There is a tremendous advantage in being able to relate planning decisions to economic decision. I agree with your use of the words "economic impact." I feel this has to be the national way to go, also.

Senator KENNEDY. I could not agree with you more. Historically that has been part of the problem. It is part of, in the Senate, in terms of organization in materials, planning and financing. I agree with the fact that unless we bring those elements together, we will not be doing the job effectively.

Hearing that from those who are on the firing line in terms of the States, I could not agree with you more. You are absolutely correct.

Dr. FINLEY. To tell you the truth, the States that have very progressive setups like New Jersey, need your support, too; because the

standard ploy—I will have to use that word—of the American Hospital Association is that, well, if there are going to be Federal controls, maybe they will have to learn to deal with them. But they would like to have separate commissions. I am sure we all understand that the separate commission can be more easily coopted.

As a matter of fact, in our State, it would cost us a whole new budget, in addition to the budget now expended in the health department. We have troubles in our own State. There is always an effort to take what I would call fiscal management processes, to separate them from the planning process.

Some of the same things, as you say, continue to go on in Washington, in committees, in agencies, and in the administration. We have got to find a way to put it all back together. So we agree.

Senator KENNEDY. Dr. Whalen?

Dr. WHALEN. Senator Kennedy, and members of the subcommittee, I can assure you there is no greater issue of concern to the State of New York than relief from the intolerable burden of increasing health-care costs, and particularly hospital costs.

We have a supreme paradox in New York State. Our costs for hospital care are among the highest, if not the highest, in the Nation. Yet, under the leadership of Governor Carey, we have, over the past 2 years, developed and implemented a program of hospital cost control that is without peer in terms of its impact on rising hospital costs. Let us explore the two extremes of hospital costs in New York State.

On the one hand, the people of New York State will spend almost $7 billion for hospital care this year, which means that a State with 8.5 percent of the Nation's population will account for an estimated 12 percent of the Nation's expenditures for hospital care.

This works out to about $380 per year for every man, woman, and child in the State, and is almost 50 percent higher than the national average.

The average hospital bill in our State is over $1,000, well above the national average. Last year, the total medicaid expenditure in New York State was almost $3 billion, or some 24 percent of the entire national outlay for medicaid. One-third of this sum went for hospital care.

Approximately half of the money spent for hospital care in New York State is public in origin, coming from the various levels of government.

In some counties of New York State, medicaid costs account for fully half of the county expense budget. According to a study published last year by Columbia University, nearly 25 percent of the expense budget of New York City was allocated for personal health care services in fiscal 1975. And that figure is exclusive of medicare payments to hospitals and physicians. Fifty-three percent of all health care dollars in New York City now go to hospitals.

The precipitous rise in health care costs, and government's increasing share of these costs, was and is without doubt one of the critical factors in the fiscal crisis that has threatened to destroy the economic viability of New York State, New York City, and many of our local governments.

New York State was among the first States to recognize the fiscal threat posed to government, employers, and citizens by the inexorable rise in hospital costs.

Beginning in 1970, the State health department was given authority to gain control of these costs by prospectively setting daily reimbursement rates paid to hospitals under medicaid and Blue Cross.

Through 1974, our efforts succeeded in reducing cost increases per patient day by an average of only about 2 percent per year. Only since the advent of the Carey administration in January 1975 can we truly say that we have begun to effectively control hospital costs in New York State.

Senator SCHWEIKER. Do you have the figures to illustrate the last point?

Dr. WHALEN. There were two studies done, Senator, sponsored by the Social Security Administration.

The one in downstate New York was carried out by Professor Dowling from the University of Washington. What he did was compare the rate of increase in hospital costs in New York City with a peer group composed of hospitals in Cleveland, in Pittsburgh, and Philadelphia, I believe.

His conclusion at the end of the study was, yes, hospital costs had been moderated for downstate New York.

There was another finding, however, which was more disturbing, and that was that although daily unit costs had gone down, it appeared as if the average length of stay had gone up.

I asked him a question at a meeting where he discussed this paper, and his response to me was, if you treat a hospital like an economic animal, it will react like an economic animal. So some of the costsavings were lost by savings of unit costs and losses due to an increased length of stay, and that is why this year we have changed the formula to include a length of stay penalty.

In upstate New York, the finding there was that the rate of increase in cost had gone down by about 2 percent, although one could not say that this was statistically significant. So for the period of 1970 through 1974, it appears as if some impact was made, but it was not a dramatic impact.

It took a series of strict measures in the last 2 years to turn this situation around.

We have placed hospitals in peer groups according to size and nature. This serves as a screen to identify hospitals that deviate from the average.

In computing allowable costs for inpatient services at these hospitals, we disallow costs in excess of the average of all hospitals in the group, and we disallow costs for days in excess of the average length of stay of all hospitals in the group. In other words, we exact fiscal sanctions for inefficiency.

This year, we have instituted a policy which denies medicaid reimbursement for patients admitted over the weekend, unless the hospital offers full, undiminished services on weekends.

We have stipulated that certain uncomplicated medical services must be performed on an outpatient basis, or reimbursement will be withheld. And we set a $50 cap as the maximum amount that will be paid for an emergency room or clinic visit.

To many people, $50 may sound like no cap at all but this was in the face of certain outpatient rates reaching a level of $70 or $75.

At the same time, we have won increased authority to reduce the capacity of the institutional health-care system. Over the past 2

years, the State Health Department has closed 22 hospitals, housing 2,433 beds; we have decertified or reclassified another 1,824 hospital beds; and we have recommended the withdrawal of expansion projects which would have added 1,723 hospital beds to the system.

As a consequence of this aggressive program, New York State has begun to make real progress in its efforts to contain hospital costs. Last year, hospital costs rose less than 5 percent in New York State.

Senator KENNEDY. Is that in the entire system, or just in medicaid?

Dr. WHALEN. That would be medicaid and Blue Cross.

We have control over those two sources of payors, not over commercial insurance.

Senator JAVITS. As a matter of fact, if you pass through increases in workers compensation, according to the Carter administration's plan, would that not take it right out through the top of the thermometer?

Dr. WHALEN. Senator, what I pointed out earlier was that not really much cost containment has occurred in the period 1970 through 1974. That was a period in which New York did passthrough all collectively bargained labor contracts.

In 1975, we adopted a rule saying that would no longer be State policy, and since that date we have not.

Now, of course, since that date, we have had a great deal of labor unrest and almost a strike last year which eventually went to arbitration and was settled.

What we are trying to do, as pointed out earlier, is, take a base-year cost and certainly this must be related to what is going on out there in the real world and develop a hospital inflation idex, which I gather is not too dissimilar to Maryland's, and take that base-year cost and say this is the way it is going to be in the next rate period.

I would guess that our projection this year would be roughly similar to yours, somewhere in that neighborhood, and that protection factor takes into consideration a rise in wages in comparable industries, purchases that hospitals make, and so on. So I think it is a very fair and equitable way.

Senator JAVITS. Just to finish that—therefore, the passthrough question is a critical question?

Dr. WHALEN. Very critical question.

Senator JAVITS. New York cannot get a waiver if it has no passthrough, and all your figures fly out the window?

Dr. WHALEN. That is correct.

Now, with regard to the act, we consider it a very positive first step, and we have a special recommendation; and one of the reasons for it is the very point Senator Javits just made; that is, our preeminent concern that in States like New York, which have ongoing cost-containment programs, that we receive a waiver.

With the legislative session about to close in New York, it is highly unlikely that we will be in a position to gain control of all hospital reimbursement by October. Over the next several years, we do plan to move toward a uniform reimbursement system for all hospital payors.

Our existing cost-containment program will save the medicaid program alone an estimated $115 million in the period 1976–78. We say to you that this effort should not be wasted. Unless we receive a waiver, it will be.

We applaud the Carter administration's recognition of the problems posed by rising hospital costs. We endorse the intentions of this

legislation. For, unless we control hospital costs, we States will never have the resources we need to contend with our most serious health problems, the ones for which hospitals are not the answer.

I will be pleased to respond to questions.

Senator KENNEDY. Senator Schweiker?

Senator SCHWEIKER. Dr. Whalen, I wonder if you would elaborate a little bit on how the peer group concept operates under your system?

Dr. WHALEN. Two separate peer groups, where they are grouped by hospital size, sponsorship, location, patient mix, and averages are set for that particular group of hospitals; and any variation of the average must be explained.

Senator SCHWEIKER. You have basically two classes?

Dr. WHALEN. Yes. We have one grouping for routine costs and ancillary costs, and another grouping for length of stay.

Senator SCHWEIKER. Roughly, what are the differences between the two groups?

Dr. WHALEN. You mean variation in cost?

Senator SCHWEIKER. Yes.

Dr. WHALEN. Senator, you would have to look at—maybe I am not explaining this properly—you would have to look at each individual grouping based on geography and so on, and the question you asked would probably be about 20 different figures, depending on group and location.

Senator SCHWEIKER. How about cost per admission?

Dr. WHALEN. Our cost for admission in the State is something like $1,800. That varies widely, whether one is in a teaching hospital for a particular diagnosis or in a small rural hospital in upstate New York.

Senator SCHWEIKER. So you end up with two peer groups.

How do you take that same figure and apply it to the two peer groups? Do you have an average cost per admission for one peer group, versus average cost for admission for another group?

Under the Talmadge bill, there would be a similar classification system with certain levels assigned to each class.

Dr. WHALEN. Essentially, we do what the Talmadge bill proposes; we take hospitals and group them for routine cost. Then the Talmadge bill says that if you vary over 120 percent of the average of the group, those costs are disallowed.

In New York, we started out with the exact approach of the Talmadge bill with only a ceiling on routine costs. In fact, I think our original ceiling was exactly as it is in that bill, at 120 percent. Over time, we moved to 115 percent. Because of the fiscal crisis 2 years ago, we had to move to 100 percent of the average, and we wanted explanations for everything over the average.

This greatly increases your workload because you have many legitimate cases for appeal under a screen like that.

I would think that a grouping with 115 percent as a group average would be a very reasonable way to approach it.

Having said that, I would caution very strongly unless you putn-additional cottrols on the ancillary cost area, and until you put addi tional controls on the length of stay, you will not save any money.

Senator SCHWEIKER. Thank you.

Senator KENNEDY. If you will not be saving very much money without a limitation, then it is not really going to achieve much of an objective in terms of cost control, is it?

Dr. WHALEN. I think that a ceiling just on routine costs will not save the money that should be saved or will not control costs, because intensity, the introduction of new technology, is all in the ancillary cost area.

Senator KENNEDY. Let me ask each of you to comment on that. In terms of your State, what does the institution of a cap mean in terms of quality of care?

We have heard a good deal in our earlier testimony that when you establish a cap, it really means deterioration in terms of quality.

What has been your experience?

Dr. WHALEN. I can give you a very clear example that happened last year.

I had occasion last year to move to close three cardiac surgery units. The reason I moved to close them was due to the fact that an expert committee of cardiac surgeons told me the work being done in these units was not on the best quality. This is after having on-site visits at the units and watching the surgical procedures.

The legal proceeding to do that is very long and complicated.

One day, sitting in the office, I decided I would write a letter saying I was closing these three units, or there were four involved.

The first one I heard from was the dean of the medical school, who called me up to congratulate me for sending him the letter because they did not think this fellow was too good, either, but nobody took him on before.

The second call came from a major religious group who thanked me. They did not know how they were going to solve this between the various hospitals they have under their control, and they thanked me for having helped them solve the problem.

The third one says, we do not want it anyway; and the fourth one was an application for new service; and the answer there was we told them if they could prove they needed it, I would testify they were to get it, and if they did not have any better information, I was going to testify against it, and they withdraw the application.

That is a concrete example in 1 year. I feel very strongly that new technology in every hospital does not lead to good patient care.

We have too many surgery units. We probably have in the country too many kidney transplant units. We have new technology, and I think one of the most popular to question now is the amount of respiratory therapy we give in this country. Certainly an unnecessary hospital admission exposes you to the risk of errors made in medication.

If we can get a system that meets our needs and does not overmeet them and can get a system where people are hospitalized when they have to be hospitalized, and not otherwise, if we can get a system where our resources are regionalized so that we can have the best capacity available to people on a reasonable basis that we can afford, I think we definitely will have improved health care in this country.

Senator KENNEDY. Dr. Finley?

Dr. FINLEY. It is a difficult question to answer in relation to a legislation that just caps something. I think there is something we are all saying, that we will accept this as a transitional method, but we will have to get something more sophisticated, akin to what the States, those of us that do have a budget review and cost center by cost center, peer-group-by-peer-group analysis, screens, cutoff points, and disallowance points.

I quite frankly do not think that the quality question will ever be answered until we also work that into the study part of the planning and ratesetting system. I think we are fortunate in New Jersey to have one of the SSA experimental reimbursement system contracts which first of all if we succeed will change methods of reimbursement to what it costs to take care of certain kinds of patient care, diagnosis related group, rather than per diem, and also permit us to take data off medical discharge abstracts and measure the difference between hospitals in terms of acceptable measures of quality of care.

Frankly, I think the cap legislation where you have, let us say, inner-city hospitals, that is really needed, that does have some of the problems of deficit because of unreimbursed indigent care, et cetera, that may be a hospital you need and it could be a better quality program if it were not capped at deficient status from last year.

Again, with the well-to-do, however, I agree more is not necessarily better. We just have to learn how to measure it.

Senator KENNEDY. Very briefly, Mr. Olson.

Mr. OLSON. Our experience in Maryland suggests you can control hospital costs without impairing quality.

Senator SCHWEIKER. I have a very brief question.

What are your respective opinions on uniform reporting requirements?

Dr. FINLEY. Well, I guess we all three have one.

Uniform reporting system is absolutely necessary and a uniform accounting system is, too.

Senator SCHWEIKER. Are all of you in agreement on that?

Dr. WHALEN. An absolute essential is uniform accounting system and uniform reporting system.

Mr. OLSON. Yes.

Senator SCHWEIKER. Thank you.

Senator KENNEDY. Thank you very much.

Very helpful.

Mr. OLSON. Thank you.

[The prepared statements of Mr. Olson, Dr. Whalen, and Dr. Finley follow:]

STATEMENT OF

MANCUR OLSON

VICE CHAIRMAN,

HAROLD A. COHEN

EXECUTIVE DIRECTOR

AND

JOHN S. COOK

DIRECTOR OF RATE REVIEW

OF THE HEALTH SERVICES COST REVIEW COMMISSION

TO THE

SENATE SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

COMMITTEE ON HUMAN RESOURCES

ON S. 1391

THE HOSPITAL COST CONTAINMENT ACT

June 17, 1977

Mr. Chairman, Members of the Subcommittee, we appreciate the opportunity to testify before you today. My name is Mancur Olson. I am Vice Chairman of the Maryland Health Services Cost Review Commission and a Professor of Economics at the University of Maryland. With me is Hal Cohen, an economist, who is the Executive Director of the Commission and Jack Cook, a mathematician, who is the Director of our Rate Review Program.

I would like to begin by stating the principal aspects of the Cost Containment bill I will be addressing in my testimony. These are:

1) The lack of positive incentives inherent in the continued use of retroactive cost based reimbursement coupled with the provision for the pass-through of labor costs.
2) The use of the GNP deflator rather than a hospital specific cost index as a basis for payment limitation.
3) Inconsistencies between the incentives and procedures of Title I and Title II.
4) The stringency and lack of equity in the appeals process.
5) The criteria for delegating rate review authority to the States.

The experience of various State regulatory bodies has demonstrated that the rate design is extremely important. For example, the experiences in Connecticut and Maryland, and of the Cost of Living Council, have shown the inadequacy of simply regulating prices, and the experience in New York

has shown that using per diem rates is also unsatisfactory. We strongly endorse the rate design suggested and consider that the concepts involved in Title II are excellent. The planning agencies must be compelled to set priorities and make allocations on the basis of need rather than for political reasons. Because of the pressures existing in most States planning will be unable to function effectively without such a bill.

I.

We are suggesting three modifications to the nature of the cost control system proposed by the President:

a) The payments by Medicare and Medicaid should be prospective. More precisely, the cost increases allowed by the proposed legislation should be paid by Medicare and Medicaid even if a hospital's costs do not rise by that amount. This provides the hospital industry with clear incentives to eliminate inefficiencies in their base period operations. This contrasts with the present proposal in which it is to the hospital's advantage to spend to the upper limit in order to maximize costs in subsequent periods.

In the second and subsequent years of the application of this system, if the hospital's costs are lower than would have been allowed under the limits specified in the proposal, the savings should be split equally between the hospital and Medicare and Medicaid. In this way both the hospital, and Medicare and Medicaid

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benefit from any savings accomplished.

b) The labor pass-through included in S.1391 should be eliminated. Hospital wages, salaries and fringes account for approximately 65% of hospital costs. The Commission has made a very thorough review of the relationship between hospital wages and non-agricultural wages for identical job classifications in Baltimore and Washington. Included in our testimony is a study by Jack Cook in which he has used Bureau of Labor Statistics data to compare hospital wage rates with non-agricultural wage rates for identical job classifications in Baltimore and Washington. This study shows that hospital wages in Baltimore for these job classifications are 18% higher than the prevailing market rate. In Washington, the comparable statistic is 20.6%.

It is true that average weekly gross earnings of hospital workers are lower than the average for non-agricultural employees. This is because hospital workers have, on average, low skill levels. In addition, the average income of people who work "in" hospitals is much higher than the average income of people who work "for" hospitals. This is because the hospital's principal resource managers, the physicians, are not usually hospital employees. The reasonableness

of the wages of hospital workers must be based on the market rate for the particular skills required. We believe the study submitted as part of our testimony proves conclusively that, based on market place criteria, hospital wages in Baltimore and Washington are higher than comparable wages in the private sector. In the past there has been very little incentives for hospital management to take a hard line in labor negotiations since the costs could simply be passed through. This has resulted in the overpayment of hospital workers just discussed. It is very important that the cost containment bill incorporate the necessary incentives to hospital management to control increases in labor costs, if it is to be effective.

c) Another concern regarding the incentives of the proposed system involves the treatment of leased services. According to Medicare regulations, services leased to physicians are treated as services provided by physicians. As currently formulated, the bill provides a clear incentive for a hospital to lease its ancillary services to physicians thereby exempting these inflationary services from the cost containment act. In our judgment such leases would completely undermine the purposes of the act. You should make clear that, e.g. if a radiology department is leased to a physician that,

while you may choose not to include the normal compensation of the radiologist within the definition of hospital services, you should include all the other costs of the department within that definition. None of those costs should be eliminated from the regulated base through a change in contract.

II.

The second major area that we would like to address involves the method by which revenue limitations are determined. In particular, we propose replacing the formula which appears in SEC.112(b) with a statement that the Secretary shall develop an index which appropriately measures the increases in costs, including wages, which a hospital might reasonably have been expected to experience. The State regulatory agencies in New Jersey, Connecticut, Maryland and New York have developed inflation indices for hospital costs, as has the American Hospital Association. It is thus clear that the development of a factor cost adjustment system can be done with the state of the art.

The GNP deflator, for some of the reasons identified by the American Hospital Association, is not an appropriate measure of hospital inflation. Our testimony outlines the development of a market basket inflation measure for hospitals. The weights assigned to each cost element are based on the actual incurred costs of approximately 40 hospitals in the State of Maryland. As can be readily seen from the information we have developed, hospital factor costs (including labor costs) can reasonably be expected to increase about 7.5% in fiscal year 1978. Then estimates have been independently confirmed by studies

carried out in New Jersey and Connecticut. We are not, however, proposing that hospital cost increases be limited to increases in factor costs, but that a provision of 1 or 2% be made for increased service intensity.

It is important to stress that most of the arguments presented by the American Hospital Association should be given relatively little weight in arguing against a 9% limitation. For example, while the increase in malpractice costs in Maryland was significant in fiscal year 1976, that increase amounted to only .61% of overall costs (see Exhibit 3). Further, while food and utility costs are rising faster than the Consumer Price Index in general, both of those components are given more weight in the Consumer Price Index than they would receive in a hospital price index. Therefore, the Hospital Association's argument that increases in the cost of food and utilities explain why hospital cost inflation outstrips the CPI are nonsense. The main reason that hospital factor cost increases exceed the CPI is probably that hospital suppliers have enjoyed an oligopoly position in the market, a problem exacerbated by cost based reimbursment.

III.

The third major area we would like to address is the treatment of capital costs and, specifically, the relationship between Titles I and II.

It is most appropriate that the Legislature specifies the amount of money it believes should be spent on hospital capital. Our experience with planning agencies indicates that unless they are forced to recognize

that the resources available for health care are limited, they will continue to approve unnecessary projects. Thus, the States should be told how much money is to be allocated for hospital capital projects and be delegated the responsibility of setting priorities given the multiple applications they receive.

The idea that the Federal Government is not to approve loans for hospital construction unless the construction project meets appropriate requirements is excellent. The Health Services Cost Review Commission has been able to stop some hospitals from getting private financing for projects which we believe are unnecessary. We have not, however, been able to stop federal financing of unnecessary hospital capital projects.

Certain improvements can be made in order to strengthen the planning process and generate more appropriate decisions. The current bill would not cause planning agencies to choose between capital projects which lead to significant operating costs and capital projects which save operating costs. We, therefore, suggest that the bill be amended to require that all hospitals making an 1122 application include an economic impact statement which would identify the impact of the project on their inpatient costs per admission and on their outpatient costs per visit in the absence of inflation in the hospital economy. The planning agencies could then be given the option of approving capital projects up to the limit assigned by the Secretary or projects having an annual economic impact of, for example, 40% of that figure. The economic impact estimate approved under Title II should then be automatically approved under Title I for the particular hospital.

Another major area needing improvement is the lack of incentives for planning agencies to close facilities and for hospitals to join in support of plans calling for the closure of underutilized hospitals in their community. We suggest that you might wish to consider two additional positive incentives. In determining the capital pool allocated to a particular state, the Secretary should be directed to consider the replacement value of any hospitals forced to close through the planning process. States which can effectively close hospitals should be given a larger capital allocation than they would otherwise receive.

The major problem with planning now is that hospitals do not compete with each other for the limited resources available. The admissions load formula undermines the incentives for hospitals to support decertification of alternative underutilized facilities. Specifically, we recommend that when one hospital in a community is closed, the other hospitals in that community should not have to fully absorb the first 2% of increased admissions. Rather, they should get their 50% variable cost payment for all increased admissions - up to 50% of the payment which would have gone to the hospital which closed. If one hospital in a community has a significant reduction in capacity or closes a service such as obstetrics, there should be no "corridor" in the admission load formula either for any local hospital which must absorb additional patients or for the hospital which gives up the service.

Finally, we would agree with the Hospital Association that the $2,500,000,000 specified in SEC.1504.(a)(1) should be increased over time by an appropriate index reflecting the change in construction and equipment costs.

IV.

The fourth area that we would wish to discuss is the appeals process. It is our opinion that the appeals process in the current bill is much too stringent and will cause unnecessary erosion of hospital capital. We suggest that the appeal criteria should be liberal, with the burden of proof falling clearly on the hospital. We recognize that the Department of Health, Education and Welfare is concerned about their ability to handle numerous appeals. Such problems can be mitigated in the following ways:

1) Exempt all hospitals under 50 beds from the cost containment bill. These hospitals represent nearly 25% of voluntary hospitals but only a small percentage of hospital costs.

2) Clearly identify how the burden of proof is to be carried by appellate institutions and use the Medicare auditors to verify the facts submitted by the hospital.

If you accept our recommendation that the Secretary should promulgate a market basket inflation amount, then the most common basis on which a hospital would appeal would be that the hospital could not control its costs for a particular factor in such a way that it would not increase beyond the Secretary's inflation factor. This would allow for hospitals to appeal wage rate increases, for example, beyond the Secretary's factor but the hospital could not pass such increases on in charges unless it showed that it could not control the cost increase.

Another grounds for appeal would be Comprehensive Health Planning 1122 approvals prior to enactment of Title II. Approvals under Title II of this bill would be automatically adjusted in the particular hospital's inflation allowance as described above.

The final appeal criteria would be that the hospital could demonstrate a substantial threat of insolvency. The basis for such an appeal would then be a demonstration that the revenue otherwise allowable is insufficient to assure the solvency of the hospital as indicated by the existence of a current ratio of assets to liabilities of less than 1.25. This is presumably well below the current ratio which is implied by SEC.115.(a)(2) but Maryland experience indicates that current ratios higher than that are not an indication of threatened insolvency.

We would point out that even if a majority of the hospitals appealed, the number of federal appeal officers required would be less than 100. This would be partially offset by reductions in Medicare personnel if Medicare and Medicaid shifted to a prospective rate system. Further, the approximately $3,000,000 of additional expense would be a small part of the savings generated from the Cost Containment Act while making the idea of a CAP per admission much more acceptable to the industry.

In considering the appeals process it must be noted that according to Section 115(D)(2) an exception granted by the Secretary will not only allow for increased charges and payments by Medicaid and Medicare, but will also allow increased charges and payments by Blue Cross, Commercial Insurance Companies and self-responsible patients. Therefore, the Commission urges that those affected parties should be allowed to

be heard in the exception process and if they are dissatisfied with a determination of the Secretary that they, just as the hospital, should be able to obtain a hearing before the Provider Reimbursement Review Board. This Commission has learned that regulators must be as accountable to the paying public when they say "yes" as they are accountable to providers when they say "no".

V.

The final topic we would like to address concerns the criteria for certain states to obtain responsibility for controls on their hospitals. While Maryland qualifies on every count, we believe other states, such as New Jersey and Connecticut, which do not qualify under the bill but are currently doing good jobs and testing worthwhile ideas should also be granted the necessary waivers. As you indicated when you introduced S.1391, Mr. Chairman, it is clearly unfair for states with delegated authority to not be allowed the equity of the federal exception process. Delegated states should have to meet the national formula (our suggested market basket plus, say, 1.5% for intensity) plus a conservative estimate of the impact of the exception process (estimated also as 1.5% if the labor pass-through is eliminated). Thus, Maryland, for example, would be allowed to run its own program subject to an overall increase of approximately 10.5%.

STATEMENT BY

Robert P. Whalen, M.D., Commissioner

New York State Department of Health

before the

Subcommittee on Health and

Scientific Research

Committee on Human Resources

United States Senate

June 17, 1977

Mr. Chairman, members of the Subcommittee, I am Dr. Robert P. Whalen, Commissioner of the New York State Department of Health. I am delighted to have this opportunity to appear before you to discuss the proposed Hospital Cost Containment Act of 1977. I can assure you that no health issue is of greater concern to New York State than relief from the intolerable burden of forever-increasing hospital and health care costs.

We are confronted with a supreme paradox in New York State - our per capita costs for hospital care are among the highest, if not the highest, in the entire nation. Yet, under the creative leadership of Governor Hugh Carey, we have over the past two years developed and implemented a program of hospital cost control that is without peer in terms of its impact on rising hospital costs.

Let us explore the two extremes of hospital costs in New York State.

On the one hand, the people of New York State will spend almost $7 billion for hospital care this year, which means that a state with 8.5 percent of the nation's population will account for an estimated twelve percent of the nation's expenditures for hospital care. This works out to about $380 per year for every man, woman and child in the state, and is almost fifty percent higher than the national average. The average hospital bill in our state is over $1,800, well above the national average. Last year, the total of Medicaid expenditures in New York State was almost $3 billion, or some 24 percent of the entire national outlay for Medicaid. One-third of this sum went for hospital care.

Approximately half of the money spent for hospital care in New York State is public in origin, coming from the various levels of government. In some counties of New York State, Medicaid costs account for fully half of the county expense budget. According to a study published last year by Columbia University, nearly 25 percent of the expense budget of the City of New York was allocated for personal health care services in fiscal 1975. And that figure is exclusive of Medicare payments to hospitals and physicians. Fifty-three percent of all health care dollars in New York City now goes to hospitals.

The precipitous rise in health care costs, and government's increasing share of these costs, was and is without doubt the critical factor in the fiscal crisis that has threatened to destroy the economic viability of New York State, New York City and many of our local governments.

New York State was among the first states to recognize the fiscal threat posed to government, employers and citizens by the inexorable rise in hospital costs. Beginning in 1970, the State Health Department was given authority to gain control of these costs by prospectively setting daily reimbursement rates paid to hospitals under Medicaid and Blue Cross. Through 1974, our efforts succeeded in reducing cost increases per patient day by an average of only about two percent per year. Only since the advent of the Carey Administration in January of 1975 can we truly say that we have begun to effectively control hospital costs in New York State.

And it took a series of strict measures to do so. Let us look at this other side of the hospital costs paradox.

For example, we've placed hospitals in peer groups according to size and nature. This serves as a screen to identify hospitals that deviate from the average. In computing allowable costs for inpatient services at these hospitals, we disallow costs in excess of the average of all hospitals in the group, and we disallow costs for days in excess of the average length of stay of all hospitals in the group. In other words, we exact fiscal sanctions for inefficiency.

This year, we have instituted a policy which denies Medicaid reimbursement for patients admitted over the weekend, unless the hospital offers full, undiminished services on weekends. We have stipulated that certain uncomplicated medical services must be performed on an outpatient basis, or reimbursement will be withheld. And we set a fifty-dollar cap as the maximum amount that will be paid for an emergency room or clinic visit.

At the same time, we have won increased authority to reduce the capacity of the institutional health care system. Over the past two years, the State Health Department has closed 22 hospitals housing 2,433 beds; we have decertified or reclassified another 1,824 hospital beds; and we have recommended the withdrawal of expansion projects which would have added 1,723 hospital beds to the system.

As a consequence of this aggressive program, New York State has begun to make real progress in its efforts to contain hospital costs. Last year, hospital costs rose less than five percent in New York State. For the current fiscal year, we are projecting a still lower growth rate in hospital costs.

And we have detected no diminution in the quality of hospital care; indeed, the hospitals we have closed have generally been the least proficient and least utilized in their particular areas. If anything, we believe we are improving the quality of hospital services.

We regard the Cost Containment Act of 1977 as a positive first step by the federal government to control the hitherto inexorable rise in hospital costs. We have but one specific recommendation concerning the Legislation, as it is drafted.

Our pre-eminent concern is that states like New York, which have proven cost containment programs, receive a waiver permitting them to continue those programs. With the legislative session about to close in New York, it is highly unlikely that we will be in a position to gain control of all hospital reimbursement by October. Over the next several years, we do plan to move toward a uniform reimbursement system for all hospital payors.

Our existing cost containment program will save the Medicaid program alone an estimated $115 million in the period 1976-78. We say to you that this effort should not be wasted. Unless we receive a waiver, it will be.

We applaud the Carter Administration's recognition of the problems posed by rising hospital costs. We endorse the intentions of this legislation. For, unless we control hospital costs, we states will never have the resources we need to contend with our most serious health problems, the ones for which hospitals are not the answer.

I will be pleased to respond to questions.

REMARKS OF:

Joanne E. Finley, M.D., M.P.H.

New Jersey State Commissioner of Health

before the Health Subcommittee of the Senate Human Resources Committee

on S 1391, The Hospital Cost Containment Act of 1977

Remarks of: Joanne E. Finley, M.D., M.P.H., New Jersey State Commissioner of Health; before the Health Subcommittee of the Senate Human Resources Committee, on S 1391, The Hospital Cost Containment Act of 1977; June 17, 1977

I. Introduction and Statement of Support

Mr. Chairman and members of the subcommittee, I am Doctor Joanne E. Finley, New Jersey State Commissioner of Health. I am most appreciative of the opportunity to appear before you today, along with distinguished colleagues from sister states that have been doing an effective and professional job of containing hospital costs within reasonable bounds. Because of our experience, our successes, and the things it is possible to learn from mistakes, New Jersey's Governor, the Honorable Brendan T. Byrne has asked me to appear today to reflect the position of our Health Department with respect to S 1391, The Hospital Cost Containment Act of 1977.

Repeatedly before this and other committees of Congress, knowledgeable individuals have stressed the problem of triple digit inflation in health care costs, the reasons, and the drastic impedance this has been to the enactment of an appropriate National Health Security bill. It is hardly necessary for me to repeat these concerns and statistics.

I will however, address S 1391, which, in general the New Jersey Department of Health supports. Our support is based on the belief that we must, in a uniform national way, address a section of our economy that is straining the budgets of all payors, including the federal government, inordinately, and that it can be done without being unreasonable, or uncaring about the needs of a precious health care resource -- our hospitals.

The basic thrust of the Administration Bill, to set a ceiling on increases in revenue intake, and therefore on operating costs, and to limit capital expenditures which can drive up those costs, is a useful approach. The measure is particularly valuable as it emphasizes proper allocation of national resources to all those services our public wants and needs, rather than depending on ever more for health care, -- a bottomless pit.

II. Background of New Jersey's Health Facilities Cost Containment Program

A. Summary of Provisions

On May 10, 1971, the New Jersey Legislature passed an imaginative and constructive statute, The Health Care Facilities Planning Act.

Its purpose:

> "It is hereby declared to be the public policy of the State that hospital and related health care services of the highest quality, of demonstrated need, efficiently provided and properly utilized at a reasonable cost are of vital concern to the public health!"

It included a concern for cost containment by providing the following in section 18 (now proposed for amendment to extend budget reviews and hospital rate-setting protections to all payors):

> a. "No government agency and no hospital service corporation organized under the laws of the State shall purchase, pay for or make reimbursement or grant-in-aid for any health care service provided by a health care facility unless at the time the service was provided, the health care facility possessed a valid license or was otherwise authorized to provide such service.
>
> b. Payment by government agencies for health care services provided by a health care facility shall be at rates established by the commissioner, based on elements of costs approved by him.
>
> c. The Commissioner of Health in consultation with the Commissioner of Insurance shall determine and certify the costs of providing health care services, as reported by health care facilities, which are derived in accordance with a uniform system of cost accounting approved by the Commissioner of Health. Said certification shall specify the elements and details of costs taken into consideration.
>
> d. Payment by hospital service corporations, organized under the laws of this State, for health care services provided by a health care facility shall be at rates approved as to reasonableness by the Commissioner of Insurance with the approval of the Commissioner of Health. In establishing such rates, the commissioners shall take into consideration the total costs of the health care facility."

In summary, this comprehensive legislation tied the role of the State Health Department in assisting and administering health planning activities then mandated under Public Law 89-749 to a specific regulatory role related to the State's traditional responsibilities for the public's health. The proof of demonstrated need and proper utilization was backed by one of the first state certificate of need programs. Efficient and high quality provision of health services provided by health care facilities was supported by a mandated inspection, licensure and certification program. Assurance of reasonable costs, at least for governmental payors and

Blue Cross, was given by establishing this as a responsibility of the Health Commissioner in consultation with the Commissioner of Insurance.

All these activities to insure New Jersey citizens access, quality and reasonable costs were integrated into the work of the Department responsible for the public's health.

B. Implementation Since 1974

Although the Act was passed in 1971, the Department of Health did not implement the program until 1974 after Governor Byrne was elected. During 1975 an initial rate review program was undertaken using the budget reports developed by the voluntary program of the New Jersey Health Research and Education Trust, on which the previous Commissioners had depended. At the same time the Department, with the assistance of professional consultants, developed a uniform financial and statistical reporting system which became the basis for hospital budget review and rate-setting in 1976.

These reports are used to review each hospital's entire budget for reasonableness using a system which initially sets a payment rate based on a formula. Total costs of hospital operation based on previous actual expenditures and patient volumes for a portion of the prior calendar year, and projections for the remainder, are taken into account. The hospital is notified of this rate and is sent a set of working documents to help it identify cost centers where the proposed expenditures are questioned. At present all elements of operating costs are considered for inclusion in the ultimate Blue Cross rates, except for a factor for unreimbursed indigent care, and working capital outlays. Proposed amendments to the Act would mandate the inclusion of these elements of cost.

The hospitals prepare documentation to support any request for reinstatement of the proposed disallowances and discuss these with Department staff which may make adjustments within the regulations which have been approved by a Health Care Administration Board. Any continuing disagreements may then be taken up on a formal appeal to a Department hearing officer. Amendments to regulations in 1976, and 1977, both reward those who submit budgets in timely fashion, and provide for immediate cash flow needs, by permitting immediate payment of the proposed initial rates developed from budget analyses, without jeopardizing a hospital's appeal rights.

C. Some Details of the New Jersey Methodology

The basic elements in the New Jersey system are:

(1.) To require a uniform reporting system with uniform definitions of cost centers.

(2.) To adjust and standardize these reported costs to account for regional differences.

(3.) To compare peer groupings of hospitals by cost centers, in order to determine the reasonableness of base period costs.

(4.) To allow the addition to the reasonable base of agreed upon patient volume increases, and appropriate adjustments for changes in the kind of care delivered to patients, for example where approved by a certificate of need.

(5.) To add an appropriate inflation factor related to price increases in goods and services purchased in the general economy, which we call the economic index.

(6.) To screen, within peer groups, cost centers, and where a hospital's budget proposes expenditures in certain categories that are above the median plus 10 percent for like hospitals, to initially disallow this, subject to detailed review.

D. Staffing Requirements

I have a staff of fourteen people involved in reviewing budgets and in setting the rates for 119 hospitals. They are under the direct supervision of a Director of the Health Economics Service, who in turn is responsible to an economist, Assistant Commissioner over Health Planning and Resources Development. Most of staff's time is spent on the detailed review with the hospital of the proposed expenditure cuts. Therefore, the size of the bureaucracy depends on the extent of the exceptions process used by the administering agency not on the basic method for determining the rates which will be paid.

In summary, a fair and equitable rate setting program can be established within a two year time frame which will review presently incurred expenditures as well as limit to reasonable levels the rate of increase in those expenditures.

E. Court Tests and Lessons Learned

Our system has been subject to judicial review in its first year. The courts required that the New Jersey Administrative Procedures Act be followed insofar as the methodology and the manual describing it had to be adopted as a regulation approved by the Health Care Administration Board after hearings. However the Courts refused to invalidate the methodology and indeed found it substantively reasonable.

A retired Superior Court judge has twice held hearings at our behest on some aspects of the methodology. He has recommended certain refinements in the economic index, and in the timing of the elimination of expenditures. Otherwise these hearings held the process to be equitable and reasonable. There are suits pending from individual hospitals on the reasonableness of the payment rate being made.

On the other hand, in 1976, when a financially pressed Medicaid program attempted to set a cap on increases in payments to hospital providers, the Courts overturned this, with the finding that the word "reasonable" in federal statutes and regulations, required more than an arbitrary cap. There had to be at least some relationship between factors in the general economy and Medicaid rates.

We have also had to modify the uniform reporting system as we discovered imperfections in the definitions or the reporting forms themselves. As a result of the learning experiences under a contract with the Social Security Administration to develop a prospective hospital reimbursement system based on patient case mix, and relative costs per diagnosis related groups, we have become persuaded that a uniform hospital accounting system is also required. Such will generate fewer errors in the uniform reports.

We would particularly like to stress the advantages of relating underlying decisions made in the planning process to hospital budget increases. Hospitals may not add new services or expand capacity without receiving planning approval and a certificate of need from the Department of Health. The regional Health Systems Agencies are under contract to the Department to undertake initial certificate of need reviews and make recommendations to the State Council which in turn recommends to the Commissioner. The Department staff has been responsible for developing certificate of need guidelines. Therefore, a hospital will not be given an increase in its budget unless it can show the necessary planning approval has been granted. In addition, we are creating planning standards for regionalized

services which require the closing of duplicative, under-used or otherwise inappropriate activities by hospitals and these will not be reimbursed under the rate review program.

Finally, the Health Economics Service, working side by side with the planners, is able to assist in a careful articulation between operating and capital expenditures. Because capital expenditures are subject to certificate of need, the wisdom of granting such certificates can be assessed by reviewing the effects on the operating costs of the applying institution. The effect of a service change in that institution on neighboring institutions and their operating expenses can also be reviewed. Health planning looks at whole systems for the delivery of care. Coupled with the rate setting system's detailed knowledge of each individual institution and its financial strengths, weaknesses and problems, planning decisions can be reinforced by setting appropriate payment rates for needed services and excluding payment for unneeded services.

F. Results

New Jersey was fortunate to have strong support from its Chief Executive, and considerable understanding from a majority of consumer-minded Legislators. In this climate the New Jersey experience suggests that an effective system for hospital operating cost controls can be established over a twenty-four month period, with an initial screening of hospital expenditures being undertaken within twelve months. Our present legislated authority only extends to Blue Cross, Medicaid, and other governmental payors such as Vocational Rehabilitation, Crippled Children's and Maternal and Child Health programs. For these payors we have restrained the rate of increase substantially over the past three years.

Savings to New Jersey Payors Over Proposed Hospital Expenditures (1974-1977)
(dollars in millions)

	1974[1]	1975	1976	1977[2]
Proposed Hospital Budget	877	1,059	1,241	1,450
Allowed Hospital Budget	-	1,001	1,083	-
Requested Increase	18%	20.8%	17.2%	16.8%
Allowed Increase	18%	14.1%	8.1%	-
% Savings on Proposed Budget Base	-	6.7%	9.1%	-
$ Savings on Proposed Budget Base	-	71	113	-

1 1974 data, base on data provided from prior rate-setting program.

2 1977 data: since the 1977 rate review program is in process, the allowed increase is not available. Therefore, the 1977 allowed increase can be viewed as a range from 7% to 9% listed below:

Allowed Increase	7%	8%	9%
% Savings on Proposed Budget Base	9.8%	8.8%	7.8%
$ Savings on Proposed Budget Base	142	128	113

It is difficult to find comparable national figures relating to hospitals budgeted expenditures. However, the American Hospital Association Report, National Hospital Economic Activities (report number 26, December 1976), gives total expenses of hospitals rising by 13.4 percent in September 1974-1975 and 21.3 percent in September 1975-1976. These time periods are slightly different from the New Jersey budget periods which run January to January. They do indicate the order of magnitude of the differences between the national figures and those of New Jersey. These aggregate results also conceal some major differences among New Jersey hospitals. In particular, inner city hospitals, which have large medically indigent populations to serve often have severe financial problems. These cannot be alleviated by a system which does not cover all payors, because it is not equitable to assess the costs of unreimbursed indigent care solely to one payor - Blue Cross.

G. Plans for the Future

As the New Jersey system was being developed, it was recognized that reimbursement rates based on per-diem costs, represented negative incentives for efficient utilization, as well as an inequitable method of payment for hospitals with the most complex case-mixes. Per-diem rates encourage not only the admission of more patients, but their retention in the hospitals. The first days usually are the most costly in terms of service requirements, therefore the hospital can literally "make more" when it receives the same rate for less costly and prolonged days. This counters the purposes of health planning and thwarts the effects of PSROs to reduce unnecessary lengths of stay.

In New Jersey we have decided that the only valid approach is to move the system toward reimbursement based on some form of payment by patient case mix. As of January 1, 1976 we required all hospitals to maintain medical discharge abstracts and to report these to the Department.

As we were preparing to move in this direction, the Social Security Administration announced an interest in new prospective reimbursement system experiments. New Jersey was fortunate to be awarded a contract to develop a prospective reimbursement system based on reasonable costs per case and by the particular mix of cases experienced by differing hospitals. We expect such a system to be capable of recognizing necessary differences in services provided to patients and in the quality of those services, and to pay appropriately for them. An essential element to this program again lies in the relationships between health planning and the budget review process.

III. Translating Lessons Learned in New Jersey: Suggestions for Effective Federal Hospital Cost Containment Legislation

There are many desirable features of S-1391 and in general concept it is an idea whose time has come. We support the concept of using the GNP deflator as the measure of reasonable price increases in the system. Pure price increases in hospitals do not have to be greater than those in the rest of the economy. As long as there is no incentive on the industry to carefully review its purchasing practices, higher than necessary price increases from supplies are automatically passed on to patients. When hospitals have to review their purchase practices, and look more carefully for competitive bids, our experience is that supply prices cease to rise at the same rapid pace as before controls were applied.

The requirement that all payors be covered by the program is vital, and one we are trying to achieve in New Jersey. We have found that wealthier hospitals with the privilege of passing on the costs of unreasonable and inflated cost centers to charged payors, can disregard recommendations for economies.

There are also improvements that could be made by amendment. We would like to make certain suggestions from the New Jersey experience.

A. Determining the Reasonableness of Base Period Expenditures

As a broad-brush short-run approach, we support the purposes of the Administration proposal. However, while it restricts the rate of increase for all hospitals, there are some hospitals which will reap undue benefits. These are hospitals which have never attempted to run efficiently, which have been in a position to pay the high cost of underused capacity or duplicated services in the community that they serve, and which now have an inflated expenditure base against which the percentage "cap" increase is allowed. This is neither rational nor fair.

The Talmadge Amendments to the Social Security Act do suggest a method for approaching this problem; a similar approach is currently in use in New Jersey. The Talmadge Bill does propose to compare the reasonableness of the base period expenditures of various groups of hospitals. The methodology is limited because it addresses only routine costs, but it is preferred to a statute that does not even attempt to deal with base period costs.

We recognize that no really accurate nation-wide review of base period hospital costs is possible at the present time because of the inadequacy of the data base. However, we do propose that consideration be given to the comparing of gross hospital expenditures per bed by type of hospital, adjusting for regional price differences. Differences above a certain level might be disallowed before the "cap" increase is applied. As

long as the parameters are set fairly generously, this would enable some of the unreasonable expenditures in high cost institutions to be excluded from payment.

This proposed modification to the Administration Proposal could be implemented within a relatively short time frame without requiring a large expansion to the bureaucracy.

B. Adjustments for Intensity

Section 112 (b)(1)(B) of the bill provides for so-called intensity increases which presumably decline over a few years to a very low number. It is not entirely clear why this is included in the first place. Intensity, if properly defined, is the application of more units of service to the same number of patients. There is no evidence from studies undertaken in this country, Canada, or Britain, that such increased resource use leads to any improvement in the health status of patients. Might it not be a good idea to simply eliminate this increase in a transitional program and only include it in a long-run program where it can be carefully monitored? Or S-1391 might be amended to allow for intensity increases only where regionalized planning, buttressed by the Certificate-of-Need process, has designated one particular hospital as a tertiary center--for example for cardiac surgery, or neo-natal intensive care. Guidelines against which such designations must occur, would require calculable added units of service, specialized staff and equipment, which should be appropriately financed.

C. Disincentives for Unnecessary Admissions

Perhaps it is difficult to deal with the question of unnecessary admissions under "cap" legislation, but we question Section 113. Previous levels of admission are used as the base for establishing reimbursement. The Congress might wish to consider relating the activities of PSRO's more closely to the cost containment bill, so that some expenditures could be disallowed where some unacceptable level of unnecessary admissions is found.

D. Adjustments to the Revenue Base When Inappropriate Services are Reduced or Deleted

Section 114 (c) does not reduce the revenue base for the inpatient charges of the hospital if a service is removed after being found inappropriate under section 1523 (a)(6) of the Health Planning and Resources Development Act of 1974 (P.L. 93-641). It is reasonable to allow a period of time for changing the use of a facility, and therefore to provide reimbursement for fixed expenses incurred by the plant space being used, though inappropriately. But there se ms no reason to pay the hospital revenues attributable to variable costs. A hospital cannot change fixed costs associated with the building, necessary maintenance and heat. It can change staffing levels, supply

purchases and other similar expenditures quickly. Other sections of the Act which permit changes in revenue based on volume changes in the hospital assume that half of the hospital's revenues relate to fixed cost and the other half relate to variable cost. It seems reasonable to apply this relationship to section 114 (c) and reduce the revenue base by the amount of inappropriate variable costs.

E. Problems with Certain Exceptions

Section 115 provides for exceptions to the "cap" to be determined by the Secretary of Health, Education and Welfare. It seems likely from our experience with the effects of capital acquisitions, for example, that this will be a considerable work-load in itself. Some increases in expert staff will be required to handle this problem. In particular, section 115 (a) (2) may create a considerable problem for the Secretary. Use of the accounting ratio of current assets to liabilities as a means of defining the solvency of a hospital leads to strong incentives for hospitals to manipulate their financial positions. There are already consulting firms working across the country to advise hospitals on how to "beat" reimbursement programs. You can rest assured that this will be an elementary problem to such experts, and the Secretary will be deluged with cries of insolvency.

Mr. William Welsh of AFSCME in his testimony to the House Committees presented reasons why non-supervisory wage increases should be a mandatory "pass-through". Section 124 makes this provision and we agree there should be an element of mandatory pass-through. However, at least in some parts of New Jersey, particularly the New York Metropolitan area, and in some other Eastern seaboard states, the level of non-supervisory wages for many categories of workers have caught up and in some instances surpassed prevailing payment rates for similar jobs in the community. Therefore, a mandatory increase for all non-supervisory wages does not seem appropriate. We feel that these wage increases can be defined in two categories which should be given special consideration:

(a) For those non-supervisory workers receiving below the federally established minimum wage, any increases to that wage level should be a mandatory "pass-through". This requirement should be written into the statute.

(b) We also feel that the Secretary should be very flexible in his administration of the Act and carefully consider exceptions for wage increases which allow non-supervisory workers to attain the "Lower-level Budget" provision of the U.S. Department of Labor.

It is particularly important to recognize, however, that deserved increases for the lowest paid workers do not

have to be reflected in the grant of identical increases to the highest paid workers. Our experience has been that hospitals, even when only a small proportion of the work force is unionized, argue that identical increases should be given to all once a settlement is reached for low income employees. Such a position does not seem particularly reasonable.

On the other hand, it is necessary that management have flexibility in determining hospital staffing patterns and in the appropriate salary structure to obtain that goal. For this reason it is preferable to review a total hospital budget, not divided into wage, and other expenditure categories. At management's discretion some wage increases can be granted in addition to those collectively bargained, if appropriate reductions are made in cost centers that are proven to be high.

F. Ensuring Care for the Needy

Section 126 proposes that any change in the admission policy of a hospital which may avoid the purposes of the Act be subject to sanction. We strongly support the intent. However, the trigger is a written complaint to a Health Systems Agency. This mechanism is totally inadequate. Again, we agree with Mr. Welsh of AFSCME that there should be detailed public disclosure by hospitals for the information of consumers, including HSA boards. This disclosure should include information about: total costs, charges, patient admissions by type of payor. We feel that consumers need to be given the right to initiate complaints. The records of the New Jersey Department of Health are subject to full disclosure. We also receive many complaints from consumers. Such State Agencies are needed to play a significant role in assisting the enforcement of this section.

G. Restrictions on Capital Expenditures

We strongly support the nation-wide "cap" on capital expenditures built into the statute. However, the formula proposed in section 1504 (a) (2) creates major problems for those states with older hospitals of which New Jersey is one. We have no need for new beds, and indeed should be reducing the number of beds. We do, however, have large numbers of beds in deteriorated facilities which need rehabilitation and renovation. While this section provides for the Secretary to develop a formula based on more than population, it does not require him to do so in a timely fashion. It's our view that the formula should be initially mandated to at least include a measure of the plant asset value per bed. We suggest the addition of the ratio of $\frac{\text{beds}}{\text{asset value of fixed plant}}$. This formula will provide more funds to those areas which have deteriorated physical plants, but will not underwrite the acquisition of more and more costly technology where it is unnecessary.

The supply ceiling of 4 beds per 1,000 proposed in section 1504 (b)(2) is a start in the right direction. But, all studies dealing with appropriate provision of health care suggest that a much lower number is appropriate. We feel that the committee should seriously consider reducing the required supply ceiling to either 3 or 3.5 beds per 1,000 population. Section 1504 (b)(3) promulgates an occupancy standard of 80 percent for hospital use levels. In New Jersey we have established a requirement of 90 percent occupancy for medical/surgical beds and 75 percent occupancy for obstetric and pediatric beds. Since the majority of beds fall into the first category and since the under use of beds falls significantly into the latter two categories, such occupancy standards are more likely to apportion resources more rationally.

Major urban hospitals, in New Jersey as elsewhere, have problems with respect to these sections of the legislation. We feel we must speak in their behalf. They must accept a disproportionately high load of the medically indigent patients so that, under standard Medicare and Medicaid cost reimbursement formulae they suffer. They also tend to have the deteriorated plant and thus have difficulty retaining physicians and other staff while they are deprived by the restrictions on their revenue from making capital improvements. Some provision needs to be made for special consideration to those hospitals for provision of care to the indigent patients. It is important also to ensure that the capital formula will not restrict the ability of major urban hospitals to renovate and improve their plant and equipment.

IV. Summary

The New Jersey Department of Health supports S-1391 because the nation cannot wait any longer to make some uniform first steps to contain health care costs. Those of us in States with pioneer programs know it can work without depriving the population of needed care of high quality. Within our State where we have come to know intimately the problems of each of our institutions, we have been able to maintain average hospital rates for protected payors at or under the approximate 9% increase proposed in the Administration's legislation. At the same time we have been able to help hospitals with special problems.

Therefore, it is essential that the Administration proposal, hopefully with some of the feasible improvements we have suggested, be recognized as it is labelled: transitional. In the long-run we have to be talking about delivering health care, rather than solely hospital care. We have to allocate our capital and operating resources in such a way that we do not encourage ever increasing expenditures for hospitals while preventive and primary care remain the orphans!

In our experience, after the first two years, a cost-based reimbursement program with reasonable restrictions will have effectively identified many areas where hospitals are not as efficient as they should be. We have even found a few in the

industry, particularly business-like Trustees, who welcome the technical and management assistance of our budget review. Then it is possible to move away from a pure cost based system to methods of payment which will provide incentives to hospitals to move in the desired direction.

It is also crucial that the health planning functions in DHEW be integrated with the cost and quality control activities. When these are well linked, as they are in New Jersey, societal decisions about what and where to expand--or contract--are made rationally and with a true knowledge of economic impact on all payors. Cost containment is not a matter of "cut and paste", snip here and tighten there. It is truly a matter of informed consent to spend resources for planned and needed services, properly located. Without the marriage of planning and cost containment, we will ever more experience the "balloon effect"... squeeze in here--and the inflation pops out on the other side!

Senator KENNEDY. The next panel is headed by Stanley Wisniewski, Service Employees International Union.

STATEMENT OF STANLEY WISNIEWSKI, RESEARCH DIRECTOR, SERVICE EMPLOYEES INTERNATIONAL UNION AND MOE FONER, EXECUTIVE SECRETARY, NATIONAL UNION OF HOSPITAL & HEALTH CARE EMPLOYEES; AND RICHARD E. MURPHY, LEGISLATIVE DIRECTOR, SERVICE EMPLOYEES INTERNATIONAL UNION, A PANEL

Mr. MURPHY. My name is Richard E. Murphy. I am legislative director of the Service Employees International Union. Our secretary-treasurer was going to be here to introduce these two gentlemen to offer testimony; and I would hope that Mr. Weinlein's testimony, which has been submitted to you, will be made part of the record.

Just a brief comment.

The Service Employees International Union represents over 250,000 health care workers. We have a vital interest in this legislation, and the points that will be made I hope will be taken by your committee and digested and hopefully acted upon.

Mr. WISNIEWSKI. My name is Stanley Wisniewski. I am research director for Service Employees.

What I am going to do is briefly summarize the major points presented in both Mr. Weinlein's prepared statement and my own.

I want to thank you for the opportunity to testify today. Our unions, together representing over 350,000 health care workers, fully support the administration's decision to slow down the rapid increase in the price of medical care.

All of the workers we represent are deeply concerned by the upward spiral of health care costs. Clearly, there is something seriously wrong with our present health care delivery system when workers who we represent in such cities as Detroit and Syracuse see the equivalent of 4½ weeks' wages go to cover the cost of their hospital bills, while just a short distance away, in Canada, workers whom we represent in the same occupations in such cities as Windsor and Belleville, Ontario, have only half as much in weekly wages claimed by hospital costs.

Inflation in the health care industry is a critical problem, especially to the many low-wage workers who are members of our unions.

Indeed, it is ironic that among the workers hardest hit by health care inflation are health care service workers whose wages still remain below the level of earnings enjoyed by workers in most other sectors of the economy. The real answer to this problem is a program of national health insurance.

Short of this, we approve of the Carter administration's approach in S. 1391. There are, however, a number of very critical problems in this legislation which we would like to discuss.

Our main concern is that the proposed program should not be used to interfere with free collective bagaining in the hospital industry nor to hold down the wages of hospital workers while prices continue to rise.

As representatives of hospital workers, we have been saying for a long time that the rapid increases in the cost of medical care are not, in any way, attributable to hsopital labor costs.

This has been documented time and again—most recently by the Council on Wage and Price Stability in a study which estimated that limiting the rise in the rate of earnings increases of hospital employees to the increases experienced by all private nonfarm production workers over the 1955–75 period would have only reduced the annual rate of increase in average cost per patient-day from 9.9 percent to 8.8 percent. In other words, total labor costs were the source of only about one-tenth of the annual increase in hospital costs.

Moreover, this figure refers to total labor cost—51 percent of operating cost—while nonsupervisory labor costs equal 35 percent of total operating costs.

Other recent studies of hospital worker wages which focus on only collectively bargaining wages indicate that the union impact on hospital costs appear to be in the range of 1 to 2 percent.

Moreover, while unionized hospitals pay higher wages, they may experience lower labor costs because, unlike their nonunion counterparts, they are troubled less by higher labor turnover rates.

With about 18 to 20 percent of all hospital workers organized and with total payroll costs representing roughly 51 percent of operating costs, organized labor accounts for only 10 percent of hospital costs. Clearly, this is too small a portion to have had a significant impact on health care inflation.

Collectively bargained wage increases in the health care industry have not been excessive as indicated by the data provided in appendix A, tables II, III, and IV. The average increase which became effective during 1975, in SEIU and district 1199, RWDSU, contracts was 7.8 percent.

For 1978, the average increase was 4.3 percent. To date, in 1977, those increases which have occurred or are expected to occur on the basis of previously negotiated settlements average 4.2 percent.

These increases can hardly be termed excessive inasmuch as the effective wage rate changes reported by the Bureau of Labor Statistics for wage settlements in the private sector as a whole averaged 8.7 percent in 1975 and 8.1 percent in 1976.

Clearly, labor costs have played a minor role in pushing hospital costs upward. Health care workers are the victims of rising health costs as much as anyone else, or perhaps even more so, since they are less able to afford such price increases.

Because they recognized this fact, and the fact that hospital workers are still severely underpaid, the administration's bill, in section 124, allows a hospital an adjusted revenue limit to permit wage increases for nonsupervisory personnel, as defined in the National Labor Relations Act.

We fully support the intent of this section as an essential part of any program on cost control. To do otherwise would represent an unwarranted interference with the rights of hospital workers to engage in free collective bargaining—a right that was finally accorded them in the 1974 Amendments to the National Labor Relations Act.

We are very concerned, however, about the application of section 124.

First, we believe that section 124(a), as it is now written, unfairly gives such an exemption only at the discretion of hospital administrators.

According to this provision, if hospitals request a modification of their revenues to eliminate the effects of nonsupervisory wages, then nonlabor costs can only rise by the permissible limit, which may be 9 percent.

If, on the other hand, a hospital does not request such a modification, then it is possible for nonlabor costs to rise as much as 14 percent by shifting the burden of the program onto the shoulders of low-wage workers through a refusal to grant any wage increase.

To overcome this serious problem, our unions would like to see labor costs, as reflected by the wages of nonsupervisory workers, and nonlabor costs, treated separately. This would require the Secretary to modify, for each hospital, the revenue increase limit, to reflect whatever change there has been in the cost of labor.

By that device, only nonlabor costs would be limited by the revenue increase ceiling. This would avoid having nonlabor hospital costs, which have been the cause of rapid inflation, exceed the limit—at the expense of the hospital workers.

As section 124(a) now reads, hospitals are given an incentive to keep wage increases below the allowable level in order to permit more of the increase to go to capital expenditures and the like. This gives hospital managements additional leverage at the bargaining table at the expense of their employees. It is clearly a loophole in the cost containment program.

Secondly, we oppose inclusion of section 124(d). This paragraph essentially gives the Secretary of Health, Education, and Welfare the power to eliminate section 124 after 18 months.

If there needs to be a review of this program at that time, all aspects should be reviewed, not just this section. Furthermore, Congress is the proper place for review.

Third, we are completely opposed to section 117, which would permit States to run their own programs. It would be a terrible mistake to permit this loophole to remain.

As it was originally planned, section 117 was designed to permit those States which now run their own programs, and have done so for some years, to continue to do so. Four States now have their own programs, Massachusetts, Connecticut, Maryland, and Washington.

As the section was written, however, especially under section 117(b) any State could run its own program for a year, and then qualify for a Federal exemption.

In other words, 1 year after the enactment of this legislation, we could have 50 States running separate programs, each with different standards. Clearly, this waiver section could undercut the entire Federal program.

More important in our view is that exempt States would be allowed to indirectly control wages, contrary to the Federal law. If you do permit State exemptions, States which are exempted must be required to meet all the criteria of the Federal program, including being required to exclude the wages of nonsuperivsory workers from their programs.

Evidence from the experience with some State programs shows the necessity for adherence to this particular Federal standard. In the State of Maryland, where the State cost review commission became

operative in 1974, the available data shows: (1) That total operating costs increased at a faster rate than the national average in 1975; (2) that the only element of operating costs in Maryland that rose slower than the national average in 1975 was payroll costs; and (3) that non-payroll costs, which are most responsible for health care inflation, increased 26.5 percent in Maryland, or nearly 4 percent more than they did nationally.

In short, the Maryland experience indicates that so far as any kind of cost control being effective, or was effective, it came at the expense of wages.

Our two unions and the rest of organized labor are firmly opposed to any type of wage controls, as is the administration. And we oppose any attempt to sidestep this issue by allowing some States to sneak controls in the back door.

Most hospital workers are low-wage workers and, until just recently, many were excluded from the protection of Federal collective bargaining law.

The wage of these workers have just now begun to catch up after years of exploitation. It is the right of these workers to be involved in determining their——

Senator KENNEDY. Mr. Wisniewski, do you want to summarize? I want to give you a full chance to present your testimony but time is running short.

Mr. WISNIEWSKI. Yes. I will try to summarize it.

We feel that workers should be involved in determining their own wages and working conditions.

With regard to other portions of the proposed legislation, our second major concern is the almost total lack of any requirement for financial disclosure by the hospitals.

We feel financial disclosure is the key to a workable program of cost control. And Mr. Foner will say more about that.

In addition to these major concerns with the exemption of non-supervisory wages, the State waivers, and financial disclosure, we feel also strongly that the Congress should avoid covering public hospitals in S. 1391.

You are well aware of the severe financial problems facing State and local governments today. Public hospitals have been hit very hard.

Often they must provide medical care to the poor and elderly when other hospitals refuse. Their costs are, therefore, much higher and their revenues much lower.

We are very worried, in addition, that despite the safeguards in this bill, private hospitals will begin dumping their "less profitable" patients into the public hospital system.

Many public hospitals now are cutting services, laying off workers in order to get by on limited funds. To further restrict their funds would severely affect those people most dependent upon public health care.

Hospital workers, more than anyone, want to support this program. They care deeply about the quality and availability of health care for all our citizens. But the Congress must realize that most of them are still unwillingly subsidizing the health care system through their low wages.

All they are asking for today is that they be treated as equitably as all other American workers. Let those who control the cost and

access to health care do their share to stop this outrageous inflation. Thank you.

Mr. Foner will now discuss financial disclosure.

Mr. FONER. I would like to summarize what we have submitted, Mr. Chairman.

Senator KENNEDY. Both of your statements will be printed in their entirety at the conclusion of your testimony.

Mr. FONER. On the issue of financial disclosure, Mr. Chairman, we have a situation in the hospital industry where it is almost impossible to find out how hospitals really spend their money. It is almost more difficult to find out that information from hospitals than it is to get a rundown on the CIA.

But I suggest that if the bill is enacted in its present form, it will leave hospital financial information exactly where it always has been—completely in the dark.

And I would just raise three items for your consideration along this line.

Senator KENNEDY. I strongly agree with you, and we are going to make every effort for the kind of disclosure that you recommend.

It seems to me that when we are talking about the amount of money in this legislation, the amount of money that the public invests in terms of the hospitals, that the public ought to have a right to know just how that money is being expended, and that goes right from the top in terms of salaries and every part of that expenditure. We will make every effort to assure that any legislation that comes out of this committee will have such information.

Mr. FONER. Yes, Mr. Chairman.

These are fundamentally the points we wanted to make. I believe that members of your committee are familiar with the complaints that we have been making on the absence of financial disclosure.

The New York State Assembly has just passed a bill that has not been passed by the senate, but which would require detailed financial disclosure, including pathologists, radiologists, the leasing out, the rundown of salaries and fringe benefits, and moneys paid for antilabor activities, et cetera. These are the things that we believe belong in such a bill.

And we agree with what you have said.

Senator KENNEDY. Well, it makes sense because actually this is public money that is being expended, is it not?

Mr. FONER. That is correct.

Senator KENNEDY. And it is taxpayers' money that is being expended through this process.

Mr. FONER. Yes; the public has a right to know how it is spending its money.

Senator KENNEDY. And the public has a right to know how that money is being expended for this health-care system. I don't have that information at the present time, and it is virtually impossible, as you point out, to be able to get that.

Now, I would think that it is absolutely essential, if we are really coming to grips with the issue of growth in costs, that we know where the taxpayers' money is going all the way down the line. It seems to me this is an essential aspect in terms of legislation that comes in: that we get public information and get public awareness and have public disclosure of those particular salaries and expenditures.

Mr. FONER. That is the thrust of the remarks that I had planned to make. And I welcome your comments on it.

May I refer to one item that Mr. Wisniewski raised, because it was discussed by the previous panel, and that is the question of non-supervisory wages in States with their own cost containment programs; States which would be permitted to get out of the provision of the proposed bill, Mr. Chairman, if it were enacted in its present form.

The New York State experience is an experience that our union has had some very direct experience with. Dr. Whalen indicated that they have kept hospital costs down to 5 percent over the past year,

Another thing that should be pointed out is that they have done it largely, although not entirely, but a great deal at the expense of the workers in the hospitals. Wages of hospital workers in the past 2 years in New York where we represent some 70,000 workers in voluntary hospitals, have been averaging 0.9 percent increase per year. Now, it is very easy for the Maryland gentleman to indicate that they believe that we should let the collective-bargaining process take effect.

In New York, we had a bitter strike last summer over the right to have binding arbitration. And when the arbitrator discussed the situation with the representative of New York State in terms of wage increases, the official representative of New York State told the arbitrator: you can do what you wish, but if you ask one penny for wages, don't come to us for anything; we will not pass a penny through in wage increases.

Now, that kind of an approach has resulted in wage freezes and really thwarts the basic thrust of the Federal act, which guarantees collective bargaining.

Now, we don't believe that it is neither fair nor wise nor just to compel hospital worker sto be the chief subsidizers of attempts to control hospital costs.

Mr. MURPHY. Mr. Chairman, on the subject of disclosure, we do have prepared and will submit——

Senator KENNEDY. Some amendments?

Mr. MURPHY. Yes, specific amendments.

Senator KENNEDY. If you submit those as part of your testimony, they will be made a part of the record. We will go over them.

Now, I think it will be very helpful if we could get the breadkown on that other information. Your testimony has been helpful.

Mr. WISNIEWSKI. I think I can add one piece of information.

This morning we heard quite a bit about hospital workers and comparing them with other industries. I don't know how the gentlemen from these Rate Review Commissions are prepared to do that, since most occupations simply are not comparable. And about 80 to 85 percent of the cases that we are talking about, Mr. Chairman, of the occupations, they simply don't exist out in other industries.

Moreover, I think it is incredible to try and compare increases in other industries with increases in the hospital industry without looking at the base from which the increases occur. And we are at a lower base in the hospital industry than in any other industry.

That is all I wanted to add about that point.

So it is difficult to try and come up with comparable information by occupation.

Senator KENNEDY. Thank you very much.

[The joint prepared statement of Mr. Weinlein, Mr. Wisniewski, Mr. Toner, and information referred to follow:]

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JOINT TESTIMONY

OF THE

SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO

AND THE

NATIONAL UNION OF HOSPITAL AND HEALTHCARE EMPLOYEES,
RWDSU, AFL-CIO

BEFORE THE

SUBCOMMITTEE ON HEALTH
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HEARINGS ON THE HOSPITAL COST CONTAINMENT ACT OF 1977
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INTRODUCTION

My name is Anthony G. Weinlein. I am the Secretary-Treasurer of the Service Employees International Union. I am here today representing George Hardy, President and the members of Service Employees.

We are presenting a joint statement today with the National Union of Hospital and Healthcare Employees, a division of RWDSU. Our two organizations are the major trade unions representing workers in the hospital industry.

Mr. Moe Foner, Executive Secretary of the National Union of Hospital Employees, will represent Leon Davis, the president, and the members of that union.

Also with us is Dr. Stanley Wisniewski, Research Director for the Service Employees.

I have a short opening statement to make.

STATEMENT

I want to thank you for the opportunity to testify today. Our unions, together representing over 350,000 healthcare workers, fully support the Administration's decision to slow down the rapid increases in the price of medical care.

Inflation in the healthcare industry is a critical problem, especially to the many low wage workers who are members of our unions. The real answer to this problem is a program of national health insurance.

Short of this, we approve of the Carter Administration's approach in S.1391. There are, however, a number of very critical problems in this legislation which we would like to discuss.

Our main concern is that the proposed program should not be used to interfere with free collective bargaining in the hopsital industry nor to hold down the wages of hospital workers while prices continue to rise.

As representatives of hospital workers, we have been saying for a long time that the rapid increases in the cost of medical care are not, in any way, attributable to hospital labor costs. This has been documented time and again--most recently by the Council on Wage and Price Stability last year.

Because they recognized this fact, and the fact that hospital workers are still severely underpaid, the Administration's bill, in Section 124, allows a hospital an adjusted revenue limit to permit wage increases for non-supervisory personnel, as defined in the National Labor Relations Act.

We fully support the intent of this section as an essential part of any program of cost controls. To do otherwise would represent an unwarranted interference with the rights of hospital workers to engage in free collective bargaining--a right that was finally accorded them in the 1974 amendments to the National Labor Relations Act.

We are very concerned, however, about the application of Section 124.

First, we believe that Section 124(a), as it is now written, unfairly gives such an exemption only at the discretion of hospital administrators.

Our unions would like to see labor costs, as reflected by the wages of non-supervisory workers, and non-labor costs treated separately. This would require the Secretary to modify, for each hospital, the revenue increase limit, to reflect whatever change there has been in the cost of labor.

By that device only non-labor costs would be limited by the revenue increase ceiling. This would avoid having non-labor hospital costs, which have been the cause of rapid inflation, exceed the limit--at the expense of the hospital workers.

As Section 124(a) now reads, hospitals are given an incentive to keep wage increases below the allowable level in order to permit more of the increase to go to capital expenditures and the like. This gives hospital managements additional leverage at the bargaining table at the expense of their employees. It is clearly a loophole in the cost containment program.

Secondly, we oppose inclusion of Section 124(d). This paragraph essentially gives the Secretary of Health, Education and Welfare the power to eliminate Section 124 after 18 months. If there needs to be a review of this program at that time, all aspects should be reviewed, not just this section. Furthermore, Congress is the proper place for review.

Thirdly, we are completely opposed to Section 117, which would permit states to run their own programs. It would be a terrible mistake to permit this loophole to remain.

As it was originally planned, Section 117 was designed to permit those states which <u>now</u> run their own programs,

and have done so for some years to continue to do so. Four states now have their own programs. Massachusetts, Connecticut, Maryland and Washington.

As the section was written, however, especially under Section 117(b), any state could run its own program for a year, and then qualify for a Federal exemption. In other words one year after the enactment of this legislation we could have 50 states running separate programs, each with different standards. Clearly this waiver section could undercut the entire federal program.

More important, in our view, is that exempted states would be allowed to indirectly control wages, contrary to the Federal law. If you do permit state exemptions, states which are exempted must be required to meet all the criteria of the federal program including being required to exclude the wages of non-supervisory workers from their programs.

Our two unions and the rest of organized labor are firmly opposed to <u>any</u> type of wage controls, as is the Administration. And we oppose any attempt to sidestep this issue by allowing some states to sneak controls in the back door.

Most hospital workers are wage workers and, until just recently, many were excluded from the protection of Federal collective bargaining law.

The wages of these workers have just now begun to catch up after years of exploitation. It is the right of these workers to be involved in determining their own wages and working conditions without government-imposed limits or standards.

Hospital workers are still underpaid and exploited in this industry. Their wages are clearly not the cause of hospital inflation. They should not be forced to bear the burden of fighting outrageous cost increases. And they certainly should not be singled out as the only group of workers in the United States to suffer the restraint of having their wages controlled.

With regard to other portions of the proposed legislation, our second major concern is the almost total lack of any requirement for financial disclosure by the hospitals.

Financial disclosure is the key to a workable program of cost control. This industry receives well over half its revenues from public sources. But who watches how this money is spent?

This is a critical consumer issue. We need to expose the scandalous financial dealings in this industry. Collusion and conflict of interest within the healthcare system is widespread. Doctors, hospital administrators and the insurance companies together control the healthcare costs of every American.

Consumers have almost no choice in either the decision to purchase medical care, or in the decision of what to pay for that care. In both cases the decision is made by the people who supply the care, and who benefit from higher and higher costs.

Both the consumer and the taxpayer should know how their medical care dollar is being spent.

We urge the Congress to require, at a minimum, of all hospitals, that information which is presently required of all non-profit hospitals by the Internal Revenue Service. This would include the total compensation of all officers and trustees of the hospital, as well as the salaries of high paid specialists on the staff.

In addition, Section 125 should require a full financial statement including a breakdown of receipts and expenses, as well as total assets and liabilities.

In addition to these major concerns with the exemption of non-supervisory wages, the state waivers, and financial disclosure, we also feel strongly that the Congress should avoid covering public hospitals with S. 1391.

You are well aware of the severe financial problems facing state and local governments today. Public hospitals have been hit very hard.

Often they must provide medical care to the poor and elderly when other hospitals refuse. Their costs are, therefore, much higher, and their revenues much lower.

We are very worried, in addition, that despite the safeguards in this bill, private hospitals will begin dumping their "less profitable" patients into the public hospital system.

Many public hospitals now are cutting services, laying off workers in order to get by on limited funds. To further restrict their funds would severely affect those people most dependent upon public healthcare.

Hospital workers, more than anyone, want to support this program. They care deeply about the quality and availability of healthcare for all our citizens. But the Congress must realize that most of them are still unwillingly subsidizing the healthcare system through their low wages.

All they are asking for today is that they be treated as equitably as all other American workers. Let those who control the cost and access to healthcare do their share to stop this outrageous inflation.

Thank you.

I'd now like the Research Director of the Service Employees, Dr. Wisniewski, to briefly summarize some of the technical material we have included in the appendix to our statement.

STATEMENT OF STANLEY WISNIEWSKI, RESEARCH DIRECTOR
SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO

The Service Employees International Union's membership is composed of nearly 600,000 workers in private industry and the public sector. The National Union of Hospital and Healthcare Employees and the Service Employees together represent more than 350,000 healthcare workers.

All of the workers we represent are deeply concerned by the upward spiral of healthcare costs. Clearly, there is something seriously wrong with our present healthcare delivery system when workers who we represent in such cities as Detroit and Syracuse see the equivalent of 4½ weeks' wages go to cover the cost of their hosptial bills while, just a short distance away in Canada, workers who we represent in the same occupations in such cities as Windsor and Belleville, Ontario have only half as much in weekly wages claimed by hospital costs. Many of our members are low-wage service workers, and, consequently, find it difficult to cope with the rising cost of medical care. Indeed it is ironic that among the workers hardest hit by healthcare inflation are healthcare service workers whose wages still remain below the level of earnings enjoyed by workers in most other sectors of the economy.

The average non-supervisory hospital worker earned $4.18 an hour in 1976--a rate lower than the average wage earned in the service sector, in manufacturing, or in the private

economy taken as a whole (illustrated in Appendix A, Table I). Most healthcare workers - nurses, nurses' aides and service workers - are inadquately paid and find it difficult to shoulder the burden of rising healthcare costs. Based on a forty-hour week, the average nonsupervisory worker's annual salary in 1976 would have approximated $8,694. By comparison, in Autumn 1976, the U.S. average cost of the lower budget for an urban family of four was $10,041, a year while the intermediate and higher levels were $16,236 and $23,759 respectively.

As a result of the inadequate wages received by healthcare workers, the gap between their earnings and the price of medical care has widened over the years. During the past ten years, hospital room rates have risen nearly twice as fast as hourly wages (see Appendix A, Figure I).

While medical expenditures have skyrocketed over the past fifteen years, less and less of the hospital dollar was spent on labor costs each year. This trend is remarkable in view of the ever-rising demand for more and better skilled healthcare workers throughout the period. The number of healthcare workers employed in hospitals increased from 1,763,000 in 1962 to 3,023,000 in 1975 and the number of workers per 100 census (average daily hospital census) more than doubled to 269 employees per 100 census. In addition, the types of healthcare workers and the skills they possess have been dramatically upgraded with the introduction of new paraprofessional and technical positions. Yet, notwithstanding these huge increments in both the quantity and quality of hospital manpower, payroll expenses have steadily declined as a proportion of total hospital expenses from 66.5

percent in 1962 to 51.1 percent in the last quarter of 1976.

Total labor costs in the hospital industry now account for a little more than half of operating costs and the salaries of administrative and supervisory personnel account for roughly one-third of these labor costs. In other words, nonsupervisory labor costs currently absorb approximately 35 percent of total hospital operating costs.

The available evidence clearly demonstrates that nonsupervisory labor costs, whether union or non-union had little to do with inflation in healthcare prices. For example, the Council on Wage and Price Stability recently released a study which estimates that limiting the rise in the rate of earnings increase of hospital employees to the increases experienced by all private nonfarm production workers over the 1955-75 period would have only reduced the annual rate of increase in average cost per patient day from 9.9 percent to 8.8 percent.[1] In other words, total labor costs were the source of only about one-tenth of the annual increase in hospital costs.

Other recent studies of hospital worker wages which focus on only collectively bargained wages indicate that the union impact on hospital costs appear to be in the range of 1 - 2 percent.[2] Moreover, while unionized hospitals pay higher wages thay may experience lower labor costs because, unlike their nonunion counterparts, they are troubled less by high labor turnover rates.

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[1] Martin Feldstein and Amy Taylor, The Rapid Rise of Hospital Costs: A Staff Report of the President's Council on Wage and Price Stability, January, 1977, p. 17.

[2] Myron D. Fottler, "The Union Impact on Hospital Wages," Industrial and Labor Relations Review, Vol. 30, No. 3, p. 354.

With about 18 to 20 percent of all hospital workers organized and with total payroll costs representing roughly 51 percent of operating costs, organized labor accounts for only 10 percent of hospital costs. Clearly, this is too small a portion to have had a significant impact on health-care inflation.

Collectively bargained wage increases in the healthcare industry have not been excessive as indicated by the data provided in Appendix A, Tables II, III and IV. The average increase[3] which became effective during 1975, in SEIU and District 1199 (RWDSU) contracts was 7.8 percent. For 1976, the average increase was 4.3 percent. To date, in 1977, those increases which have occurred or are expected to occur on the basis of previously negotiated settlements average 4.2 percent. These increases can hardly be termed excessive inasmuch as the effective wage rate changes reported by the Bureau of Labor Statistics for wage settlements in the private sector as a whole averaged 8.7 percent in 1975 and 8.1 percent in 1976.

Clearly, labor costs have played a minor role in pushing hospital costs upward. Healthcare workers are the victims of rising health costs as much as anyone else, or perhaps even more so, since they are less able to afford such price increases. Workers engaged in manufacturing earn at least a full dollar more

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[3] A weighted average increase including both first year adjustments and adjustments resulting from prior settlements (based on Appendix A, Tables II, III and IV).

than the average hospital worker. In actual dollars and cents, hospital workers gained only $1.39 in increased hourly wages since 1970, while the average worker in the private sector increased his earnings by $1.65. Therefore, we believe that a hospital cost containment program should not promote inequitable wage treatment for hospital workers, but rather it ought to be directed towards controlling the real sources of hospital care inflation -- mismanagment, poor planning, and wasteful duplication of services.

In order to effectively attack the major determinants of hospital inflation, limits need to be established directly on the rate of increase in administrative costs and capital expenditures. Unfortunately, S. 1391 contains a serious flaw which may prevent it from being effective in controlling the major sources of healthcare inflation.

Section 124 which purports to exempt wage increases for non-supervisory personnel from the hospital revenue limit, instead provides hospitals with an incentive to continue to increase expenditures in those areas which have been most responsible for healthcare inflation. This horrendous loophole is created by the optional nature of the adjustment to revenue limits offered in Section 124. According to this provision, if hospitals request a modification of their revenues to eliminate the effects of non-supervisory wages, then non-labor costs can only rise by the permissible limit,

which may be 9 percent. If, on the other hand, a hospital does not request such a modification, then it is possible for non-labor costs to rise as much as 14 percent by shifting the burden of the program onto the shoulders of low-wage workers through a refusal to grant any wage increase. A numerical example which illustrates the problem is provided in Appendix B.

To overcome this serious problem, a revenue limit based on separate calculations of non-labor costs and nonsupervisory labor costs would have to be made for all hospitals, not merely those making requests. In other words, if non-labor costs which are responsible for healthcare inflation are to be held to a 9 percent rate of increase, the Secretary of the Department of Health, Education and Welfare must be required to modify the in-patient hospital revenue limit for all hospitals to permit separate treatment of wage increases. If every hospital were subject to this adjustment, then the 9 percent cap on non-labor costs would hold the effect of the actual increase on such expenditures to 5.85 percent (9 percent x 65 percent).[4]

Briefly then, the examples provided (in Appendix B) serve to illustrate why we believe Section 124 (a) needs to be amended by deleting the language: "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," and instead begin with language which reads:

[4] See Appendix B

"The Secretary shall modify...." Furthermore, the same sort of mechanism for making this adjustment ought to exist in any state cost control program as a criteria for eligibility for waiver from the Federal program in order to guarantee the effectiveness of state efforts to control the major sources of healthcare inflation.

Evidence from the experience with some state programs shows the necessity for adherence to this particular Federal standard. In the state of Maryland, where the state cost review commission became operative in 1974, the available data shows: (1.) that total operating costs increased at a faster rate than the national average in 1975; (2.) that the only element of operating costs in Maryland that rose slower than the national average in 1975 was payroll costs; and (3.) that non-payroll costs, which are most responsible for healthcare inflation, increased 26.5 percent in Maryland or nearly 4 percent more than they did nationally. In short, the Maryland experience indicates that non-labor costs continued to explode at the expense of wages.

Another necessary ingredient for an effective cost containment program is full disclosure of financial and price information. Disclosure is a key element in promoting a more efficient allocation of hospital resources.

The demand for services in the hospital industry is somewhat unique insofar as it is controlled largely by physician providers, rather than by consumers. Physicians have direct control over the number of patients admitted to the hospitals and the types of services they receive. Moreover, physicians indirectly control other aspects of the hospital's operations such as capital spending and the level of nursing care.

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One of the reasons why consumers exercise so little influence over the demand for and the price of hospital services, is that they are uncertain about judging the quality of services themselves and, consequently, defer to the judgment of the experts. Carried to an extreme, the result of this practice is to identify quality with price. In other words, a high price is often viewed as the consumer's assurance of quality medical care. Yet another reason why consumers seem to make so little effort to shop around for hospital services is that there is hardly any information available to help the consumer to make rational choices. The costs of administrative inefficiency, underemployment of expensive equipment, and excessive payments to provider subcontractors are hidden from the consumer in room rates and other seemingly legitimate hospital charges.

Without complete and accurate information about the actual cost of specific hospital services, consumers have no basis for evaluating the choices that may exist. Indeed, consumers may not even be aware that a choice is available. It is precisely this lack of information that permits providers to tightly control the demand for healthcare services. It insures that demand is insensitive to upward price movements. Therefore, a key element in any plan to control hospital cost inflation ought to be full financial disclosure. S. 1391 is terribly inadequate in this regard. Clearly, a substantially strengthened financial disclosure provision is in the public's interest.

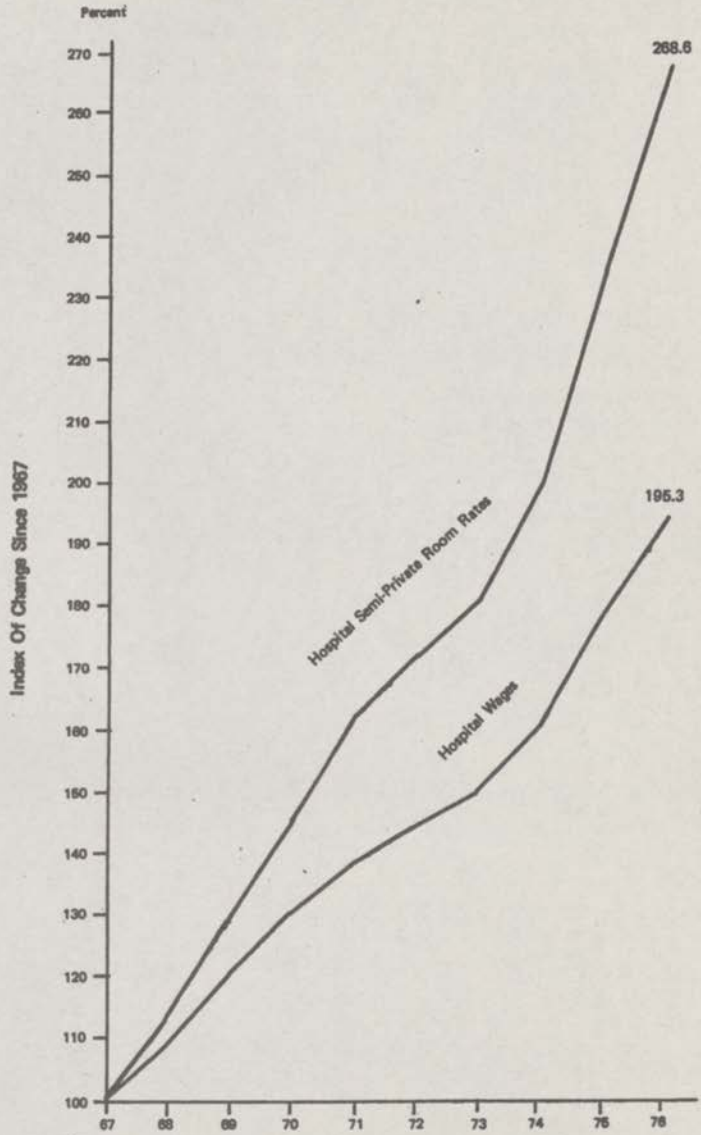
APPENDIX A

TABLE I. Average Hourly Earnings
(Non-supervisory employees)

	Total Private	Service	Hospitals
1968	$2.85	$2.43	$2.31
1969	3.04	2.61	2.57
1970	3.22	2.81	2.79
1971	3.43	3.01	2.96
1972	3.65	3.40	3.08
1973	3.92	3.46	3.22
1974	4.22	3.76	3.45
1975	4.54	4.06	3.83
1976	4.87	4.36	4.18
Dollar Increase 1968-76	$2.02	$1.93	$1.87

Source: Bureau of Labor Statistics

Fig. 1 Hospital Room Rates Increased 1.8 Times Faster Than Hospital Worker Wages



Source: Computed from Bureau of Labor Statistics Data

TABLE II. SEIU COLLECTIVELY BARGAINED HOSPITAL AGREEMENTS

State	Increase Dates	Unit Percent Increase	Percent Increase, Selected Occupations				
			Nurse's Aide	Maid	Porter	LPN	Other
CALIFORNIA				Hskp.aide			
14,900 employees	1976	8.2%	8.5%	8.7%		8.1%	
(more than 26 hosps.)	1977	7.2	7.2	7.4		7.1	
	1978	6.8	7.4	7.6		7.0	
COLORADO			Clinic aide				
272 employees	1975	11.0	11.0			11.0	
(1 hospital)	1976	12.0	12.0			12.0	
	1977	6.5	6.5			6.5	
	1978	6.0	6.0			6.0	
DISTRICT OF COLUMBIA							
1,700 employees	1975	9.7	11.0	11.0		9.2	
(1 hospital)	1976	6.3	7.1	7.2		6.0	
	1977	7.1	7.3	8.0		6.8	
ILLINOIS							
4,021 employees	1975	7.4	7.1	6.8			
(3 hospitals)	1976	7.9	8.0	7.3			
	1977	6.2	5.8	7.9			
MASSACHUSETTS							
330 employees	1976	8.0	8.0	8.0	8.0	8.0	
(1 hospital)							

State	Increase Dates	Unit Percent Increase	Percent Increase, Selected Occupations					
			Nurse's Aide	Maid	Porter	LPN	Other	
MICHIGAN							RN's	Med. Tech's
				Maid/Porter				
2,327 employees	1975	8.2%	8.1%	7.7%		10.1%		
(6 hospitals)	1976	6.4	7.1	7.1		6.3	7.8%	5.6%
	1977	5.9	6.5	6.5		5.4		2.1
	1978*	4.4	4.6			4.5		
MINNESOTA								
5,000 employees (20 hospitals)	1976	5.0	5.3	5.3				
MISSOURI								
500 employees	1976	10.6	11.4	11.4				
(1 hospital)	1977	9.6	10.2	10.2				
NEW YORK								
6,000 employees (14 hospitals)	1976	5.0	5.0	5.0	5.0	5.0		
OHIO								
2,391 employees	1975	6.4	6.6	6.9	6.5			
(4 hospitals)	1976	6.6	7.5	7.9	6.8			
	1977	7.1	8.2	8.7	8.2*			
	1978	7.0	7.2*	7.8*	7.6*			

* One hospital

State	Increase Dates	Unit Percent Increase	Percent Increase, Selected Occupations				
			Nurse's Aide	Maid	Porter	LPN	Other
				Hskp.			Clericals
OREGON							
980 employees	1975	8.0%*	8.6%	8.5%		8.0%	9.0%
(4 hospitals)	1976	7.3	7.3	7.7		7.7	7.0
	1977	7.1	7.0	7.0		7.4	7.1
	1978	6.7	7.0	6.7		7.0	6.8
PENNSYLVANIA							
650 employees	1976	11.3	11.0	12.4		9.8	
(5 hospitals)	1977	8.8	10.0	7.6		9.6	
	1978	10.4	13.1	8.7		11.4	
WASHINGTON							
760 employees	1975	8.0	9.2	9.2			
(3 hospitals)	1976	8.2	9.7	9.3		9.5	
	1977	7.5	7.2	7.3		7.6	

* One hospital

TABLE III. DISTRICT 1199/RWDSU

COLLECTIVELY BARGAINED HOSPITAL AGREEMENTS

State	Percent Wage Increase		
	1975	1976	1977
MARYLAND			
6,500 employees	7.0%	3.8%	
NEW JERSEY			
5,000 employees	8.8	6.0	
NEW YORK			
40,000 employees	7.4	0	3.5%
PENNSYLVANIA			
9,000 employees	10.0	10.0	

TABLE IV. SUMMARY: SEIU AND DISTRICT 1199/RWDSU COLLECTIVELY BARGAINED HOSPITAL WAGE INCREASES

	1975	1976	1977
SEIU weighted average	7.8%	7.1%	7.1%
DISTRICT 1199/RWDSU weighted average	7.8	2.4	3.5
SEIU and 1199/RWDSU weighted average	7.8	4.3	4.2
SEIU and 1199/RWDSU median	8.1	7.6	7.1
SEIU and 1199/RWDSU range	6.4-11.0	0 -12.0	3.5-9.6

Source: Derived from Tables II and III.

APPENDIX B

Examples I and II:

Numerical examples demonstrate flaws in the optional nature of proposed S. 1391, Section 124. If hospitals request a modification of their revenues to eliminate the effects of non-supervisory wages, then non-labor costs can only rise by the permissible limit (e.g. 9%). If, on the other hand, a hospital does not request such a modification, then it is possible for non-labor costs to rise by as much as 14% by shifting the burden of the program onto the shoulders of low-wage workers by not granting such workers any increases.

The following numerical examples illustrate the problem.

Assumptions:

1. Nonsupervisory labor costs = 35% of total operating costs.
2. Non-labor expenses plus administrative salaries = 65% of total operating costs.
3. CAP = 9%

I. If a hospital requests a modification of the in-patient hospital revenue increase then under the formula discussed in Section 124(b) the following calculations would be made:

Non-labor cost cap 9% x .65 = 5.85

Labor costs assuming rise of 9% x .35 = 3.15

Total Increase 9.00%

II. If, however, a hospital does not request a modification under Section 124, then the 9% cap is applied on the basis of total revenues. Therefore, if a hospital can hold wage increases to 0% the net effect is as follows:

Labor costs held to 0% x .35 = 0%

Non-labor costs rise by 13.85% x .65 = 9%

Total Increase 9%

In other words, non-labor costs which have been the source of healthcare inflation would increase by nearly 14%.

STATEMENT OF
MOE FONER, EXECUTIVE SECRETARY
NATIONAL UNION OF HOSPITAL AND HEALTHCARE EMPLOYEES, RWDSU, AFL-CIO

The disclosure of fiscal information provisions of Section 125 are totally inadequate. If adopted, hospital finances would be left exactly where they are--completely in the dark.

Americans spend more than one hundred billion dollars each year to buy health and related services. Most of this money goes to hospitals and doctors. Nearly nine cents of every Federal dollar goes for hospital care.

Are we getting our money's worth? Are the hospitals spending the money wisely?

In most cases the public can't really tell. In the matter of finances, non-profit hospitals are virtually closed worlds, answerable only to themselves. It's often more difficult to find out how hospitals spend their money than it is to get a financial rundown on the CIA.

This is true even though non-profit hospitals are built with federal funds, supported by community contributions and receive tax-exempt status. Today, most of their funds come from the federal and state government in the form of Medicare and Medicaid.

But unlike publicly traded companies regulated by the Securities and Exchange Commission (SEC) or labor unions regulated by the Labor Department, hospitals aren't required by law to make detailed reports on their finances. Facts and figures that corporations and unions are legally required to make public as a matter of routine are not available from hospitals.

Because of this, the suspicion has grown that hospital secrecy

hides wasteful spending and corruption. In some cases these suspicions have been dramatically confirmed.

Among the practices believed to be sealed inside many closed hospital financial records are:

- business dealings with hospitals that provide special advantages to the private businesses of hospital trustees;
- outrageously high salaries and fringe benefits to hospital administrators;
- lucrative franchise operations for pathologists, radiologists and anesthesiologists.

The Long Island newspaper Newsday concluded last year after a study of some of the above abuses that "Non-profit hospitals aren't legally required to tell you many things about the way they're run--and that could be dangerous to your physical and fiscal health."

CONFLICT OF INTEREST

Hospital trustees often engage in business transactions involving their private firms and the hospitals they serve. No federal or state law forbids this. Is it a conflict of interest? In most cases, there is no way to find out.

The Newsday study of Long Island hospitals in October, 1975 found that "some hospital trustees are key employees of banks (and) investment houses...that have accounts as large as $15,000,000 with their own medical institutions."

In 1973, the Washington Post revealed that a District of Columbia hospital kept more than $1,000,000 in non-interest-bearing accounts at

its trustee members' banks. It has also been charged that trustees have conflicts of interest when dealing with hospitals in such fields as insurance, linens, real estate, food service, and others.

Last year, the General Accounting Office reported finding trustees selling goods or services to their own institutions at 17 of 19 hospitals reviewed.

The GAO urged Congress to pass a public disclosure law requiring all hospitals receiving federal funds to reveal the dual interests of their trustees, as well as the extent of competition involved in awarding contracts.

Should we leave it to the hospitals to police themselves? That's what the hospitals would like. They have fought tooth and nail to prevent real disclosure legislation in the past and can be expected to continue in the future.

For example, the Newsday study said "many Long Island hospital trustees believe that their actions are not the public's business." Several hospital administrators and trustees "reacted with indignation when a reporter asked for full details of their trustees' dealings with their own hospitals," Newsday added.

The New York Times reported on Dec. 26, 1975, that 18 months after being asked by New York City Comptroller Harrison Goldin to respond to a questionnaire regarding conflict of interest, more than half of the voluntary hospitals and all of their trustees failed to do so.

There are many other examples which point up the need for effective legislation requiring non-profit hospitals to disclose their

finances to the public.

KENTUCKY FRIED CHICKEN SYNDROME

In addition to the administrators and doctors earning inordinately high salaries and receiving unusually liberal fringe benefits, a large number of hospital specialists do not work on a salary basis. Instead, they receive a percentage of their department's income under what has been described as the "Kentucky Fried Chicken Syndrome."

A hospital is constructed with federal funds. Then the hospital sets up pathology, radiology and anesthesiology departments and hires specialists, provides them with expensive equipment and covers their overhead.

But instead of operating these departments and billing the patient directly, many hospitals lease them out, just like a Kentucky Fried Chicken Franchise.

The GAO has estimated these specialists earn as much as 300 percent more than similar specialists who work for a straight salary. There is a special irony about "non-profit" hospitals sanctioning such profit-making arrangements, which carry the additional threat of over-utilization encouraged by profit-hungry specialists.

At a hearing of the Senate health subcommittee which he heads, Sen. Herman Talmadge (D.-Ga.) last summer read off the names of some pathologists and radiologists who receive from $100,000 to more than $400,000 a year for their services. "It is not really the hospital that pays for the pathologist, but the public as taxpayers, insurance policy holders and paying patients," he declared.

Sen. Talmadge pointed out that a part-time pathologist at the Washington (D.C.) Hospital Center made $200,000 in 1972 under a percentage contract arrangement and that this same physician also had a similar contract with another Washington hospital which refused to disclose the amount of compensation.

Referring to his information as "a clear pattern of data," the senator offered the following factual information:

"The pathologist at Union Hospital in nearby Elkton, Md., negotiated a $433,000 contract in 1975 for the provision of pathology and nuclear medical services. The hospital board was subsequently able to reduce this amount to $293,000. According to the Baltimore Sun, the hospital's attorney contended that the contract was set because, 'when you are dealing with a monopoly, you don't have much choice.'

"These are not isolated instances. St. Mary's Hospital in Cumberland, Md., was paying two pathologists $300,000 per year until the Maryland Rate Review Commission reduced this amount to $180,000.

"In rural Nebraska, a circuit-rider pathologist serving six small hospitals was compensated $70,000 from two of the six hospitals. This amount was verified from 1974 accounting information disclosed to us on a confidential basis. If the pattern is the same in all six hospitals that the pathologist served, his compensation would be over $200,000.

"Then there is the 33-bed rural hospital in California where the pathologist was allegedly compensated $198,000 after paying the hospital a mere $750 a month for the use of its facilities.

"I am not just singling out pathologists. A similar situation can be found in the compensation of radiologists under percentage

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arrangement. For example, a 424-bed hospital in Pennsylvania, where the chief radiologist was compensated $200,000; South Amboy Memorial, a 95-bed hospital in New Jersey, compensated its radiologist $201,000 in 1975; Morristown Memorial Hospital in New Jersey, a 495-bed facility, compensated 4.7 radiologists $571,000 for an average of $121,000 each."

Specialists with such astronomical incomes are understandably reluctant to have the public find out how much they earn.

"The disclosure of this type of information is a very dangerous political weapon...Complete disclosure of salaries...(would result in) the problems of wealthier people who have been subjected to harassment, even kidnappings," testified Eugene Van Voorhis, a lawyer for the New York York State chapter of the American College of Radiology, at March 6, 1974 State Health Department hearings in Albany on disclosure legislation. Van Voorhis complained that disclosure of large salaries would "play upon the widespread jealousies of lesser-paid individuals."

LAVISH ADMINISTRATORS' SALARIES

The absence of public accountability may also account for a salary and fringe benefit structure for top hospital administrators and physicians that often surpasses those of the largest corporations.

"Do the fringes and so-called perks (perquisites of office) accorded hospital administrators include limousines and chauffeurs?

"Do they include rent-free and maid-serviced penthouses and private houses?

"Do they include annuities, pensions and expense accounts, and are their children offered music and dance lessons and free college tuition?"

These are questions that deserve answers. These are questions that labor has been asking for years. And these questions were asked in a recent New York Times article, March 20, 1977, which described the growing public concern about hidden luxuries enjoyed by hospital administrators paid for with public funds.

Because the precise facts are not available, the Times' information is severely limited to what can be obtained from private sources and an occasional public hearing.

For example, the New York City Council Health Committee heard testimony last June that:

A former director of community medicine at Long Island Jewish Medical Center was paid a total of $107,000 a year in salary and fringes which included a 17 percent non-contributory and fully vested annuity and a $250,000 life insurance policy.

The Times' reporter did ask several hospital administrators about their pay and benefits. Here are some of the answers:

-Dr. Ray E. Trussell, director of Beth Israel Medical Center, receives an annual salary of $82,000. He also gets an auto and a driver and a rent-free duplex apartment with housecleaning provided by the hospital. It is reported that the maid service for his apartment and his chauffeur are hidden inside the hospital's budget.

-R.N. Kerst of Columbia-Presbyterian Medical Center gets $91,785 a year. Presbyterian says it provides him no fringes other than the standard pension plan for hospital officials. The hospital did not explain what the benefits of that pension are.

-Dr. David D. Thompson, director of New York Hospital, receives $85,000 a year plus a rent-free six-room apartment that he rarely uses because he lives in nearby New Jersey.

-Dr. Martin Cherkasky, head administrator of Montefiore Hospital, is paid $80,042 a year, He also receives a rent-free brick home including utilities and maintenance, a hospital-paid insurance policy, a Buick sedan and driver, plus an expense account.

-Dr. S. David Pomrinse of Mount Sinai Hospital wouldn't tell the Times what he earned. He is reported to receive $125,000, a rent-free penthouse and a Cadillac.

Indications are that pay and fringe benefits like these are topped off in many cases by free life insurance policies worth twice the administor's annual salary and annuities for which hospitals regularly pay 17 percent of the administrator's salary.

Hospitals have also been conducting anti-union campaigns and obtaining $500-a-day reimbursement from Blue Cross and Medicaid in order to pay "labor consultants." More than $150,000 of public monies ended up with an outfit in Massachusetts a few months ago.

In New York funds paid to the League of Voluntary Hospitals and Homes to represent some 45 hospitals in collective bargaining are also covered by public funds. In addition, these same hospitals spend more than a million dollars a year for labor relations attorneys--monies for which the institutions are reimbursed as a "reasonable" expense.

But nowhere in any of these institution's reports can one find how much is paid to whom and for what purpose.

CURRENT DISCLOSURE LAWS INADEQUATE

Hospitals were once strictly charitable institutions that gave free care to the poor and were financed entirely by religious groups and/or wealthy public-spirited citizens. Today, however, less than one percent of their funds come from private sources. And with public funding has come a dramatic increase in size. For example, The Presbyterian Hospital of New York, with over 1,000 beds at more than $200 a day and employing more than 5,000 employees, just misses making Fortune magazine's list of the nation's 500 largest companies. Presbyterian, along with Beth Israel and Mount Sinai Hospitals are among "the largest landlords in the city," New York City Councilman Carter Burden told a Senate subcommittee last summer. He pointed out that the vast real estate holdings of these voluntary hospitals are tax exempt.

But despite these changes in the nature of voluntary hospitals, there has been no major change in the legislation dealing with financial disclosure by hospitals.

WHAT SHOULD BE DISCLOSED

We submit the following specific recommendations to be included in an amended Section 125. The financial disclosure section should include:

1. A full financial statement including breakdown of receipts, expenses and disbursements as well as total assets and liabilities (equivalent to IRS for 990).
2. Identification of all employees receiving more than $30,000 per year including job title and actual total compensation (wages and fringe benefits).

3. Listing of others who received in excess of $30,000 per year for professional services rendered including a description of the type of service rendered and total compensation received.
4. A listing of trustees, their names and private businesses as well as statements regarding any conflict of interest.
5. A listing of the hospitals' major vendors and the amount of money they receive.
6. Supporting data similar to that required by IRS form 990.

We are attaching a copy of a hospital financial disclosure bill passed this week by the New York State Assembly. We believe this bill contains all the necessary requirements referred to above.

CONCLUSION

A study by two Columbia University sociologists published by the Center for Policy Research in January 1976 called for legislative and regulatory controls over non-profit health institutions to combat "profit-making abuses." The study called attention to "omissions, ambiguities and loopholes" in the laws affecting these institutions which make it possible for all types of abuses to exist.

A real disclosure law would lay to rest the myth that places a major share of the blame for skyrocketing hospital costs on the workers. For too long hospitals have responded to critics by claiming that labor represents 60 to 70 percent of their costs.

Hospitals are labor intensive institutions. They operate seven days a week, 24 hours a day. They must have large staffs of employees

with hundreds of different skills.

But once you remove the top administrators, supervisors and doctors from the total you get a different picture. For example, a study of one of the largest teaching hospitals in New York City reveals that the unionized sector (service, professional, technical and clerical employees) which is 52 percent of the entire work force represents only 40 percent of the payroll. Voluntary institutions have for too long hidden "profit-making abuses" behind a shield of secrecy. Those institutions that are free of these abuses owe it to the entire health care industry to join with labor and other consumer-oriented groups in seeking effective disclosure legislation that would remove voluntary hospitals from the grey area of suspicion they now occupy.

S. LBD7-36-287

SENATE

IN SENATE--Introduced by

--read twice and ordered printed, and when printed to be committed to the Committee on

A.

ASSEMBLY

IN ASSEMBLY--Introduced by

--read once and referred to the Committee on

AN ACT

to amend the public health law, in relation to disclosure of financial transactions of general hospitals

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Section twenty-eight hundred five-a of the public health law, as added by chapter three hundred ninety-three of the laws of nineteen hundred seventy-three, is hereby amended to read as follows:

Sec. 2805-a. Disclosure of financial transactions. Every general hospital operating under the provisions of this article shall file with the commissioner of health within one hundred twenty days after the end of its fiscal year a certified report showing its financial condition and all of its financial transactions, including receipts and expenditures during the fiscal year.

The report shall be in such form as shall disclose all financial transactions as the commissioner of health may determine necessary to disclose accurately and specifically the financial condition of each hospital and its expenditures for the preceding year including but not limited to:

(a) Its operations and accomplishments.

(b) Its receipts and disbursements, or revenues and expenses, during such fiscal year in accordance with generally accepted accounting principles by categories, clinical services and departments as set forth under the by-laws of the institution and including but not limited to salaries and other benefits, personnel expenses, operating expenses, equipment and supplies, and all other direct and indirect disbursements allocated to each department and clinical service. Information regarding salaries shall detail the name and job title of each salaried employee earning twenty thousand dollars or more. The names and addresses of each vendor receiving disbursements from such institution in excess of one thousand dollars in any fiscal year shall also be detailed.

(c) The name and address of each of the trustees, the nature of their business if any and whether or not the trustee is directly or indirectly involved in doing business with the

institution of which he is a trustee and if so, the dollar amount of such business.

(c) (d) Assets and liabilities at the end of its fiscal year including the status of reserves, depreciation, special or other funds, and including the receipts and payments of these funds.

(d) (e) Loans and investments, interest, rents and profits from investments of the hospital.

(e) (f) The location of any real property owned by the hospital.

The commissioner may to effectuate the purpose of this article vary the nature of the report required according to the size or capacity of the hospital.

The contents of all reports submitted hereunder shall be public information and such reports shall be available for public inspection under such conditions as the commissioner shall prescribe.

All books and records of account shall be preserved for a period of five years after the filing of the reports based on the information which they contain. The officers and agents required to prepare and file reports hereunder shall be responsible for the maintenance and preservation of books and records of accounts required hereunder.

The commissioner of health when he has reasonable cause to believe that the books or records do not accurately reflect the financial condition and/or financial transactions of the hospital, may examine the books and records of the hospital, subpoena witnesses and documents and make such other investigation as is necessary to enable him to determine the facts relative thereto.

If any clause, sentence, paragraph, or other part of this section shall be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph or part thereof directly involved in the controversy in which such judgment shall have been rendered.

Sec. 2. This act shall take effect on the sixtieth day after it shall have become a law.

Senator KENNEDY. Our next panel consists of David D. Thompson, director of the New York Hospital and chairman, Council of Teaching Hospitals; David Everhart, president, Northwest Memorial Hospital, and chairman of the Council of Teaching Hospitals, Association of American Medical Colleges; and Robert M. Heyssel, executive vice president and director of the Johns Hopkins Hospital, Baltimore.

STATEMENT OF DAVID D. THOMPSON, M.D., DIRECTOR, THE NEW YORK HOSPITAL, NEW YORK CITY, CHAIRMAN, COUNCIL OF TEACHING HOSPITALS, ASSOCIATION OF AMERICAN MEDICAL COLLEGES; ROBERT M. HEYSSEL, M.D., EXECUTIVE VICE PRESIDENT AND DIRECTOR, THE JOHNS HOPKINS HOSPITAL, BALTIMORE, MD., ACCOMPANIED BY JOHN A. D. COOPER, M.D., PRESIDENT, ASSOCIATION OF AMERICAN MEDICAL COLLEGES; AND RICHARD KNAPP, DIRECTOR, DEPARTMENT OF TEACHING HOSPITALS OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES, A PANEL

Dr. THOMPSON. I am David D. Thompson, M.D. This year, I am the chairman of the Council of Teaching Hospitals and director of the New York Hospital.

We have submitted a detailed statement of the association's position on S. 1391 for the consideration of the subcommittee and we would request that it be included in the record. In the interest of brevity, I will summarize the association's concern with S. 1391 and discuss recommended alternatives for containing hospital cost increases.

The AAMC and its members fully appreciate the fact that total national health expenditures and hospital expenses have increased dramatically in the past 3 years. We also appreciate the problems that these trends have created for consumers, insurers, labor and industrial organizations, and governments. We recognize that there is a need to reduce the rate of increases in health care costs and are willing to work constructively with all parties to develop, promote, and advance cost containment programs which are practical, equitable, administrable, and which insure high quality patient care. The AAMC is opposed, however, to the program of arbitrary revenue and capital expenditure limitations recommended by the administration.

The $2.5 billion ceiling on capital expenditures is completely inadequate to provide for the capital expenditures necessary merely to meet the requirements of national, State, and local regulations and codes and to meet the capital requirements of obsolete facilities essential to patient care.

The AAMC is opposed to the imposition of a cap on hospital renevues when no other segment of the economy is similarly controlled.

Senator KENNEDY. Dr. Thompson, unfortunately, I am not going to be able to stay for the testimony, but could I just ask the panel a question?

I understand you have some substantial concerns about the direction of this legislation.

It has been our experience up in New England, specifically in Massachusetts, at Massachusetts General Hospital, that last year their increases were 10 percent. With the kind of capitation that has

been discussed I am not hearing complaints from the teaching hospitals in my own State on this particular issue.

I am wondering whether there are some special matter of concern here in terms of the New York situation?

I am sure a lot of people would prefer not to have the capitation but why does it appear to be more of a problem in terms of New York than in terms of the teaching hospitals in my own State?

Dr. THOMPSON. Well, I don't think that the problem in Massachusetts is generically different for the teaching hospitals. New York State, as the Commissioner has just reported, has had some unique problems which require them to approach it as described, in an attempt to control the cost.

You have to take a look at what they are doing and what types of patients they are treating and how are they going to be able to take on additional tertiary care patients under the regional plan if you do have a cap that is an across-the-board cap? And by the same token, those hospitals which are no longer providing those services, Mr. Chairman, do not necessarily need to have the same increase. So that I would say that our concern here is the equitable control of the situation. And we think this can be done.

New York State, as the Commissioner has described, has approached it by looking at peer groups of hospitals and then establishing ceilings in relation to that.

Senator KENNEDY. You do not think the exceptions provisions are adequate to deal with it?

Dr. THOMPSON. I would think not, because the legislation does not include in it a recognition of the differences in the types of patients that we care for. The exception procedure really is not targeted, as I read it, toward looking at that matter. It really has more to do with whether or not the fiscal viability of the institution has been threatened.

What we are suggesting is that we take a look at the classifications of hospitals; establish appropriate groups; and then when that is done, it is possible to put ceilings on their costs, which I think will—as they have in New York State—effect a significant cost control. It is a more equitable way and really deals with the problem of regionalization of care, which is a critical way of maintaining quality while at the same time keeping the costs——

Senator KENNEDY. If we implemented your recommendations, what do you think the savings would be?

Dr. THOMPSON. I cannot put a figure on it. However, you have heard some numbers this morning which I think probably maybe even surprised you. And, this has been possible in States with rate-setting commissions or, as in New York, where the State health department has established control. It seems to me that the evidence to date suggests that these various mechanisms are successful. I think if they are allowed to work in the States where they are set up, and under general Federal guidelines that this is probably a better way to go.

The tying in of the reimbursement to the planning process I think as a key concept here. That planning process is certainly best carried out in the States and in the regions. If it is done properly it will have in impact on reimbursement. I think this is the best way to be sure that you maintain quality while at the same time controlling the costs.

Senator KENNEDY. OK.

I think you have identified what has to be the basis for any ongoing continuing mechanisms. I could not challenge that. I think it makes a good deal of sense.

I think the real problem is that until we are able to get there with some kind of comprehensive health insurance; that we should see what can be done in the meantime to begin to save those billions of dollars.

We cannot make any mistake about that. If we are not able to do that, we are going to pay for it in other health costs and in a failure to provide other programs that are vitally needed.

Dr. THOMPSON. I do not think, Senator Kennedy, it would take a long period of time to establish this type of classification system. There is a good deal of experience in various States and that experience can be built upon to look at it nationally. I think, if it is approached that way—with due consideration of the peer groups of hospitals, that you can effect controls as readily as you can, Senator, by putting on an arbitrary cap that does not take into consideration the variations. This is the major concern we have. It is not that the percentage figure is right or wrong. It is, by its very nature as an across-the-board cap, Senator, not really going to satisfy the need to maintain quality, as we all would wish.

Senator KENNEDY. We will be glad to work with you.

Dr. HEYSSEL. Senator, if I could speak to that?

At the hearings in the House on this same bill, I appeared primarily pecause Johns Hopkins Hospital was cited by the Secretary as a hosqital which had a rate of increase in unit costs last year of about 10 percent—and is going to be below 9 percent this year.

At that time, I made the point that that was not done overnight. One of the problems with this legislation is that we set an arbitrary cap of 9 percent to be done in 1 year for all hospitals; and I think we have all struggled with increasing costs. We have all struggled to keep them down.

We had a program to achieve consideration, Senator, over a 3-year period. We were able to do so without large layoffs and certainly without any sacrifice in the quality of care. And, in fact, during that time, we initiated some new programs which were needed. But to do so without giving the industry a chance to respond in a graded, gradual, and realistic fashion, I think is going to be a real problem.

If I could just comment on the capital side, Senator, the same thing is true. You can save money by spending capital money in terms of saving operating costs sometimes. And I think the capital requirements that have been placed are going to create a great deal of difficulty in that same area; and that is because of the arbitrary nature of it.

Dr. THOMPSON. I would like to comment also about the capital side.

I think, as was stated earlier by several of the people, the problem in the inner cities with obsolete facilities is something that has to be looked at. I would suggest the committee look carefully at excluding from those capital limitations capital costs that are really mandated by government regulations, code requirements and various pieces of legislation. I think these should be excluded, as should the obsolete facilities which need to be replaced to provide optimum care.

Where the limitations should be imposed, in my view, is on the introduction of new services and new technology. And this is really what the HSA's have been asking to do and are in the best position in doing: to assess whether or not that new service or that technology should be introduced and where it should be introduced. I think it is possible to keep the capital expenditures within bounds but it should not include those mandated requirements and replacement or obsolete facilities.

Senator SCHWEIKER. Dr. Heyssel. In response to a question I asked Secretary Califano when he appeared before this panel, he gave me this answer: "Senator, if Johns Hopkins, the hospital that is one of the finest hospitals in the world and with the most sophisticated equipment in the world can operate at 9 percent, I think the rest of the hospitals in this country can operate at 9 percent."

Was the Secretary correct? If Johns Hopkins can do it can any other hospital do it?

Dr. HEYSSEL. Senator, when I testified in the House, I indicated first that I indeed did answer in the affirmative that Johns Hopkins could live within that 9 percent next year. I did that without understanding much of the rest of the law and, in fact, having never seen the law. I also indicated that while that might be true for my institution, which had worked very hard over a 3-year period to bring costs down that that might be exceedingly difficult for other hospitals for a whole variety of reasons. Second, I pointed out that the cap tended to discriminate against the institutions that were in fact operating reasonably efficiently as opposed to those that were not.

Now, I will also comment, just as I did a moment ago, that to ask hospitals that are currently operating at levels of 14 or 15 percent—for whatever reason—to suddenly cut back to 9 percent, Senator, cannot be done without some loss in services or quality in services. I just don't simply think it can be done that rapidly. I think there will be labor problems in many institutions and I think New York State is an example of what happens when an arbitrary limit of payments is put on.

I repeat that it would be exceedingly difficult for many institutions and would not be easy for us to operate within that limit.

Senator SCHWEIKER. In view of your concern about an arbitrary cap, which I share, do you have any alternative suggestions, doctor, that would achieve similar results?

Dr. HEYSSEL. I think that the testimony as outlined by the AAMC is a real start in that direction. Certainly the exposure of hospital budgets and the prospective rate review is in my judgment the way to go. If there is the necessity for an arbitrary cap, then I would make a much more gradual imposition.

I will also just say here that I do not think that labor costs for non-supervisory employees should be, as is written in this bill, passed through—whatever the level of cap that is put. That is, after all, a large part of our costs.

Senator KENNEDY. Do you favor national uniform accounting and reporting?

Dr. THOMPSON. Uniform reporting I think has a good deal of advantage because——

Senator KENNEDY. Excuse me?

Dr. THOMPSON. There are advantages to uniform reporting. If you are going to compare peer hospitals, you need to have uniform reporting of costs if you are going to be able to do that. Uniform accounting is another matter. I doubt it is really necessary for it does tend to make an inflexible system, which really reduces management's prerogatives in some degree. If they do not have the flexibility—and this is going to be more important as the costs are reduced—then uniform accounting could put a straitjacket around management which is not really needed.

So in summary we support the idea of uniform reporting. Uniform accounting, we think, at least as presently described, we think is unnecessary.

Senator KENNEDY. Do the other members of the panel have any reaction?

Dr. HEYSSEL. No.

Senator SCHWEIKER. What about classification of hospitals, which is part of the Talmadge approach? What is your assessment of that kind of provision?

Dr. HEYSSEL. Well, I feel very strongly that some classification of hospitals has to be done in any sort of regulatory system. One of the problems with this law is that it ignores that issue totally and makes the exceptions process exceedingly difficult. Hospitals are different by nature. Teaching or tertiary care hospitals are very different. And we are rapidly changing because of the thrust of regionalization. As an example, our neurology and neurosurgical services have grown enormously over the last 3 years. That is because in part we have had new technology. There should be a mechanism to allow exceptions for tertiary care hospitals, Senator, which will allow the regionalization process to go forward. Otherwise, it simply will not go forward.

I feel that there must be really some means of classification of hospitals, which has to do with their product or what they produce and do.

Senator SCHWEIKER. Would you suggest any specific criteria for classification?

Dr. HEYSSEL. I think there also needs, incidentally, to be classifications that take into the rural or inner-city nature of hospitals; that take in the question of sizes, of whether they have teaching programs and how many, that takes into consideration whether or not a hospital has within it a series of special-care programs, such as for burns, renal dialysis, open-heart surgery, neurological services of certain types.

Senator SCHWEIKER. Dr. Thompson, do you want to add to that?

Dr. THOMPSON. I agree.

I would say that generally speaking the items that Dr. Heyssel has mentioned are what have been used in New York State in order to determine the grouping of hospitals. So that "tertiary care hospitals" are defined as those hospitals of a certain size and teaching involvement and special services as Dr. Heyssel has described. I think it is a very reasonable approach and one which is worth looking at from the standpoint of developing the proper hospital classification.

Senator KENNEDY. If I could just get back to the other point.

What are your reservations about uniform accounting?

Dr. THOMPSON. Mainly, Senator Kennedy, having to do with establishing charts of accounts such that the management of the

hospital, in dealing with those accounts has flexibility in terms of how to utilize the resources——

Senator KENNEDY. They can put it into any category they want, but we are just getting a uniform accounting kind of process so that we can make some sense out of the reporting. If you just get the reporting and you do not have accounting, I think you are going to have blanks in some places and larger figures in others; and you do not get very much help.

What is the objection to getting to an understanding? We could let you people work out what that form ought to be; because none of us knows; but we need to get that information soon.

Do you see anything wrong with that?

Dr. THOMPSON. It is obvious that a hospital needs to have a chart of accounts. I think that there are valid reasons why hospitals would approach this matter in a different way. I am not an accountant myself, but my own experience is that sometimes the tail wags the dog a little bit when you get into these matters of trying to develop a chart of accounts. With uniform reporting, on the other hand, it does in fact allow you to look at hospitals and see what the costs are and compare them. You do not need a chart of accounts to do that; and I think that the secret to this matter, as far as developing your peer groups of hospitals, is to be able to say that you now have under a uniform reporting system, Mr. Chairman, costs that are truly comparable.

Senator KENNEDY. Well, that is what we are desirous of.

Can you give us an illustration in terms of why accounting in one situation would be so much different than in another?

Dr. THOMPSON. Well, it seems to me, in my own experience, that the manner in which accounting programs are set up are sometimes misconstrued and used for purposes of trying to develop management strategies. In my experience, that is the wrong way to go at it. Accounting should be a tool which the managers can use in order to know the results of what is going on. I think that there are reasons to change accounting systems from time to time when it does not seem that the objectives of the institution are best identified and analyzed in terms of the present way in which the accounting is performed.

Senator KENNEDY. I suppose that is a question of reading it and how you interpret it; is it not?

Dr. HEYSSEL. Senator, may I speak to that specifically? In Maryland, we have a uniform reporting system. And in fact, we have to assign costs according to their accounting system, which is really quite different than what we do internally. Let me give you two specific examples. The quality assurance program in our hospital is assigned as a staff expense; whereas, under their system, it would be part of administration. We report it for their purposes under "Administration." But in terms of accounting and for the reasons that Dr. Thompson has alluded to, we do not operate that way internally. If we were asked to do it their way, I think it would limit our flexibility.

A second example is nurse staff administration, Mr. Chairman, where the directors of nursing in the various medical-surgical-pediatric units are included in those cost centers. In the Commission's report, they would be part of the central nursing staff.

I think reporting does imply including the same costs in the same cost centers for all hospitals at all times. That would be for reporting

functions. But how the hospital handles that internally, it its own books and its own management, I think, is the issue here.

Senator KENNEDY. That is a good point.

Maybe either the Maryland system or your system is better, and I don't know and don't want to make a value judgment about that.

It would seem to me that in terms of assessment that it would be valuable to get the hospitals together to see how their resources are expended.

Dr. HEYSSEL. Well, we fully agree with that; because as I say, for reporting functions, Mr. Chairman, we report exactly the way all other hospitals in Maryland do.

Senator KENNEDY. OK.

Dr. COOPER. Senator, one statement.

We really had six points here that we have outlined as ways that we think costs can be controlled. One has not been discussed. It relates to two programs that the Congress has already put in place to help control costs and which really have not been able to completely be implemented and have their effect on costs. One of the points that the association makes here is we think the PSRO program should be extended to cover all of the patients in the hsopital rather than only those under medicare and medicaid. This is beginning to be an effective program in looking at the delivery of care in the institutions.

The second one is that the health planning agencies, certainly the HSA's, should be strengthened. In particular, if one is looking at total health care costs and not just hospital costs, the certificate of need proposals should certainly be extended beyond just hospitals to all providers, Mr. Chairman, for the kind of sophisticated and large equipment which does add to the cost of hospital care.

There is evidence, I think, around the country where this part of the law is being subverted by the fact that individuals or groups of physicians are obtaining this equipment outside of the certificate of need law and HSA's have no controls over the numbers that are being purchased.

Senator KENNEDY. Thank you very much.

Your statements will be placed in the record.

[The joint prepared statement of Dr. Thompson, Dr. Heyssel, Dr. Cooper, and the Association of American Medical Colleges follows:]

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Revised DRAFT 6/16

STATEMENT BY THE
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
ON THE
HOSPITAL COST CONTAINMENT ACT OF 1977

Mr. Chairman and Members of the Subcommittee:

I am David D. Thompson, M.D., Chairman of the Council of Teaching Hospitals of the Association of American Medical Colleges and Director of the New York Hospital. I am accompanied by Robert M. Heyssel, M.D., Executive Vice President and Director of the Johns Hopkins Hospital in Baltimore, and by John A. D. Cooper, M.D., President of the Association.

I have submitted a detailed statement of the Association's position on S. 1391 for the consideration of this Subcommittee and inclusion in the record. In the interest of brevity, I will summarize the Association's concerns with S. 1391 and discuss recommended alternatives for containing hospital cost increases.

The Administration's Proposal

The AAMC and its members fully appreciate the fact that total national health expenditures and hospital expenses have increased dramatically in the past three decades. We also appreciate the problems that these trends have created for consumers, insurers, labor and industrial organizations, and governments. We recognize that there is a need to reduce the rate of increase in health care costs and are willing to work constructively with all parties to develop, promote, and advance cost containment programs which are practical, equitable, administerable, and which ensure high quality patient care. The AAMC is opposed, however, to the program of arbitrary revenue and capital

expenditure limitations recommended by the Administration.

The $2.5 billion ceiling on capital expenditures is completely inadequate to provide for the capital expenditures necessary merely to meet the requirements of national, state, and local regulations and codes and to meet the capital requirements of obsolete facilities essential to patient care

The AAMC is opposed to the imposition of a cap on hospital revenues when no other segment of the economy is similarly controlled. Hospitals are thus put in a potentially untenable position of having to pay for items, the price of which is uncontrolled, while at the same time are arbitrarily limited by a ceiling on revenue.

An arbitrary cap has other deficiencies and inequities:

- It fails to recognize or account for regional and institutional variation in uncontrollable costs,
- It can unduly benefit providers with a high proportion of fixed costs,
- It has a relatively punitive effect on the already efficient providers, and
- It penalizes providers whose costs have been held down by state rate review agencies.

In addition, by indiscriminately providing highly favorable payments to some hospitals and relatively punitive payments to others, an arbitrary revenue cap threatens to disable the hospital industry, to impose irrational and unintended effects, and to create additional residual problems for any long-run containment of hospital costs.

At least five components of S. 1391 threaten to undermine the effectiveness of teaching hospitals: (1) it provides no mechanism for necessary additional revenues resulting from changes in diagnostic case mix; (2) it does not provide the additional revenues necessary to increase the number of residency positions available to meet the needs of expanded medical school graduates and to provide new opportunities in primary care training; (3) it does not recognize that controlling the incomes of salaried hospital physicians, while other physicians are not controlled, will severely hamper the ability of teaching hospitals to recruit staff physicians; (4) by requiring

virtual insolvency in order to obtain an exception, it may require hospitals to liquidate endowments; and (5) it provides no appeal mechanism for any hospital subject to an operational review which finds that the binding recommendations for improving the efficiency or economy of patient care services undermine teaching and tertiary care. Each of these problems threatens severe financial and service disruptions in teaching hospitals.

The Recommended Alternatives

Fortunately, the Administration's revenue and capital limitations are not the only alternatives available for this Subcommittee's consideration.

In the past twelve years, there have been four major health planning programs initiated at the Federal level. Each has been constrained by limited jurisdiction, inadequate financial support, and delayed implementation. Rather than planning permanent and arbitrary limits on hospital capital expenditures, bed supply, and occupancy levels, the AAMC supports full implementation of and support for the National Health Planning and Resources Development Act and further recommends the following amendments: (1) inclusion of all providers, regardless of setting, under the Certificate of Need programs and (2) establishment of positive incentives for providers to bring health care facilities and service in line with community needs. The Association believes, that if the present health planning law is allowed to operate effectively, it will provide the necessary mechanisms to review and determine the need for proposed capital expenditures.

As a result of substantial past efforts and legislation, the components of a six point program that would moderate hospital expenditures are available for rather immediate implementation: The first component would be the adoption and implementation of a uniform hospital cost reporting system. In addition to ensuring that published data on hospital costs may be

meaningfully interpreted, a uniform reporting system would provide the data to examine hospital cost trends, patterns, and cost containment accomplishments.

Secondly, hospital financial statements and charge data should be published and made available to the community. Consideration should also be given to furnishing admitting physicians with information on the charges for their patients.

Third, to ensure that the impacts of federal legislation and regulation upon hospital costs are recognized, the Congress should require every bill or regulation affecting hospital operations to include a cost impact statement.

Fourth, the AAMC supports full implementation and an expansion of PSRO and health planning programs. The impact of PSRO agencies should be increased by expanding their authority to include all hospital inpatients and the Certificate of Need program should be expanded to include significant capital expenditures made by all providers, regardless of setting. This Certificate of Need proposal will help ensure that capital expenditures are not being shifted from the controlled institutional setting to the uncontrolled, noninstitutional setting.

Fifth, a rational program of hospital payment limitations could be based on reimbursement limitations derived from national cross-classification schemes that are carefully constructed and conscientiously implemented to ensure that similar hospitals and costs are being compared. An appropriately phased system which requires uniform hospital reporting, removes atypical and uncontrollable costs from comparisons, and provides an effective exceptions process could reduce the present rate of hospital cost increases. If incentives were included which enabled hospitals to share in the advantages of reducing costs below the reimbursement limitation, an important stimulus would be added to the present cost containment efforts of governing boards, hospital

executives, and physicians.

Sixth and finally, consideration should be given to permitting Medicare to pay state-agency determined rates where the state system meets all of the following conditions: it (1) applies to all hospitals, (2) applies to all revenue, (3) bases rates on the full financial requirements of hospitals, (4) is an independent agency with appropriate staffing, (5) includes formal procedures including public hearings, and (6) provides due process and judicial review.

Taken together, the AAMC believes that this six point program provides an opportunity to commence a national cost containment strategy which will provide an equitable, realistic, and administerable foundation for a longer-run cost containment effort.

Johns Hopkins Situation

Mr. Chairman, because the expenditures of the Johns Hopkins Hospital have been discussed at this hearing by several other witnesses, including the Secretary of HEW, I would like to conclude, with your permission, by allowing Dr. Heyssel, Director of the Johns Hopkins Hospital, to his views on this subject.

aamc association of american medical colleges

TESTIMONY SUBMITTED ON S. 1391
BY THE
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
TO THE
SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
COMMITTEE ON HUMAN RESOURCES
U.S. SENATE

June 17, 1977

The Association of American Medical Colleges (AAMC) is pleased to have this opportunity to testify on the "Hospital Cost Containment Act of 1977," S. 1391. In addition to representing all of the nation's medical schools and sixty academic societies, the Association's Council of Teaching Hospitals includes over 400 of the nation's major teaching hospitals. These hospitals: account for over sixteen percent of the admissions and approximately twenty percent of the ambulatory care services provided by non-Federal short-term hospitals; provide a comprehensive range of patient services, including the most complex tertiary services; and are responsible for a majority of the nation's graduate medical education programs. Thus, the hospital revenue limitations and capital expenditure controls proposed in S. 1391 and the consequences of these controls are of a direct interest and a vital concern to the Association's members.

For ease and clarity of presentation, this testimony is organized in two parts with two supporting appendices. The first part addresses cost containment in the hospital industry, including a review of the causes of increased hospital costs; the inherent problems of using arbitrary percentage

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caps as found in S. 1391; and an alternative to the President's proposal. In addition, Appendix A provides a section by section description of specific problems which are present in the revenue limitation provisions of S. 1391. The second part of this testimony addresses capital expenditures by hospitals, the arbitrary characteristics and likely adverse impacts of S. 1391, and recommendations for strengthening the National Health Planning and Resources Development Act. Appendix B provides a section by section statement of the specific problems of Title II of S. 1391.

HOSPITAL COST CONTAINMENT

The Problem of Hospital Expenditures

The AAMC and its members fully appreciate the fact that total national health expenditures have increased from $12.7 billion, or 4.5% of the Gross National Product, in 1950 to $139.3 billion, or 8.6% of the GNP, by 1976 and that aggregate expenditures for hospital care increased from $3.9 billion in 1950 to $55.4 billion in 1976. These twenty-seven year expenditure trends are paralleled by the trend for hospital expenses per unit of service. For example, hospital expenses per patient day[1] were $7.98 in 1950, $16.46 in 1960, $118.69 in 1975.

The Association also appreciates the problems that these cost and expenditure trends have created: health insurers have had to seek substantial increases in premiums at frequent intervals, industrial firms and labor unions have had increases in the costs of the health insurance fringe benefits that

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[1]The statistic "expenses per patient day" is deficient as a basis for examining cost trends because it treats all hospital days as homogeneous, ignores ambulatory care provided in the hospital, and assumes the hospital product is a constant. Nevertheless, it is used here as an example of the statistical data which have contributed to the public's perception of the problem of hospital costs.

exceeded the expectations of all negotiating parties, consumers have found premiums for existing coverage rising at the same time that they have needed to increase their coverage limits to obtain adequate protection, and government officials and agencies have seen expenditure increases that have limited the opportunities to initiate new programs or strengthen existing programs. As a result, a national consensus is evolving that there is an urgent need to reduce the rate of increase in health care costs.

The AAMC recognizes this national concern, and the Association and its members are willing to work constructively with all parties in government and the private sector to develop, promote, and advance hospital cost containment programs which are practical, equitable, and administerable and which continue to maintain the quality of patient care demanded by the public. In order to develop a cost containment program consistent with these characteristics, factors responsible for the present rate of increase in the costs of hospital services must be understood and considered.

Sources of Increased Hospital Costs

Hospital cost increases are primarily the result of changes in the following cost components:

- the inflation in the general economy;
- the imposition of government-mandated programs;
- the introduction and changing mix of services and technologies;
- the population's utilization patterns; and
- the hospital's increasing complexity and its coordination needs.

Hospitals must purchase goods, services, and manpower. General and multi-purpose goods such as food, fuel, utilities, and general liability insurance are purchased from suppliers serving many industries. In purchasing these goods and services, cost increases for hospitals will be

similar to those experienced by the general economy. Hospitals also purchase goods and services of a distinctly medical character. Pharmaceuticals, laboratory supplies and reagents, and malpractice insurance have limited markets; changes in the prices of these goods may be greater or less than the economy's average inflation. Similarly, in recruiting personnel, hospitals compete in markets shared by other industries -- such as food service, housekeeping and construction -- and in specialized markets -- such as those for medical, paramedical, and technical personnel. In each of these labor markets, hospitals have traditionally experienced relatively low wages for their employees; however, as employee and community attitudes have changed in the past decade, hospitals have had to become and remain competitive with the general community in salaries and fringe benefits. For goods, services, and manpower, hospitals now pay a competitive price, and price increases in both general and specialized resource markets must be incorporated into hospitals' changing costs.

Hospitals are subject to government-mandated programs enacted by federal, state and local governments which increase costs. The hospital must comply with building, fire, and life safety codes. Antipollution and solid waste control standards must be attained. Pension reform provisions must be met. Higher Social Security taxes must be funded. Each of these programs, regardless of its social desirability, increases the operating expenses of hospitals without increasing their services.

Hospitals of the mid-seventies are significantly different from those of the early fifties. New and more effective diagnostic and therapeutic modalities are available. Life saving technologies such as intensive care and renal dialysis have been introduced. Standards of medical practice for many diseases have changed in response to new procedures and techniques.

Some of these developments have reduced hospital costs by providing comparatively less expensive therapies for previous services; many, however, have increased costs by adding new and complementary capabilities to hospitals. As a result, Social Security Administration findings, shown in Table 1, document that for the past twenty-five years approximately 50% of the total increase in hospital costs has resulted from improvements in hospital services.

The population's use of the hospital is changing. Increasing levels of education and income are accompanied by increasing demands for the most sophisticated and costly hospital services. Emergency rooms and organized outpatient departments are providing complex specialty and ancillary services in addition to primary ambulatory care. Increased numbers of aged citizens with serious acute disorders and severe chronic conditions require increases in the ancillary and nursing support provided by the hospitals. Long-term and self-care facilities organized apart from hospitals are being used for the less expensive recuperating patients, while the complex and expensive patients have remained in hospitals. Each of these changes contributes to increasing hospital unit costs.

As a public resource, hospitals are expected to meet the needs of their community. Therefore, hospitals have added new services, equipment, and personnel to meet the public's desire for access to the latest medical and scientific accomplishments. Unfortunately, some duplications of underutilized, but expensive, services have also occurred. As hospitals have increased services and staff, coordination of activities has become more difficult to maintain. Additional reporting and control systems requiring more staff have been developed and implemented to maintain institutional effectiveness. In these respects, hospitals, and their costs, are no different from other industries which have also found it necessary to expand administrative

Table 1

Average Annual Percentage Increase in Hospital Costs Resulting from Improvements in Hospital Services

Time Period	Average Annual Percentage Increase
1951-1960	50.0%
1960-1965	48.5%
1965-1967	60.3%
1967-1969	41.8%
1969-1971	44.7%
1971-1973	48.7%

Source: Social Security Administration. Medical Care Expenditures, Prices and Costs: Background Book. September, 1975. Page 39.

services and, thus, to increase organizational overhead.

A cost containment program to reduce hospital costs without disrupting necessary health services must be designed with full recognition of the hospital's limited ability to influence or control many of its cost components. This is especially true of the inflation level present in the economy and the requirements of government-mandated programs. These cost increase factors are beyond the control of hospitals, individually and collectively.

Also beyond the control of hospitals are the unclear and inconsistent policies and priorities confronting these public service organizations. For example,

- Practitioners are encouraged to "optimize" the use of hospital services to contain costs while large malpractice awards to patients with adverse outcomes encourage practitioners to request more professional consultations and ancillary services and dramatically increases malpractice premiums.

- Regionalization of health services, which concentrates expensive services in a few hospitals, is sought while reimbursement programs seek to apply uniform payment levels without recognition of case mix differences.

- Health planning regulations for capital expenditures in institutions are undertaken while similar expenditures in physicians' offices are excluded from review and approval.

- Free care and below cost care are mandated for public patients while third party payors and consumer groups pressure the hospital to prevent charges from exceeding costs for paying patients.

- Certification and licensure are sought and frequently legislated for paraprofessional and technical personnel while hospitals are encouraged to use fewer and more flexible personnel.

- Primary care emphasizing ambulatory and preventive services is sought while outpatient clinics lose money and special program funds for catastrophic care are more easily attainable and abundant.

- Utilization controls to optimize the use of hospital services are sought while fully-insured patients seek to remain through complete recovery and while chronic patients must remain until a long-term bed is available.

- Optimum standards for care are sought while high costs are opposed.

- Expanded health benefit programs are incorporated in collective bargaining agreements while consumer and industrial groups oppose increases in health insurance premiums.

Hospitals serve patient and societal needs. The presence of inconsistent patient expectations and contradictory public policies have placed these institutions in the position of trying to do everything for everyone. The absence of disciplined expectations and consistent policies has reinforced and heightened the impact of the five hospital cost components discussed earlier. Effective programs to contain hospital costs will depend on the emergence of more consistent public expectations and clearer public policies for hospital services.

To contain hospital costs in an effective and socially desirable manner, the AAMC believes public and private programs must include efforts (1) to moderate increases in the factors underlying hospital costs, (2) to unify and clarify societal expectations of hospitals, and (3) to design payment systems which provide hospitals with incentives to limit operating expenditures.

Title I of the Carter Administration's Proposal

Sharing the public's perception that the rate of increase in hospital costs is unacceptable, the Carter Administration, in Title I of S. 1391, has proposed a "temporary" mechanism for limiting hospital revenue increases, from all payors, effective one hundred and six days from today. The Association of American Medical Colleges believes that this proposal of a nationwide cap on revenue is unreasonable in the short-term and that it will

have highly adverse effects on our nation's ability to rationally limit hospital expenditures in the long-run. In addition to the specific provisions and problems with S. 1391 discussed in Appendix A, the AAMC is concerned about several generic issues and problems underlying this proposed method for limiting hospital expenditures.

The Association is opposed to any proposal which prescribes an arbitrary percentage to cap payments to hospitals. While such an approach does limit third party and patient expenditures and hospital revenues, an arbitrary percentage cap is defective and inequitable by its very nature. First, a nationwide cap fails to recognize or account for the very real regional and institutional variations in uncontrollable costs. Hospitals in a region where the malpractice insurance crisis has already occurred have high insurance premiums already in their base, but those in areas just encountering the substantial increases in premiums will have to use a significant portion of their allowable increase in revenue just to pay the revised premiums. Second, an arbitrary percentage increase can unduly benefit hospitals with high proportions of fixed costs. For example, a recently constructed hospital with high debt service requirements can use the percentage increase calculated on these expenditures to add and improve services while older, inner-city hospitals with few capital debts have to use a significant portion of their revenue increases simply to repair and maintain an aging physical plant. Third, an arbitrary percentage increase has a punitive effect on the hospital which has already responded to the national objective of containing hospital costs. Having voluntarily worked to limit its cost increases, the hospital with an effective cost containment program has neither excess resources nor cost containment potentialities which could be used to offset the effects of

of the cap; the inefficient hospital does have such margins incorporated in its past operating expenditures as well as in its inefficient practices. Thus, voluntary compliance with cost containment goals is punished and possibly discouraged. Fourth, an arbitrary percentage increase penalizes hospitals whose costs have been held down by state rate review, for these hospitals start out with a smaller and more restricted base. Fifth, an arbitrary ceiling places an unusually heavy burden on tertiary care/teaching hospitals which pioneer new patient care services, must accept referrals of the most costly and complex patients, and are training expanding numbers of new physicians including those specializing in primary care.

In addition to its inherent defects, the Administration's proposal is highly inequitable for the following reasons:

- It seeks to limit hospital revenue in the absence of any similar limitations on hospital input prices. Goods, services, and manpower in the general economy are unrestrained and likely to increase independent of the hospitals' ability to pay such increased costs.

- No procedure or controls are proposed for limiting or distributing the volume of patient services required.

- Methods to adjust for case mix or patient care intensity are not provided. Regionalization of complex patient services is occurring as intensively ill patients are being referred to teaching hospitals. This regionalization, while cost effective when viewed nationally, results in greater cost increases for tertiary care/teaching hospitals than in other hospitals and, thus, more severe problems with arbitrary revenue limitations.

- There is an implicit assumption that net operating revenues in the base year were adequate to meet the operating revenues in the base year and no relief is provided for hospitals with inadequate revenues in the past.

Each of these four inequities means that some hospitals may easily comply with an arbitrary revenue limitation while other hospitals, of similar or greater efficiency, encounter substantial operating difficulties and

financial risk.

The Administration's proposal erroneously assumes that aggregate hospital characteristics are characteristics of individual hospitals. While the mix of patients cared for nationally by all hospitals may be stable, individual hospitals may encounter substantial changes in patient mix. Moreover, the presence of a revenue limitation provides some incentive for hospitals to avoid or transfer the more complex and costly cases to tertiary care and teaching hospitals. Concentrating complex cases is not undesirable, but, if it occurs in the presence of an arbitrary revenue limitation which does not include a case mix adjustment or exception, it seriously threatens the financial integrity of tertiary care and teaching hospitals. Secondly, the proposal assumes that any single ratio describing the relationship of fixed to variable expenses for the industry may be equitably applied to each individual hospital. This is untrue. Some hospitals may be able to adequately adjust to changes in the number of patient admissions if the revenue for the incremental patients is equal to fifty percent of the average revenue. For other hospitals, which would need to involuntarily terminate workers entitled to substantial unemployment payments as the volume of service decreased or which would need to re-open patient floors as volume increased, a volume adjustment of fifty percent would be most inadequate. Third, the hospital industry has historically maintained a relatively small operating margin of income over expenses. It should be understood, however, that not all hospitals have positive operating margins. For example, a study of the financial position of 295 teaching hospitals found that 128, or 43.4% had negative operating ratios for the twelve month period ending September 30, 1974. A more recent study in New York State continues to demonstrate this variation in operating margins. Thus, while

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some have argued that a temporary program of revenue limitations will not cripple the industry, it may be financially catastrophic for a significant number of hospitals having negative operating margins. Lastly, while the proposal assumes that a decrease in the average length of patient stays will decrease per admission costs, it may actually increase costs in individual hospitals while simultaneously reducing revenues. In summary, because hospitals are not a homogeneous set of institutions, each of which can be individually characterized by nationwide averages, many of the adverse impacts of this proposal must be examined in terms of the individual hospital and its community.

The Administration's proposal ignores historical trends and recent developments in health care delivery which necessitate increased revenues. Medicare and Medicaid have improved the access and use of hospital services by our poorer and older citizens who often have severe and complex medical needs. The added services that have resulted are a tribute to our nation's hospitals. The costs of these additional services should not be considered as inflation. Secondly, utilization review and medical audit programs operate to minimize under-utilization as well as over-utilization of health services. By creating a medically appropriate range of discretionary services and treatment alternatives, these federally-instigated programs restrict the hospital's ability to adjust its operations in the face of inadequate revenues. Third, the Health Professions Education Assistance Act of 1974, P.L. 94-484, includes an expanded emphasis on primary care training opportunities. To meet the Act's objectives, the number of primary care residency positions in existing programs will have to be expanded and new programs will have to be added in additional hospitals. These expansions and additions will increase hospital costs and necessitate new revenues. The presence of an

arbitrary revenue limitation which does not recognize the justifiable increases accompanying primary care expansion threatens to thwart the Congressional intent of P.L. 94-484. Lastly, tertiary care and teaching hospitals have been increasing the number of salaried hospital physicians. While these physician costs increase the hospital's budget, it is not clear that they increase overall health care costs, for they are removed from the costs of non-institutional providers. An arbitrary percentage cap on hospital revenues threatens continuation of this desirable trend and may reverse it. Each of these four developments in the hospital industry is the result of its continuing evolution. The AAMC believes that these trends should not be indiscriminately reversed by the imposition of an arbitrary limitation on hospital revenues.

The revenue limitations of S. 1391 apply only to the inpatient services of hospitals. While this has been done to foster further development of ambulatory care services, it fails to recognize three key characteristics of ambulatory services: increased emergency services often increase rather than reduce admissions; increased outpatient clinic services, especially if established in underserved areas, often increase rather than decrease hospital admissions and inpatient days; and increased ambulatory services at many hospitals will require new capital expenditures which are restricted by Title II of the bill. The Association of American Medical Colleges has an active program for the improvement of ambulatory services in teaching hospitals. The proposed legislation threatens that improvement by failing to recognize the relationship between ambulatory and inpatient services and by ignoring the need for additional capital expenditures for ambulatory care services.

The rise in hospital costs which has led to the growing consensus

that the rate of increase in hospital costs must be contained developed across several decades. This rise in costs has several contributing components including rising expectations for the hospitals by the public. Arbitrary revenue limitations, while administratively easy to impose at the payors level, are inequitable, based upon false assumptions of hospital homogeneity, ignore historical trends and recent developments, and do not recognize the inter-relationship of hospital activities. Moreover, by indiscriminately providing highly favorable payments to some hospitals and relatively punitive payments to others, an arbitrary revenue ceiling threatens to disable the hospital industry, to impose irrational and unintended effects, and to create additional residual problems for any long-run containment of hospital costs. Therefore, the Association of American Medical Colleges strongly recommends that Title I of S. 1391 not be enacted.

Cost Containment Alternatives

The Association's opposition to S. 1391 should not be interpreted to imply that the AAMC is opposed to all efforts to reduce the rate of increase in hospital expenditures. The Association and its members do understand and appreciate the fact that increasing hospital expenditures mean that relatively fewer dollars are available for other public programs and private purchases. The AAMC is concerned, however, the some have focused their attention primarily on these expenditures and proposed the imposition of immediate controls to drastically reduce the increases. The Association's concern is not based on indifference to the problem or on intransigence. Rather, it is based on the firm belief that: (1) relatively little is known about the effectiveness and consequences of various containment strategies; (2) cost containment programs may

unintentionally undermine or significantly alter the attainment of present health goals; and (3) hospitals, as public service institutions, have a responsibility to meet community needs for patient care services and to support the training of future health manpower.

Put simply, no one knows very much about effective cost containment programs. For example, the National Center for Health Services Research recently published a report on Controlling the Cost of Health Care in which they sought to summarize what ". . . is known about the consequences and effectiveness of various strategies intended to reduce or minimize increases in the costs of such (i.e., health) services." Unfortunately, it only required seventeen pages of text and three pages of references to summarize "what is known". Any national program that is proposed must be considered to be essentially untested. It should be examined carefully and implemented cautiously.

As the National Center has further stated: "Many of the incentives for rising medical care expenditures are the result of public policy. Cost containment strategies which are designed to modify these incentives will limit the achievement of other health objectives." This is a serious conclusion for it necessitates that ". . . no cost containment strategy should be initiated without assessing how incentives and disincentives currently influencing behavior in the health care system will respond to its imposition. Conversely, expectations of the positive impact of particular instruments of cost containment must reflect the influence of incentives and disincentives which may offset the impact." Because every cost containment strategy will influence the achievement of other health goals, nationwide proposals must be carefully examined and cautiously implemented.

The vast majority of this nation's hospitals are sponsored by governmental agencies and nonprofit corporations. Therefore, they were organized and are operated to meet community needs. Each day, the non-Federal hospitals of the AAMC's Council of Teaching Hospitals admit 14,600 patients, care for 35,300 emergency room visits, and provide almost 100,000 outpatient visits. Filling vital roles in their communities, these institutions are naturally concerned with proposals to radically alter their funding -- the patient care requirements will remain regardless of the availability of funds. Hospitals have changed dramatically in the past two decades, but the changes have been gradually implemented. National proposals to radically reorient the lifeblood of institutional funding in a short period of time are viewed with alarm. More cautiously implemented controls will undoubtedly be less disruptive and receive greater support.

Fortunately, the Administration's revenue limitation proposal is not the only alternative available for this Subcommittee's consideration. As a result of substantial past efforts and legislation, the components of a six point program that would moderate hospital costs are available for rather immediate implementation. The program would be based on (1) implementing a system of uniform hospital cost reporting, (2) publishing hospital cost data to the general community and to community physicians, (3) expanding and fully supporting utilization and health planning controls, (4) permitting Medicare to pay state-determined hospital rates where state rate/budget systems meet necessary federal standards, (5) ensuring that new health program legislation is supportive of national cost containment goals, and (6) enacting prospective reimbursement limitations such as those derived from cross-classification

schemes. Because each of these program components is independent of others, work on them may proceed simultaneously to obtain the maximum cost reduction potential.

Uniform Cost Reporting

The nation's hospitals are a set of relatively autonomous organizations separately incorporated and managed. Financial reporting systems within these hospitals have been created to serve the functional needs of management and the documentation requirements of third party payors. As a result of this individuality, it is extremely difficult to compare costs across hospitals. A nationwide system of uniform cost reporting is a most important requirement for the proper measurement, evaluation, and comparison of hospital costs. Uniform cost reporting will help ensure that published information on hospital costs may be meaningfully interpreted by physicians and patients. It will also provide the data for an adequate statistical base to examine hospital cost trends, patterns, and cost containment accomplishments. Therefore, the AAMC strongly recommends the immediate development and implementation of uniform hospital cost reporting system as the first component of a national cost containment program.

Publication of Financial Data

Hospital cost information should be published and made readily available to both the general and physician communities. In addition to the publication of routine financial statements, hospitals should, on a semi-annual basis, publish information on the charges for frequently utilized hospital services. To help ensure that this data is meaningful, the information should be published in a form which shows the average charges of similar services in similar institutions. The comparative

data should be developed and made available to hospitals by the Secretary of HEW. Financial statements and charge data will provide the consumer with some necessary information to compare hospitals.

Because many of the hospital services are ordered by the physician on behalf of the patient, special attention should be given to providing physicians with information on hospital charges. In publishing the charges for frequently used services, hospitals should be required to send a copy of this information to each member of the hospital's medical staff. Consideration also should be given to furnishing the admitting physicians with information on the charges for their patients. In this manner, physicians should become more aware of general hospital charges.

Existing Programs

In the Professional Standards Review Organization legislation and in the National Health Planning and Resources Development Act, Congress has attempted to establish programs and policies which will stimulate a more efficient and effective health industry. Unfortunately, both programs have been constrained by their limited jurisdiction, inadequate financial support, and delayed implementation. The AAMC supports full implementation and expansion of PSRO and health planning legislation as a third component in a national cost containment program.

The PSRO program was established to determine that medical services supported with Federal funds are necessary and timely. PSRO agencies are now stimulating changes in the system by altering utilization patterns. As these agencies reduce admissions, length of patient stays, and ancillary services, the increase in hospital expenses will be reduced. The impact of these agencies can be increased, however, by expanding their authority

to include all hospital inpatients. This change would provide an important step in a short-run cost containment program and a foundation on which long-run programs could continue to build.

The health planning agencies established by P.L. 93-641 are also taking effect. With more adequate funding and more timely Federal direction, they could have a more immediate impact on hospital services and facilities which would reduce hospital operating costs. The effectiveness of health planning agencies in containing costs is severely handicapped, however, by the exclusion of noninstitutional services from the mandated Certificate of Need process. For example, in some areas where hospitals and health planners have worked cooperatively to rationally introduce CT scanners, the cost savings to the community have been eliminated by physicians acquiring scanners in office-based settings not subject to review. By controlling capital expenditures only when undertaken in an institutional setting, expenditures are shifting to the uncontrolled non-institutional setting. The AAMC supports broadening the Certificate of Need process to cover all providers, regardless of setting, as one step in fully implementing existing programs to contain costs.

If the jurisdiction of PSROs is expanded to include all patients and if the Certificate of Need process is expanded to include capital expenditures in all settings, further gains in their cost containment potential will depend upon the level of funds appropriated to support them and the Executive agencies deligence in implementing and assisting them. The AAMC fully supports increased government funding, expanded technical assistance, and full implementation for these programs.

State Rate and Budget Reviews

In the past decade, several states -- including some states with

large number of hospitals -- have established mechanisms for reviewing hospital budgets and/or establishing hospital rates. While some of these programs have achieved some success, each has had its effectiveness limited due to the failure of Medicare to participate in the process. The AAMC recommends that legislation be enacted which would permit Medicare to pay state agency determined rates where the state system meets the following conditions: (1) it applies to all hospitals; (2) it applies to all revenue sources; (3) its rate/budget determinations are based on the full financial requirements of hospitals; (4) it is an adequately financed, politically independent agency headed by a small number of full-time, well compensated commissioners appointed for relatively long staggered terms of office and staffed by competent professionals; (5) it includes clearly defined formal procedures, adopted after public hearings, for systematic review of rate or budget applications and provisions for routine changes to be made with minimal procedure and expense; and (6) it provides due process, including the right of judicial appeal for the applicant and others affected by the decisions, and specific provisions against undue delays in action. State systems with these features offer one serious long run alternative for cost containment. Where they are presently established, they also offer immediate reductions in the rate of hospital expenditure increases.

Promoting Legislative Consistency

Each year the Congress considers many bills which significantly effect the cost of hospital operations. In addition, HEW annually promulgates regulations effecting the cost of hospital operations. While many of these bills and regulations may be desirable on their own merits, in the aggregate their impact on hospital costs may be

unacceptable. To ensure that the impacts of federal legislation and regulation upon hospital costs are adequately recognized, the Association strongly recommends that the Congress require every bill or regulation significantly affecting the costs of hospital operations to include a cost impact statement.

As example, on March 30th the Association testified before this Subcommittee on S. 705, the Clinical Laboratory Improvement Act of 1977. In that testimony, the AAMC stated its concern over the personnel qualifications and credentialing of Section 3. The Association noted, that in a recent study of the Employment Impacts of Health Policy Developments, published by the National Commission for Manpower Policy, Professors Rashi Fein and Christine Bishop made the following recommendation: "As growth in hospital employment lessens, it will be necessary for public authorities to intervene more actively to alter the credentialing and certification processes for various health occupations. The cost of inflexibility is always high. It is likely to be even higher in a slow-growth situation. Special attention must be paid to these matters . . . Health policy makers should be aware of the impact of their proclivity to equate input quality with output quality, and attempts should be made to encourage more flexible staffing patterns for health providers." Personnel credentialing imposes artificial rigidities on the number and types of laboratory personnel who may be employed and on the tasks they may be assigned. Those rigidities inhibit efforts to improve laboratory productivity, increase necessary manning requirements, stimulate "feather-bedding," and constrain the introduction of new procedures requiring skills not learned by those with established credentials. Each of these restricts the ability of hospital management to contribute to national efforts to

contain health care costs; therefore, until a clear and present benefit from credentialing is documented, the Association is opposed to mandatory personnel credentialing of personnel in hospital laboratories. Because mark up on S. 705 has not been held, this Subcommittee has an excellent opportunity to implement a policy of accompanying program legislation with a cost impact statement. It could establish a precedent which would help ensure that system changes are introduced following a full consideration of their cost impacts.

Prospective Payment Limitations

Prospective cost limitations are presently being imposed on hospitals by Section 223 of the 1972 Social Security amendments. While the AAMC has challenged the regulations implementing these routine service cost ceilings, the Association believes this program has had a restraining effect on hospital expenses. A more rational cost containment approach could be based on reimbursement limitations derived from national cross-classification schemes that are carefully constructed and conscientiously implemented to ensure that similar hospitals and costs are being compared. An appropriately phased system which requires uniform hospital reporting, removes atypical and uncontrollable costs from comparisons, and provides an effective exceptions process could reduce the present rate of hospital cost increases. If incentives were included which enabled hospitals to share in the advantages of reducing costs below the reimbursement limitation, an important stimulus would be added to the present cost containment efforts of governing boards, hospital executive, and physicians. This position on prospective payment limitations should not be interpreted to preclude state level administration of rate review systems, established either voluntarily or by statute, providing such systems meet the six

conditions specified earlier.

Conclusion

It cannot be over-emphasized that the present levels of hospital costs have developed over a long period of time and as a result of hospital responses to national and state legislation, the prevailing economic and social conditions and public demands. The problems of instituting controls over the reimbursement system to reduce increases in cost have been described by Alice Rivlin, Director of the Congressional Office of the Budget, in her May 17, 1976 testimony before the Subcommittee on Health of the Senate Committee on Labor and Public Welfare: "It is clear that the development of financial incentives and disincentives which can restrain inflation and wasteful expenditures without at the same time curtailing desirable improvements in quality of health services, and imposing undesirable rigidities on the delivery system will be a sensitive and difficult task."

Thus, one of the functions that these hearings can serve should certainly not be overlooked. Several government agencies, such as the Office of Technology Assessment and the National Center for Health Services Research and Development, have the authority to examine health issues of national concern. Following these hearings, this Subcommittee will be in a position to provide such agencies with an agenda particularly relevant to hospital cost containment. For example, the agencies could be encouraged to investigate:

- alternative schemes to classify hospitals to ensure that similar institutions are grouped together;
- the operating characteristics and policies of hospitals at the extremes of cost distributions in the grouping methodology currently in place under Section 223 of P.L. 92-603;

- methods for computing and reporting the impact of diagnostic case mix on hospital costs;
- a chain weighted price index which would measure the impact of inflation on hospital purchases;
- regional and institutional variations in the utilization of ancillary services;
- variations in the ratio of the marginal and average costs of hospital services.

There are undoubtedly other issues which have been or will be identified by other witnesses, and these should be added to this suggested agenda.

After careful examination, the AAMC believes that a six point program based on uniform reporting, published financial data, fully implemented PSRO and health planning programs, Medicare payment of state-determined rates, cost impact statements for new legislation and regulations, and comparative prospective payment ceilings provides an opportunity to commence a national cost containment strategy which will provide an equitable, realistic, and administerable foundation for a longer run cost containment strategy.

TITLE II

LIMITATION ON HOSPITAL CAPITAL EXPENDITURES

Title II of the proposed "Hospital Cost Containment Act of 1977" (S. 1391) would establish permanent limits on hospital capital expenditures of the type, size and scope presently controlled under both Section 1122 of the Social Security Amendments of 1972 (P.L. 92-603) and the "Cerfiticate of Need" provisions of the National Health Planning and Resources Development Act of 1974 (P.L. 93-641).

Before considering this new proposal, it is useful to examine the evolution of health planning in our nation. In 1965, the Regional Medical Programs Act (P.L. 89-239) was passed to promote regionalization, local participation in health planning, and a dual funding mechanism for both planning and operations. However, RMP's potential contribution to health planning was rendered negligible, in significant part due to inadequate funding, a lack of policy guidance, and needed technical assistance. In 1966, the Comprehensive Health Planning Act (P.L. 89-749) was enacted to promote comprehensive health planning for services, manpower and facilities at every level of government, primarily through a strengthening of leadership and capacities of state health planning agencies. CHP "B" agencies were chronically underfunded due in part to appropriations below authorization, and in part due to an inability to raise local funds to meet federal matching requirements.

In 1972 Section 1122 of the Social Security Act was enacted to tie federal reimbursement for capital expenditures to the planning process by requiring prior notification of a capital expenditure proposal by health care institutions and by further requiring a determination by the planning agency of the proposal's consistency with standards, criteria or plans developed on an areawide basis.

The current national health planning law, P.L. 93-641, combines the best features of each of its predecessors into a single program of state and local planning and development. Nevertheless, though authorization levels under P.L. 93-641 substantially exceed previous CHP funding levels, the issue of adequate funding for health planning remains a concern.

In the past twelve years, our nation has had four major health planning programs. The Administration is now proposing a fifth major change, one that would combine the local focus of health planning with a nationwide ceiling on total capital expenditures and with nationwide standards for bed supply and hospital occupancy. With this past history, the AAMC urges the members of Congress to ask whether it is logical to continue every few years to enact new federal health planning legislation to replace previous statutory programs that failed because they were poorly financed, ill-staffed and not given a fair chance to succeed. Or, has the time come to permit the current planning law an adequate opportunity to fulfill its promise by strengthening and improving existing mechanisms (i.e., capital expenditure review, Certificate of Need and review of new institutional health services) through increased government commitment in funds and priorities. The Association believes that, if the present health planning law is allowed to operate effectively, it will provide the necessary mechanisms to review and determine the need for proposed capital expenditures without introducing the arbitrary, inequitable and unadministerable provisions of Title II of the Administration's hospital cost containment proposal.

Title II is arbitrary by its very nature. Prior to the beginning of each fiscal year, the Secretary of HEW would establish an annual national limit on new capital expenditures by acute care hospitals under Title II of the proposed hospital cost containment act. The amount of this limit may not exceed $2.5 billion. This ceiling is too low, and would necessitate an immediate drastic

cut of about 50% in the current level of capital expenditures (approximately between $5-6 billion) by acute care hospitals in this country.

The capital expenditure ceiling is not only arbitrary, it is also inflexible. While the provisions of Title II are permanent, they contain no language that would leave room for exceeding the $2.5 billion figure under any justifiable circumstances. Thus, hospitals would be confronted by a permanently fixed ceiling, inadequate at the start and becoming more so in later years as construction and equipment costs increase.

The AAMC is opposed to the $2.5 billion ceiling not only for the reasons already described, but also because it fails to consider the sizeable capital expenditures that hospitals must make each year in order to comply with mandatory changes required by various codes, standards and regulations to which the hospitals must conform. Among the more frequently identified codes and standards are:

1. Joint Commission on Accreditation of Hospitals
2. Section 504 Regulations on Discrimination Against the Handicapped (45 CFR, Part 84).
3. Inspection standards and codes for federal and state hospitals and other government facilities.
4. Manufacturer's standards and instructions for operating equipment and devices.
5. American National Standards Institute standards.
6. National Electrical Manufacturers Association codes and standards.
7. Underwriter's Laboratories standards.
8. American Society of Heating, Refrigeration, and Air Conditioning Engineers standards.
9. Electronic Industries Association standards and publications.
10. Institute of Electrical and Electronic Engineers standards and related publications.

11. American Society for Testing and Materials standards.

12. Instrument Society of America standards and recommended practice.

13. U.S. Department of Health, Education, and Welfare, Public Health Service, Minimum Requirements of Construction and Equipment for Hospital and Medical Facilities.

14. National Safety Council safety-evaluation checklist.

15. Model Code Groups/Southern Standard, Building Officials and Code Administrators, Uniform Building Code.

16. National Fire Protection Association.

These public, governmental and industrial bodies have exerted increasing pressure on hospitals to meet increased environmental and life safety standards that mandate changes which by themselves could require acute-care hospitals in this country to expend as much as, if not more than, the $2.5 billion figure that has been proposed as a national capital expenditure limit under S. 1391.

Unfortunately, the magnitude of the capital invested yearly by hospitals on mandatory changes required by such sources as the Life Safety Codes is not well documented. But enough is known to realize that the proposed $2.5 billion ceiling on national capital expenditures is a capricious recommendation that might even fail to keep hospitals abreast of their current basic capital needs. Hospitals are beset with standards and regulations to which they must conform in order to keep their doors open. For teaching hospitals, JCAH Accreditation requirements are critical for without such accreditation the hospital loses its educational accreditation. Thus, the AAMC opposes the arbitrary $2.5 billion cap proposed under Title II, but strongly urges HEW to undertake detailed cost-benefit studies of the mandated capital requirements of hospitals and provide valid data on this subject for future reference.

S. 1391 also requires the Secretary to establish for each fiscal year a national ceiling for the supply of beds within health service areas and a national standard for the rate of occupancy of hospital beds within such areas.

No projects resulting in net bed additions will be approved in health service areas with more than 4 beds per 1000 population or less than 80% occupancy of hospital beds. These arbitrary standards have been challenged in the past and are strongly opposed by the AAMC. They are insensitive to local needs and conditions, to interarea migration of patients for tertiary level care, and to the difficulties and costs of local planning to accommodate such federally imposed mandated formulas. They ignore the fact that rural hospitals need a wider margin of safety than an arbitrary floor of 80% occupancy would allow. There are a number of medical centers which function as national referral resources which must maintain bed-to-population ratios in excess of the standard established in the President's proposal. Such areas as Durham, North Carolina and Rochester, Minnesota are well recognized examples of such referral resources.

Additionally, it remains unclear how the term "beds" is defined in each area. Are the standards applicable only to an institution's total licensed beds? Its total bed capacity? The total beds staffed and in operation for a given period of time? Only acute care beds? Are special care units to be included in the computation? Finally, while the provisions leave some room for flexibility by stating that the Secretary may establish a different supply ceiling or occupancy standard for health service areas which have special characteristics or which meet special requirements, the bill provides no guidance as to what these special characteristics or requirements might include.

The AAMC recognizes and concurs in the need to eliminate excess beds and to raise occupancy rates in some areas. The Association has supported utilization control mechanisms such as utilization review (UR), Professional Standards Review Organizations (PSROs) and the JCAH, and is working to make the product of these efforts more meaningful and useful. However, the Association questions whether an annual bed supply ceiling of 4 or less beds per 1000 population and

an 80% or above minimum occupancy rate for a health service area are standards which are workable and based in reality.

In summary, the Association of American Medical Colleges is strongly opposed to the permanent and arbitrary limit on hospital capital expenditures, the ceiling on the supply of hospital beds and the standard for occupancy of hospital beds to which short-term acute care hospitals would be subjected under Title II of the Administration's Hospital Cost Containment bill, S. 1391. Instead, the AAMC supports the following major recommendations as more appropriate means of achieving effective and efficient use of capital expenditures by hospitals and other providers in the health care industry:

- The National Health Planning and Resources Development Act of 1974, P.L. 93-641, must be strengthened and improved by means of increased government funding and technical assistance to give the health planning law the opportunity to further local areawide planning and determination of need.

- The Certificate of Need process under P.L. 93-641 should be strengthened so that all states will possess an operating approved program to review and determine the appropriate use of capital expenditures. The definition of "new institutional health services" under the Certificate of Need program should be broadened to include all providers of health care, regardless of the setting.

- The DHEW is strongly urged to perform or commission studies on approaches to introduction, deployment and cost-benefit analysis of expensive new medical technology (e.g., CT Scanner).

- DHEW is strongly urged to undertake or sponsor cost-benefit studies of mandated capital requirements of hospitals and provide valid data for later reference on this subject.

- The government should establish positive incentives for providers to bring the health care facilities and services available in an area in line with community needs. Such incentives may be provided through the reimbursement mechanism or capital expenditure review process. Mergers, shared services and other cost containment efforts should be promoted while preserving or improving high quality care.

P.L. 93-641 will, if allowed to operate up to its maximum potential, induce hospitals to be more critical and rational in their growth and program plans and to relate these plans to those of other institutions and to the needs of the community.

APPENDIX A

to the Testimony of the
Association of American Medical Colleges
on S. 1391

The foregoing testimony of the Association of American Medical Colleges discusses general issues raised by the hospital revenue limitations proposed in S. 1391. This Appendix supplements those general concerns with a section by section review of specific issues arising from Title I of the bill.

Section 111: Imposition of Limit on Hospital Revenue Increases

This section is deficient in four areas: (1) the use of gross costs and charges for determining limits, (2) the establishment of at least four separate classes of payors, (3) the retroactive controls of the updating procedure, and (4) the absence of a carry forward provision for deferring increases.

In establishing a revenue control program using gross revenues for calculating the limitation, S. 1391 ignores important operational characteristics of hospitals: (1) Cost-based payors frequently do not make a final determination of payment until two to four years following an accounting period. Thus, the hospital cannot accurately determine its limitation for cost-based payors. (2) If cost-based payors alter the provisions of their contractural allowances, net hospital revenues could vary substantially from the limit imposed. (3) The average charge imposed for charge-based payors has no consistent relationship to the amount of monies received by the hospital, for the volume of charity care and the bad debts experience are constantly changing. Thus, the hospital limited to increasing its gross charges has no assurance that its net revenues will

actually increase or even remain constant.

The establishment of separate payment categories for determining revenue limitations for Medicare, Medicaid, other cost-based, and charge-based payors does not recognize the payment characteristics of patients or the operational realities of hospitals: (1) the classification system is not mutually exclusive, for many patients are supported by two or more of these four types of payors. No information is provided in the bill on how such patients and their derived revenues would be classified. (2) The classification of patients by payor assumes each patient may be categorized prior to or upon admission. This is frequently not true for patients supported by Medicaid, workmen's compensation, automobile liability insurance, etc. (3) With per admission revenues limited by class of payor, hospitals appear to be unable to increase revenues from third-party payors which alter their benefit structure to cover additional services. (4) Unless hospitals abandon efforts to provide "one class" service and create separate and defined service units for different classes of payors, the proposal will necessitate four separate hospital control systems. At a minimum this will increase administrative costs; at worst it will render the institutions unmanageable.

The updating procedure for retroactively determining allowable increases from the conclusion of Fiscal Year 1976 to September 30, 1977 (and to the beginning of other fiscal years) is unreasonable and punitive: (1) the procedure for determining increases adds allowable increase percentages across fiscal years rather than compounds them. The effect of this procedure will be a reduction in the allowable revenue ceiling equal to the difference between (a) multiplying this year's allowable increase by last year's allowable ceiling and (b) adding this year's percentage increase to all past percentage increases and multiplying this sum by the base year

(1976) revenue limit. (2) For hospitals which have experienced cost increases in excess of 15 percent since the end of fiscal 1976, the retroactive provisions for the period from the end of fiscal year 1976 through September 30, 1977 proposes to limit recognition of expenditures which have already been made and which were allowable costs for reimbursement at the time they were made. (3) The retroactive adjustment and roll forward adjustments are stated in terms of costs rather than revenue. As a result, hospitals incurring cost increases below the allowable limits will have a decreased revenue limitation in future years. Thus, it is reasonable to hypothesize that the revenue ceiling simultaneously becomes an operating expenditure floor. (4) By stating the retroactive provisions in terms of costs rather than revenues, the procedure for determining limitations for charge-based payors effectively limits charge increases, in both the past and future years, to the program's recognized increases in costs. As a result, any hospital which presently has charges less than cost will be precluded from increasing charges to cover costs. Moreover, hospitals which adjusted charges to cover costs during fiscal years 1975 and 1976 will be forced by the mathematics of the retroactive and roll forward provisions to have charges below costs from Fiscal Year 1977 until the termination of the program.

Section 112: Determination of Adjusted Inpatient Hospital Revenue Increase Limit

The proposed procedure for determining a hospital's adjusted inpatient revenue increase limit has the following deficiences: (1) it provides for inadequate notice of allowable increases, (2) it uses a wholly inappropriate measure of general economy inflation, (3) it does not provide any recognition for the atypical costs of teaching hospitals, and (4) it ignores governmentally-imposed cost increases.

Under the proposal, the Secretary would establish a new revenue limitation no more than ninety days prior to its effective date. As a practical matter, the delays inherent in federal statistical reporting could provide at most thirty days notice of the new limitation. Because personnel expenses are the largest portion of a hospital's expenses and because many hospitals require more than thirty days in order to involuntarily terminate an employee, hospitals would have difficulty reducing anticipated costs with only thirty days, or even ninety days, notice.

The implicit price deflator of the Gross National Product was not designed to measure general economy inflation because it measures both price and product mix changes. This has been acknowledged by the Commerce Department in a letter to the Hospital Association of New York State. The net effect of this deficiency is that the implicit price deflator understates the level of price inflation present in the general economy.

Teaching hospitals frequently include a substantial physician component in the hospital's budget. If these physicians were practicing in the general community, their incomes would not be controlled. However, because they are included in the hospitals' operating costs, they are subject to control. This will severely hamper the ability of hospitals to recruit physicians for their salaried staffs. Moreover, it is likely to encourage physicians presently on the staff to re-evaluate and change their source of income from salaries to patient fees. In addition to increasing costs, this threatens established community patterns of providing faculty services for graduate medical education. Secondly, the combination of expanded numbers of medical school graduates and new opportunities in primary care requires increasing the number of residency positions available. With no adjustment for these cost increases in educational programs, established teaching hospitals are unlikely to expand

or change their residency programs and hospitals without residencies are unlikely to seek them.

Hospitals are frequently incurring new costs to meet governmentally imposed requirements for such items as pension reform, occupational health activities, life safety activities, etc. The proposal provides no recognition, pass through, or exemption for these costs although they could exceed the allowable increases in revenues.

Section 113: Promulgation of Admission Load Formula

The admission load adjustments, or corridors, are always calculated in terms of the base year, fiscal 1976, regardless of how long the program lasts. In the present fiscal year, this poses a significant problem for some hospitals whose size, case mix, or community role has dramatically changed. In future years, increasing numbers of hospitals will face volume changes generating marginal revenues equal to 50% of or 0% of the average allowable revenues per admission.

Of nine studies of hospital economics published between 1970 and 1973,[1-9]

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[1]Ralph E. Berry, Jr. and John W. Carr, Jr., "Efficiency in the Production of Hospital Services," unpublished paper (June 1973).
[2]Robert E. Kuenne, "Average Sectorial Cost Functions in a Group of New Jersey Hospitals," Research Monograph #1 (Princeton University: General Economic Systems Project, October 1972).
[3]Judith Lave, Lester Lave and Larry Silverman, "Hospital Cost Estimation Controlling For Case Mix," unpublished paper (1972).
[4]Robert Evans and H. Walker, "Information Theory and the Analysis of Hospital Cost Structure," Canadian Journal of Economics, Vol. 5 (August 1972), pp. 398-418.
[5]Robert Evans, "Behavioral Cost Functions For Hospitals," Canadian Journal of Economics, Vol. 4 (May 1971), pp. 198-215.
[6]Judith Lave and Lester Lave, "Hospital Cost Functions," American Economic Review, Vol. 6 (June 1970), pp. 379-395.
[7]Judith Lave and Lester Lave, "Estimated Cost Functions for Pennsylvania Hospitals," Inquiry, Vol. 7 (June 1970), pp. 3-14.
[8]Harold Cohen, "Hospital Cost Curves With Emphasis On Measuring Patient Care Output," in Herbert Klarman (ed.), Empirical Studies in Health Economics (Baltimore, Maryland: The Johns Hopkins Press 1970), pp. 279-293.
[9]Edgar Francisco, "Analysis of Cost Variations Among Short-Term General Hospitals," in Herbert Klarman (ed.), Empirical Studies in Health Economics (Baltimore, Maryland: The Johns Hopkins Press 1970), pp. 32[illegible]2.

only one estimated the marginal costs of changes in patient volume to be approximately equal to 50% of average costs. Each of the other eight estimated that the marginal costs of volume changes to be substantially greater than 50% of the average cost. Thus, the Carter proposal seriously understates the marginal costs of changes in patient volume.

The renal dialysis program is presently attempting to establish regionalized centers for kidney care. Many have argued that this regionalization of referral services should occur for other tertiary care services; however, the marginal revenue volume adjustments of the proposal will discourage the development of new regionalized referral services.

Section 114: Base Inpatient Hospital Revenue

The base revenue period proposed does not provide for an adjustment for hospitals whose operating expenditures exceeded net revenues for that fiscal year. Thus, as with Economic Stabilization Program, the proposal traps those hospitals in a deficit position in 1976 in a deficit position throughout the period of this bill.

The base revenue period does not provide an adjustment for hospitals whose charges did not equal the costs of services provided in the base year. Thus, such hospitals are effectively precluded from increasing charge-based revenues to cover costs unless a reduction in bad debts happens to have this effect for one or two years.

By selecting a 1976 base year for a program that begins in fiscal year 1978, the program must establish a means of bridging 1977. The selected method (see Section 111) works to reduce the permissable 1978 revenue increase by the extent to which the increase in fiscal year 1977 operating costs exceeds base year costs by more than fifteen percent.

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Section 115: Establishment of Exceptions

The exceptions process proposed in S. 1391 is deficient because: (1) it provides no mechanism for necessary additional revenues resulting from changes in diagnostic case mix, (2) it requires a hospital to approach insolvency as a condition of granting any exception, (3) it requires a hospital to spend its unrestricted endowments in order to qualify for an exception, (4) it does not ensure that a hospital improves its current ratio before losing its exception status, and (5) it requires hospitals to accept all recommendations made by an operational review ordered by the Secretary in order to maintain exception status.

The exception process is available to hospitals in only two circumstances: hospitals with costs increased because of changes in inpatient volume exceeding ±15% and hospitals with costs increased because of changes in the scope of services available in the hospitals. No other grounds for exceptions are provided. In particular, no exception basis is provided for hospitals with costs increased because of changes in the diagnostic mix of patients treated. For tertiary care teaching hospitals which are the ultimate referral point for complex and costly cases, this is a most serious shortcoming.

Hospitals seeking exceptions as a result of volume and/or scope of service changes must also demonstrate that they are approaching insolvency by having a current ratio in the lowest quartile of all hospitals. For hospitals having serious financial problems at the present time, this additional requirement has little significance; however, for hospitals which presently are financially sound, this requirement constitutes financial brinksmenship. Such institutions must temporarily, and probably permanently, weaken their financial stability, increase their level of risk in the eyes of financial institutions, and increase their necessary borrowing for working

capital requirements. More significantly, hospitals approaching insolvency but without the required volume or scope of services changes have no basis for seeking an exception under the proposal.

Many hospitals have traditionally been the beneficiary of gifts and memorials which have been used to establish endowment funds. Hospital governing boards, in their fiduciary role, have frequently invested the endowment principal to preserve its perpetual character. Endowment income has then provided a source of revenue for a variety of hospital purposes, including the provision of care to those unable to pay. Because the definition of the "current ratio" proposed in this section includes marketable securities, hospitals may have to liquidate the invested endowment principal before qualifying for an exception. This violates both the fiduciary responsibility of the Board of Directors and the expectations and intentions of the donor.

Even if a hospital meets the conditions for an exception, there is no assurance that the exception will prevail until the current ratio improves. If some hospitals formerly in the upper 75% of the current asset distribution drop below the current ratio of hospitals granted exceptions, the cutoff point for the lowest 25% of hospitals will fall. Thus, a hospital that is exempt in fiscal year 1978 may not qualify for an exemption in fiscal year 1979 because its relative solvency has improved though its absolute solvency remains unchanged.

Finally, hospitals granted an exception are required to accept an operational review ordered by the Secretary. In addition, hospitals are required to implement all recommendations made by those conducting the operational review. No mechanism for appealing of reconsidering these recommendation is provided in the bill. For teaching hospitals with joint patient care and education

goals this is a significant issue. If the operational review recommends changes strengthening or improving the efficiency or economy of patient care services at the expense of the hospital's educational goals and programs, the binding recommendations could change the nature and character of the hospital.

Section 116: Enforcement

Many providers are currently challenging the legality of their Medicare and/or Medicaid payments. If these administrative appeals and suits are successful, the hospitals would normally be entitled to increased revenues. The proposal does not appear to recognize or adjust revenue limitations for such retroactive reimbursement gains. Further, it, in effect, precludes Medicare and Medicaid from correcting such deficiencies in the present or future fiscal years by imposing serious penalties on the states and hospitals involved in such payments. Thus errors in past years would be perpetuated.

Section 117: Exception for Hospitals in Certain States

States with approved cost containment programs may be granted an exception if the Governor certifies that the aggregate rate of increase granted under the state program will not exceed the aggregate rate of increase that would have been granted under the federal program. While this permits the state programs operational flexibility, it neither establishes operational standards for state administered rate programs nor provides assurances that the state will not impose a substantially more stringent rate of revenue limitation.

Section 124: Exemption of Nonsupervisory Personnel Wage Increases from Revenue Limit

By providing an exemption for wage increases granted nonsupervisory employers as defined by the National Labor Relations Act, the Administration's

proposal is likely to increase the demands of these personnel for increases. Increases granted to nonsupervisory personnel will probably determine the wage increase expectations of personnel defined as other than nonsupervisory. Without a similar exemption for these latter employees, the hospital may be unable to grant wage increases fulfilling expectations; morale will decrease, turnover will increase, and supervisory-nonsupervisory personnel tensions will increase.

By exempting pay increases for nonsupervisory personnel, the hospital's labor force may be artificially inflated. Labor saving and cost effective capital equipment may be avoided where capital and operating revenues are limited but nonsupervisory pay increases are exempt. In the long run, this will increase rather than decrease costs.

Section 126: Improper Changes in Admission Practices

While this provision is designed to prescribe continued acceptance of charity or partial pay patients, it ignores the issue of the diagnostic mix of the patients which are accepted. This may adversely effect teaching hospitals if hospitals complying with this provision substitute low cost admissions for high cost admissions without penalty.

APPENDIX B

to the Testimony of the
Association of American Medical Colleges
on S. 1391

The foregoing testimony of the Association of American Medical Colleges discusses general issues raised by the capital expenditure limitations proposed in S. 1391 and addresses the $2.5 billion national capital expenditure ceiling, the 4 beds per 1000 population ceiling for the supply of hospital beds and the 80 percent standard for occupancy of hospital beds specifically. This Appendix supplements those general concerns with a section by section review of other issues arising from Title II of the bill that were not addressed in the formal testimony.

Section 1504.(a)(2)

Following his determination of an annual hospital capital expenditure limit, the Secretary would apportion the sum among the States on the basis of the ratio of their individual total populations to the nation's total population (at least for the first 18 months subsequent to the bill's enactment). The sources to be used for these population figures are not identified. This straight allocation-by-population method of distributing capital expenditure funds among the states is too simple and completely inequitable. It totally disregards such major factors as the need for capital expansion or modernization; the category of hospitals under consideration by level of care they provide and their case mix; construction costs which vary widely by geographic location; demographic and trend data on the population served; patient origin information and more. The provision suggests that these and other factors potentially important to equitable apportionment will be taken into account by the Secretary in later years. However, until then states such as New York, whose excess hospital bed condition has often been an item for discussion in

the press and by that state's governor, would receive a sizeable allocation though its use would be limited due to its already being overbedded. While, on the other hand, numerous hospital facilities in the south are facing obsolescence, but will not be able to make necessary improvements due to small state populations and, in turn, lower capital expenditure appropriations. Thus, many of the more populated, overbedded states will be rewarded for unsound planning, while many other states where hospitals desperately need capital improvements will be punished because of their smaller population sizes. This establishes a cap for capital expenditures in each state for the fiscal year (as promulgated within 60 days of the beginning of that fiscal year) and would severely limit the states' ability to plan to meet its local needs (as promoted under the existing national health planning law).

Section 1527 (a)(1)(2)&(3)

These provisions in Title II pertain to the Certificate of Need Program required under Section 1523 (a)(4)(B) of the Health Planning Act. The first two provisions generally conform to the language used in P.L. 93-641 to describe the basic intent of Certificate of Need programs to review and determine the need for services, facilities and organizations proposed to be offered or developed and administer the program to assure that only those found to be needed are offered or developed. The third provision is where the Administration's proposal begins to amend Title XV of the Public Health Service Act as it pertains to Certificate of Need programs by adding totally new stipulations to the Act. In this provision, the state is required to specify the capital expenditure ceiling (at the institutional level) that is tied to the Certificate of Need being issued. This is interpreted to mean that the institution would be told what it could spend on a capital project regardless of the source of funding. Thus, even if government funds account for only a small portion of the capital

to be expended, the state will establish a limit on the hospital's capital expenditure based on their analysis and interpretation of what the total project cost should be.

Section 1527(a)(4)

This section ties the total dollar amount of Certificates of Need awarded by a state in a fiscal year to the previously established (by population ratio) annual limit for new capital expenditures for that particular state in that fiscal year. However, it does allow a state to carry forward the unused portion of that fiscal year's state allocation to the next succeeding year. But it is not clear whether the amount carried forward in the next year can continue to be added to the state's allocation in subsequent years (a second year, a third year, etc.). This provision would also provide that if in a fiscal year there was a closure of a hospital (or part thereof) through which services found to be inappropriate were provided, then the undepreciated value of that hospital (the amount by which the hospital's historical cost exceeds the total amount of its depreciation claimed for purposes of establishing its reasonable costs of services for reimbursement under Medicare) can be added to the state's capital expenditure allotment for the next fiscal year. Again, it is unclear whether this additional amount can continue to be carried over into subsequent years.

Section 1527 (b) (1) & (2) and (c) (1) & (2)

Under these provisions, if a hospital proposed a capital project under Certificate of Need that would increase a state's bed to population ratio beyond the applicable bed supply ceiling previously established for that area or produce a number of hospital beds which would result in a hospital bed occupancy rate within that area which is less than the applicable occupancy standard for that area, then the proposed project would be rejected and denied a certificate of need, as well as, any federal grants, loan guarantees or tax

subsidies for construction. The arguments against these stipulations are the same as those pointing out the invalid and arbitrary nature of the standards themselves, as presented in the body of the Association's testimony. Once again the definition of the term "beds" is open to question. With the underlying theme being encouragement of hospital closures, these provisions also provide that if in any fiscal year the number of hospital beds is in excess of the supply ceiling applicable to a health service area or the hospital bed occupancy rate within that area is less than the applicable occupancy standard, then a certificate of need may be granted for such a service or facility that would result in a number of new hospital beds which is not more than 50 percent of the number of beds removed permanently from service in that health service area in that fiscal year. Under the circumstances of Title II, this would seem to allow some flexibility in areas where the established standards have not been successfully met. However, if an institution in such an area desired to build a totally new hospital, would it then be forced to build one half its current size? And can the replacement beds be of a different category than those removed (e.g., can tertiary care beds replace primary care beds)?

Section 1527 (a) (6)

The term "hospital" is defined for purposes of Title II. As in Title I of the Act, Federal hospitals are excluded, as are hospitals deriving more than 75 percent of its inpatient care revenues on a capitation basis, disregarding revenues received under Medicare, from one or more HMOs. However, unlike Title I, included in the Title II definition are those hospitals who have for less than two years fulfilled the conditions for participation for reimbursement under the Medicare program. Such an institution may not have had time to establish an adequate revenue base or credit rating to

undertake necessary improvements on the basis of community health service needs and will be prevented from acquiring the capital necessary to undertake essential projects.

Section 1527 (a) (7)

This section defines the term "capital expenditure" under title II. One criterion for this definition is that the expenditure (not chargeable as an expense of operation and maintenance) exceeds $100,000. This dollar threshold is inconsistent with that established in the final certificate of need regulations at $150,000. The $150,000 figure was defended by the Secretary at that time on the basis of (1) the experience of section 1122 and certificate of need programs; (2) the fact that few significant capital expenditures are less than $150,000; and (3) the inflation in the cost of medical equipment in the years since enactment by Congress of the section 1122 program. This appears to be sufficient justification for maintaining the dollar threshold at $150,000, as established in the existing regulations. This section also states that any donation of any equipment to a hospital shall be considered a hospital capital expenditure and included in determining whether such expenditure exceeds $100,000.

Section 1527 (d)

This provision would alter the length of the cycle for review of proposed health system changes under P.L. 93-641 from 90 days to one year. The major concern here is that if review was done once a year, it would create a one year moratorium on all construction the first year of the bill's enactment, even though it would probably provide a mechanism for a more

objective, organized and quicker review process. The bill also fails to describe how the review process would operate under the new cycle length. Would the HSA take a backlog of applications and make determinations? Take all applications received for the rest of the year and put in descending order?

Section 202 (a) (1)

This provision amends section 1122 of the Social Security Act to authorize the Secretary to directly perform the review functions for new capital expenditures when a state has not entered into an 1122 agreement with the Secretary and does not have an approved certificate of need program. This would only add to the already unreasonable amount of authority given the Secretary under Title II and add another level of review into an already crowded arena. Currently, there are 37 states that have section 1122 contracts, and for the moment, no states have an approved certificate of need program for reasons discussed earlier (i.e., a combination of failure to develop viable health plans on the part of local agencies and the lack of guidance and patience on the part of the government). All the states are required to establish approved Certificate of Need programs and will if given the opportunity and assistance necessary to get such programs off the ground. The intent of P.L. 93-641 was the furtherance of areawide planning and determination of need at the local level, and any intervention by the Secretary would defeat this purpose before providing it a chance to succeed.

This section also amends section 1122 (d) (1) (B) (ii) (II) of the Social Security Act and establishes a multiplier (ten times) to the amount of money that is denied by the Secretary for reimbursement for depreciation, interest on borrowed funds, a return on equity capital (for proprietary facilities) or other expenses related to capital expenditures. In essence, this authorizes the Secretary to increase the financial penalty for those who have their projects denied, but subsequently proceed. This may be another example of the unreasonable authority placed in the hands of the Secretary as well as the potential that would exist for endangering the community health services. Such services may be vitally needed, but were rejected at the state agency by a slight margin due strictly to fiscal problems which no longer existed when it was decided to proceed with the project without delay. Of course, this example may be stretching things a bit, but one should consider whether the multiplier of "ten times" is too severe or not. These penalties would not apply in states where approved Certificate of Need programs have been established and therefore reaffirms the belief that if such programs are allowed and assisted to develop and operate appropriately, such harsh penalties would not be necessary.

Section 203(a)

It would appear that this section amends the internal revenue code of 1954 by adding a new subsection F. This new subsection appears to remove the tax exempt status for interest derived from income relating to hospital tax exempt bonds. This subsection ties this penalty to the applicable hospital bed supply ceiling. First, there is a question whether or not this particular sanction can be legally prescribed at all. Second, will the penalty only apply to new bond issues or will it have a retroactive effect on past

obligations? Third, it is not clear what process or procedures will be involved in applying this new subsection and how they might involve the Health Systems Agency, the State Planning Agency, etc. and the extent to which the bureaucracy will grow in order to monitor these bonds. Fourth, denying the hospital the benefits of tax exempt bonds for necessary capital expenditures would only serve to raise the cost of health care and defeat the purpose of the Administration's cost containment proposal. Fifth, approved Certificate of Need programs, allowed to fulfill their roles, would negate the need for such a penalty, since most bond merchants monitor certificate of need and require prospective capital investments in the hospital industry to undergo the Certificate of Need process first.

SUB-ISSUES SURROUNDING TITLE II

The following are some issues arising out of the content, or lack thereof, of Title II and which were not necessarily addressed directly, or at all, but should be considered:

- No Real Relationship Between Titles I and II of the Act - Even if approval is obtained under Title II for a new capital expenditure, there is no guarantee that expenses incurred in operating the approved new activity, service or facility will be allowed under the operating cost ceiling under Title I. In response to this situation, financing will become more difficult to obtain. Hospitals have been acquiring capital more and more through debt financing arrangements. Under such arrangements, there will be greater hesitancy by financing groups to invest in hospitals since the President's proposal would make it less certain that a hospital will have adequate future reserves to pay back the principal and interest of the debt or be able to pay off the debt

through the exceptions process under Title I. The exceptions process requires a hospital to be almost insolvent (with a very low current ratio), while most lenders give a hospital a good quality rating if its current ratio is at least 1 1/2 to 1 or better. Thus, this would retard or eliminate debt financing as a feasible alternative for acquiring needed capital, since the inability to guarantee reimbursement of debt principal and interest under the cost containment act would undoubtedly produce much higher interest rates to hospitals.

- Titles I and II Convey Different Messages On Encouraging Increased Outpatient and Ambulatory Services - Title I appears to foster the development of outpatient services, shifting away from unnecessary utilization of inpatient services. Title II, on the other hand, constrains the entire institution, impeding the shift from inpatient services to increased expenditures for hospital development of its outpatient facilities. Thus, it appears that the Administration wants to encourage increased development of ambulatory care, but in free-standing units and not in hospitals where they may fear too much of a shift of overhead to the outpatient areas.
- Permanence of Title II - Unlike Title I which is transitory in nature, Title II is a permanent proposal. Since there is nothing to say that Title II will change over time, it may be a worthwhile planning tool for hospitals if HSAs included a capital expenditure component in their Annual Implementation Plans (AIPs) to provide some fixed point from which hospitals can work each fiscal year.

Senator KENNEDY. That is a vote, and so we will recess briefly. Senator Schweiker will be back in a couple of minutes.

[Brief recess.]

Senator SCHWEIKER. The Senate Health and Scientific Research Subcommittee will reconvene, and we will call as our next witness, Prof. John D. Thompson, chief, division of health services administration, Yale University School of Medicine.

STATEMENT OF JOHN D. THOMPSON, CHIEF, DIVISION OF HEALTH SERVICES ADMINISTRATION, YALE UNIVERSITY SCHOOL OF MEDICINE

Senator SCHWEIKER. Professor Thompson, I know you had a loss in your family over the weekend. We certainly appreciate your being here today.

Mr. THOMPSON. Thank you, Senator.

Rather than repeating or reading my testimony, which you have a copy of, I think I would like to address some specific questions that were raised at various times in the testimony this morning as they affect my main points.

I think probably the most important problem is illustrated by my table which shows that the variation in costs per nonmaternity day for all Connecticut hospitals was from $269.92 a patient day to $127.87 a patient day.

Now, obviously, within this variation, there are hospitals that are inefficient and hospitals that are efficient. By increasing revenues with a standard percent for each hospital, one will be maintaining those kinds of differentiations.

This morning, Senator Kennedy asked an important question, and that was: Why would a State cost commission be preferable to a Federal program such as is envisioned in this proposal?

I think there are three reasons why State cost commissions operating under Federal guidelines might be more effective.

The first is that it would be easier and faster to institute either uniform cost reporting or uniform cost accounting State by State; and that the comparison across hospitals could be made more meaningful within a State.

The second reason deals with my second point which is that it is at the State level where the PSRO's, the HSA's, the cost commissions, and the health maintenance organizations could get together and consider these cost problems in an interrelated way.

My major point was that there are two ways to cut hospital costs.

One is to decrease the cost of the product and the other is to decrease the number of products used in this case the number of hospital inpatient days used.

The PSRO's, the health service agencies, and the HMO's are aimed at that second target; a target which I believe will probably have more long-term effect on containment of hospital costs than shaving $2 or $3 off the hospital day.

The third reason was also brought up several times in the testimony this morning and that was about the viability of some of the State agencies already existing and in place.

My comments were limited to those seven State and regional agencies now being funded by the Social Security Administration under

Public Law 92–603. We visited all seven and only two of those seven programs would be eligible under the act as a State agency.

The reasons for this are varied. Some of the seven programs do not include a whole State. Some of them will not be ready to institute any kind of meaningful cost controls for at least another year. Some of them have their eye on the long-range effects of hospital costs rather on the short range; and therefore probably would not meet the requirement for a 9-percent cap.

On the other hand, these seven programs are examining some very interesting problems in hospital cost containment, almost every one of which was addressed in testimony here this morning.

Senator Kennedy specifically asked Senator McIntyre about a total cap and the Rochester cost containment experience talks about a "community cap" rather than a "hospital cap." In other words, there will be a certain amount of dollars the ciommunity can spend on all kinds of medical services—hospitals, nursing homes, et cetera, et cetera. That is a very interesting kind of idea. And that experiment would be wasted if the critieria established by this law were to be placed in effect.

You talked about grouping hospitals. It is our opinion that hospital groupings really reflect differences in diagnostic mix. Dr. Finley spoke about that in her testimony.

The New Jersey experiment is considering both routine and special-service costs in relationship to diagnostic mix. Perhaps the way to reimburse the hospitals may not be by the patient-day but by a flat amount for a total hospital stay of a patient with certain characteristics and who is being treated for a specific diagnosis and complications and who is undergoing certain surgery.

We estimate that a hospital can be classified by 383 such diagnostic related groupings.

The Pittsburgh program is trying to factor in teaching, education, and other aspects of community service, which costs the AAMC group have requested be included when one groups hospitals.

So what I am really concerned about, then, is the fact that the potential of these programs may never shed light on the cost containment problem because they will be more or less superseded by this particular legislation.

There was a great deal of discussion this morning about uniform cost accounting and uniform cost reporting and what would be good and what is wrong about either one of them.

I think the problem was never dealt with very clearly because the secret of both is a uniform chart of accounts and a uniform method of allocating indirect costs into direct costs. Once a uniform chart of accounts is accepted by all hospitals plus a uniform allocation system so that one can allocate administrative expenses, et cetera, into service departments—then I don't think it is as serious a matter as toıwhether all hospitals should be going into uniform accounting or uniform reporting.

Connecticut has had a uniform cost reporting system since 1948 and good comparisons between costs in Connecticut, Mr. Chairman, are possible on the basis of this reporting system.

The problem that hospital administrators have with uniform accounting systems is that the hospital's own accounting system reflects management's assignment of responsibility, and it is called

"Responsibility Accounting." Depending upon the way the hospital is organized, different kinds of people may be responsible for different kinds of functions in the hospital. Both uniform cost reporting and uniform cost accounting have to have a uniform chart of accounts or neither one of them is any good. Uniform reporting does not interfere with management's organizational preferences.

It would be my recommendation that a uniform cost reporting system, based on a detailed uniform chart of accounts, and an agreed upon cost allocation system would certainly be adequate for the first phase of any cost containment program.

And I am open to questions about any of these other aspects of cost containment.

Senator SCHWEIKER. Thank you, Professor Thompson. The full text of your statement will, of course, be placed in the record.

Senator SCHWEIKER. Do you have any specific suggestions as to how we might strengthen the Planning Act, PSRO's, or the HMO program to better achieve cost containment objectives?

You did mention limiting the number of products or days; and therefore, limiting costs in that way.

Mr. THOMPSON. It is my opinion, and it is known by the staff here, Senator, that the PSRO's are not paying as much attention to the cost aspects of hospital care, that is, utilization review and unnecessary admissions as they should, or as the law tells them they should.

Probably the single factor that would assist the PSRO's and HSA's in any cost-containment program, would be a uniform data set and access by all three agencies to data.

You are in a very delicate position here because the PSRO's are insisting upon the privacy of certain kinds of data. I certainly believe that no patient's name should ever appear on any kind of shared data.

On the other hand, I don't know how much of the PSRO's concern for the privacy of the data is a defensive mechanism. I see no reason why data could not be aggregated by physician. I see no reason at all why data could not be aggregated by hospital.

The PSRO's are supposed to create a hospital profile which would give the cost control and the planning groups some idea of that hospital's performance on diagnostic specific lengths of stay and whether or not that hospital was overutilizing beds. And I cannot plan a hospital system if I do not know the role each hospital is playing within that system and of the efficiency with which that hospital is carrying out that role.

We talked this morning about regionalization. We talked this morning about teritiary care hospitals. If I have hospital profiles on all hospitals, I can determine the extent to which a teaching hospital is a real tertiary care hospital by its diagnostic mix.

Senator SCHWEIKER. What about the HSA's?

Mr. THOMPSON. Well, I believe, along with Dr. Finley—and I think she probably expressed it better than anybody else—that the HSA's are a central part of this system. But again they are suffering from a lack of data. The only place I know of where the HSA's, the PSRO's, and the hospital cost commissions can get the same kind of patient-centered data is in Maryland. In other words, these three federally-funded agencies are all walking around out in the field and

wanting each other's data and not being able to get it so that they could make some fairly tough decisions.

Senator SCHWEIKER. How do you feel the feasibility of classification of hospitals, such as Senator Talmadge has proposed?

Mr. THOMPSON. I feel that the first factor in the classification of hospitals should be the diagnostic mix. In other words, we reviewed some MADOC medicare tapes of Connecticut's hospitals and found, for example, that in one hospital about 22 percent of its cases had some kind of cancer while in another hospital only 6 percent of its cases were being treated for some kind of cancer. Once we can deal with diagnostic mix, then we can begin to arrive at teaching costs, research and development costs, and community service costs, which are the four areas that seem to be at question here in the differences between a large teaching hospital and the rest of the hospitals.

Senator SCHWEIKER. And you feel that prospective reimbursement experiments under section 222 should be exempted?

Mr. THOMPSON. You know, I think you could probably just write a blanket exemption for those that are being funded by SSA. And then I think you could stimulate further experiments by stating that such future experiments could also be subjected to a special waiver.

Senator SCHWEIKER. What is your reaction to the wage pass-through provisions?

Mr. THOMPSON. The wage pass-through provisions—well, you heard enough from New York State about the wage pass-through provisions. You are between a rock and a hard place. There is no question that with a wage pass-through provision, Senator, you will never gain your 9-percent goal. And the real question is how far beyond your 9-percent goal are you willing to go? It is just that clear.

Senator SCHWEIKER. It is just that clear, I agree. Nevertheless the committee will have to grapple with it.

Well, Professor, I want to thank you very much for being here. I think between your written statement and your answers to the questions, we have good input on a number of important issues.

We appreciate your appearance very much.

[The prepared statement of Dr. Thompson follows:]

TESTIMONY OF PROFESSOR JOHN D. THOMPSON,

CHIEF, DIVISION OF HEALTH SERVICES ADMINISTRATION,

YALE UNIVERSITY SCHOOL OF MEDICINE

Before the Subcommittee on Health and Scientific Research,

Committee on Human Resources, U. S. Senate

My name is John D. Thompson. I am a professor of Health Services Administration at Yale University. I want to make it quite clear that I believe some form of containment of medical care costs, including hospital costs, is central both for the efficient and effective use of our health resources and to increase the accessibility of these resources to the public.

I assisted the State legislators of Connecticut in framing that State's hospital control legislation, testified in favor of the bill at the time of its consideration, and have been serving as a consultant to Dr. Joanne Finley, the Commissioner of Health of the State of New Jersey in the implementation of that State's legislation. I have been actively engaged in research on hospital costs and utilization for ten years and have participated in two studies with the Subcommittee on Oversight and Investigations of the House Committee on Interstate and Foreign Commerce on two aspects of cost containment, the Professional Standards Review Organizations and Prospective Reimbursement for Hospital Care. I am here to express three major concerns about Title I of S. 1391. The first deals with the equity of restraining costs through a uniform cap on all hospitals without knowing more about the comparability of hospital costs. The second is the lack of interrelationship or concern for the effectiveness of existing federal legislative programs directed

toward the control of hospital costs. The third is the possible interference of this legislation with the seven federally funded efforts at cost containment through Prospective Reimbursement.

As to the first point -- you have before you the average costs for a non-maternity day of all Connecticut hospitals. These are the bases upon which "costs-payers" and Blue Cross reimburse hospitals in Connecticut. A uniform percent cap will undoubtedly be requested by each if S. 1391 passes. Note the variation in cost from $269.92 in hospital 1 to less than half of that, $127.87 in hospital 35. Hospital 1 is eligible for an increase of around $24.29 based on a 9% cap, while hospital 35 would be eligible for $11.50, a difference of $12.77 a patient day. Again, supposing a 9% increase were negotiated for next year, hospital 1 would be eligible for a $26.87 increase and hospital 35, $12.54, a difference of $14.33.

All the hospitals in Connecticut are accredited by the Joint Commission on Hospital Accreditation: all are treating a fairly homogenous population within a small state. The real question of restraining costs is why are these costs so different. We are now engaged in research on just this problem and are convinced that the particular diagnostic mix each hospital treats influences its costs. By ignoring these and other factors, the proposed system continues to reward the inefficient, constrain the efficient and freeze the differentials between these two kinds of hospitals.

Even more importantly, all of our Connecticut hospitals have been on a uniform cost reporting system based on a uniform chart of accounts since 1948. When one examines the data from other states, one is not sure of what "cost figures" mean, so comparisons as indicated in Section 125 of the bill our meaningless. It would seem that the first requisite for any cost containment program would be the imposition of uniform cost reporting or cost accounting with the specification of uniform charts of accounts.

As to the first point -- Title I of S. 1391 is attempting to constrain costs without examining the comparability of cost patterns in any depth and, further, is interfering with any future ability to deal with the real issue of cost by failing to provide for rational public accountability. Even a transitional program should address the issues of freezing a status quo which no one seems to understand and interfering with public accountability and the future ability to understand and deal with the reasons for cost increases.

There are two ways to contain hospital cost. The first is to control the price of the service unit, i.e., admission of patient day, and the second is to decrease the number of units purchased. Many feel that the second strategy is likely to be more effective than the first. The federal government has passed three pieces of legislation to deal with this approach.

The first, Professional Standards Review Organizations (Social Security Amendments of 1972, Public Law 92-603), is charged with insuring that care is provided only to those who need

it and that such care is of the highest quality consistent with professional standards. The approach within this program termed utilization review, is aimed at decreasing the number of units of service (hospital days) purchased per individual, and accomplishes its objectives by decreasing admissions to medical institutions or shortening the length of stay in these institutions.

The second, the National Health Planning and Resources Development Act of 1974 (Public Law 93-641), is charged with achieving "equal access to quality health care at a reasonable cost." The act addresses the problem of decreasing costs through the certificate of need approach. By approving only needed capital expenditures with their subsequent depreciation or debt allowances and their resultant operating expenses, there is a direct effect on medical care costs. Decreasing the number of hospital beds per unit of population will enable utilization review programs to work more effectively.

The third approach, the Health Maintenance Organizations Act of 1973 (Public Law 93-222), attempts to decrease utilization of institutions by changing the manner of the delivery of services from the traditional fee-for-service mode to prepaid group practice. Evidence that prepaid group practice has often resulted in as much as a 30% reduction in patient days indicates that this program would have considerable impact on the cost of institutional health services.

5.

When one examines the relationship of these three programs at the local level, one is amazed at the lack of any meaningful interface. The three programs do not share data usually; many planning bodies are, consequently, operating in a vacuum. The PSROs have not dealt in a meaningful way with hospital profiles which could give the Health Services Agencies some idea of whether or not over-hospitalization is occurring in their region. Pre-admission certification, second opinions on elective surgery, and other programs which, by penalizing physicians as well as hospitals, could reduce over-stays and unnecessary admissions, have not been widely adopted by PSROs.

Hospital costs are directly linked to the length of stay and the type of patient treated within the hospital. There is no evidence that the function of the PSROs is even related to hospital costs in S. 1391. Mention is made of HMOs and the planning bodies, but rather pangentially. There is no evidence of the kind of support HMOs require in obtaining prepaid contracts under Title XIX in many states, nor, is their evidence of fiscal support for the additional duties the HSAs are mandated to carry out.

The main conclusion of my second point, then, is that even a transitional cost containment proposal should support existing federal programs aimed at these same targets or that the success or failure of three existing programs should be assessed before new legislation is proposed.

We have recently visited each of the seven prospective reimbursement programs funded by the Social Security Administration under Section 222 of Public Law 92-603. These programs are examining many of the complex issues involved in cost control such as reimbursement and costing by diagnosis, fixed and variable costs, community medical care budgets rather than hospital budgets, funding depreciation for positive planning, shifting of patient care to alternative institutions and programs, and the use of various reimbursement approaches. This transitional proposal endangers the future of some of these experiments. Some cover only parts of states. Others will not affect costs for two or three years, and others cannot guarantee a percentage cap on costs without interfering with their proposed programs. It would be a tragedy for future knowledge of these aspects of cost controls if even one of these programs were to be wasted by S. 1391.

Florence Nightingale once said that "It may seem a strange principle to enunciate as the very first requirement in a hospital that it should do the sick no harm." What is of concern here is that a bill, even though labeled a transitional stage, might do some harm in its lack of rational approach to identify the real issues of hospital cost escalation, its failure to support, strengthen, and interrelate existing federal programs aimed at cost containment, and above all, its lack of concern for laying a base for the future development of effective control of all aspects of medical care delivery.

VARIATION IN COST PER NON-MATERNITY PATIENT DAY

ALL CONNECTICUT HOSPITALS

1976

Rank	Population Density	Number of Beds	Cost per Non-Maternity Day
1	C	120	$269.92
2	A	880	218.41
3	C	80	200.32
4	A	340	191.50
5	A	935	191.42
6	A	490	188.76
7	B	110	188.75
8	C	85	184.86
9	C	80	183.13
10	A	650	178.53
11	A	350	176.05
12	C	340	173.08
13	C	175	170.30
14	A	195	166.30
15	B	325	166.30
16	B	320	165.35
17	B	400	165.26
18	B	460	165.14
19	A	555	160.83
20	B	240	159.29
21	C	85	156.44
22	B	320	155.13

2.

Rank	Population Density	Number of Beds	Cost per Non-Maternity Day
23	B	225	152.89
24	B	260	151.99
25	B	390	151.43
26	A	415	149.79
27	B	150	148.59
28	C	80	148.28
29	C	165	143.53
30	B	385	143.18
31	B	85	143.11
32	B	270	137.56
33	B	305	136.56
34	C	190	135.13
35	B	215	127.87

Key:
A = more than 5,000 population per square mile

B = 1,000 - 4,999 population per square mile

C = Less than 1,000 population per square mile

Source: Connecticut Hospital Association

Senator SCHWEIKER. Our next witness is Dr. Edward S. Hyman, American Council of Medical Staffs.

STATEMENT OF EDWARD S. HYMAN, M.D., AMERICAN COUNCIL OF MEDICAL STAFFS, ACCOMPANIED BY WESLEY SERGE, M.D., VICE PRESIDENT; JAMES PENDLETON, M.D., AN OFFICER, AMERICAN COUNCIL OF MEDICAL STAFFS; AND JAMES H. WHITE III, ESQ., HOSPITAL ADMINISTRATOR, BIRMINGHAM, ALA.

Dr. HYMAN. Thank you.

Senator SCHWEIKER. Dr. Hyman, would you introduce your associates for the record please?

Dr. HYMAN. Yes, sir.

First, if I may, I would like to submit my written comments to the stenographer.

Senator SCHWEIKER. Without objection, so ordered.

Dr. HYMAN. With me is Dr. Wesley Segre, vice president, American Council of Medical Staffs; Dr. James Pendleton, Philadelphia, an officer of the Council of American Medical Staffs; and James White, a hospital administrator and lawyer from Birmingham.

I regret that Senator Kennedy had to leave early because I would remind him that Massachusetts would have less trouble meeting this law than others because they are already well above the national average.

For example, the 9-percent rise in Massachusetts would be, dollar-wise, Senator, a 17-percent rise in Louisiana.

If I may set up my equipment in order to comply with the 5-minute limitation?

Senator SCHWEIKER. Surely.

You will be making a slide presentation, I understand.

Dr. HYMAN. Yes. That is the way I prepared it.

If I may have the first slide.

Senator SCHWEIKER. Go right ahead.

Dr. HYMAN. Senators, as privately practicing physicians who attend sick people in hospitals, we are obliged to come here to tell you that the Government is the major cause of the abnormal rise in the cost of hospitals.

[Slide shown.]

Dr. HYMAN. In this slide, in the Consumer Price Index, the rise in the cost of hospitals broke and became much more rapid in 1966 with medicare and the introduction of Government methodology into the non-Government hospitals.

Government hospitals have always been much more expensive than private hospitals, and their cost is rising faster. Unfortunately, because of Government methodology, this greater income has not been available to update those hospitals, to divide the wards into bedrooms such as is required by medicare, to air-condition the wards as in private hospitals, or even to modernize their safety codes. They have copious paperwork and highly-polished floors.

Now, as HEW imposes the same Government methodology on private hospitals one would expect the price to rise and the quality to decay to that of the Government prototype. This is the real explanation for the break in the CPI curve and for the abnormal rise in

cost of our country's hospitals. Let us witness the mix of featherbeding and extra paperwork.

A hospital with 12 salaries in the biochemistry laboratory added another 12 in the personnel office and 27 more in the catacombs of the medicare office to serve sick paper.

There two officers did not exist, nor did the personnel, prior to medicare. The extra paperwork caused by the Government, or by a Government-controlled agency, has resulted in superfluous personnel at desks and in the hallways, and has taken our able-bodied nurses away from the bedside to fill out audits, nursing plans, and other useless paper.

Before medicare, one nurse or an aide would be at that desk. This is a new expense.

Untrained aides attend the sick and we have invented the patient representative. One-half of the rack for patients' charts is now devoted to a file for rules and regulations, and most of the time at medical staff meetings is similarly abused.

Clearly, these bureaucratic expenses are not controlled by the doctors' orders, and if hospital utilization is reduced, these fixed costs would simply be redistributed over fewer patient days.

When the three doctors in Hinesville, Ga , complained that the business office of their 17-patient hospital has expanded from 2 to 11 persons since medicare, that the cost of operating their pharmacy has soared, and that 56 new audits were responsible for 44 percent of the increase in costs of their hospital, they asked HEW to turn back the clock, and to reduce the featherbedding in order to cut the costs. Of course HEW said, "No".

New medical equipment like this heart monitor is somewhat expensive, but it costs no more than a new IBM typewriter and the service contract for the typewriter costs more. We have more new typewriters, and each typewriter is equipped with a jockey. The cost of paperwork is spread throughtout the accounting system.

Figure A. The Government requires utilization review of all patients. Of the 31,000 admissions in 1 year to the New York Hospital, 9,500 charts were reviewed, 6 overstays were detected and the cost was $34,000 per overstay detected. Figure B. Dr. McSherry, of the surgical department, extrapolated the cost of utilization review nationwide from the costs in New York City and found that this useless procedure is more expensive than the research budget of any of the Institutes of the National Institutes of Health. Utilization review is a failure and it contributes dramatically to the costs of hospitals.

In 1969 when the featherbedding of hospitals had already exhausted the medicare money the heads of Social Security wittingly misrepresented data in a fraudulent press release and told the press that doctors had overutilized hospital stays.

This and the subsequent coverups resulted in the euphemism called professional standards review or PSRO. In brief PSRO is but another set of catacombs with a bureaucratic office force with typewriters reviewing more paper as shown in this photograph of a prototype with 21 employees. This very same paper has already been reviewed in the catacombs I showed you in the hospital and again at the desks of the Blue Cross.

But by any reasonable estimate the additional money to be spent on PSRO in 2 years would buy a CAT-scanner for every

hospital in America. Let's not deny our patients the wonderful advances such as the CAT-scanner which would shorten hospital stays and help sick people. Instead let's reduce the cost by getting rid of sick paper.

If a ceiling of 9-percent cost rise per year is imposed on hospitals, medical care will be sealed in a closed container along with this expanding malignant bureaucracy. The malignancy will smother medical care.

The 41,000 privately practicing physicians of the Council of Medical Staffs urge you in Government to lower the cost of hospitals by getting rid of the added Federal bureaucracy and not by cheapening drugs, nor by cheapening medical care, nor by rationing medical care.

More of the cause is not the cure. If the Government is alarmed by the rise in cost of hospitals, it should stop causing the rise.

Thank you.

Senator SCHWEIKER. Thank you Dr. Hyman. That was a very concise presentation.

I do want to acknowledge the presence of Dr. James Pendleton a Pennsylvanian I know whom you introduced a moment ago. I appreciate his being here today.

Dr. Hyman, one question I have relates to the administrator's responsibility in controlling costs.

There is a great deal of controversy as to whether when the doctor orders the service the administrator can be held responsible.

How do you come down on that issue?

Dr. HYMAN. Senator I have written orders on patients' charts now for 33 years. The doctor's orders have very little to do with the cost of the hospital. Let me give you an example.

If I order another blood count on a patient, it costs the patient so many dollars—or a serum sodium or some other determination—but the cost to the hospital of that test is not that same $6. The additional cost to the hospital may be 6 cents, because the major cost in that hospital laboratory is the cost of the technician and the cost of maintaining that laboratory service. And they are paid by the month or by the year.

The majority of that $6 goes not to that laboratory but goes to the lobby; goes to that jockey over that typewriter and to the audits that occur in that hospital. That is where the money goes.

And the same goes with drugs.

There is nothing I could do to affect those costs. And should I not order more tests, the tests that I think are necessary, then the same fixed cost must be redistributed over fewer tests, but the total costs would be essentially unchanged. I don't think the administrator, either, has any control whatsoever over these fixed costs because they are caused by the requirements of the various audits that are brought by the Federal Government, or by agencies which are largely controlled by the Federal Government.

You see, Senator, all of this is new since the Government decided to synthesize medical care over a committee meeting.

Senator SCHWEIKER. In general terms, what is your response to the Talmadge bill's approach?

Dr. HYMAN. I have not read the bill very carefully. I have heard only that it would be a disaster, but perhaps—Mr. White, would you like to address any remarks to that?

Mr. WHITE. I would suggest from Dr. Hyman's point of view, Senator, it would be worse than the bill before you in that it would tend to increase the bureaucracy involved in setting charges.

Insofar as it is a prospective reimbursement type of an approach, and an approach in which each hospital has to make a case for finding itself in one category or the other, it is going to introduce a whole new raft of forms and paperwork and regulations.

Dr. HYMAN. Senator, if I may add to that, again, as Mr. White said, this is additional paperwork and additional cost. And this is very much like the two programs I mentioned, which were designed to control the costs but have actually added to the costs—and those are the utilization review and the PSRO.

Senator SCHWEIKER. Well, Doctor, I certainly thank you for your presentation and your answers. As I said earlier, we will place your entire statement in the record. We appreciate your appearance here today.

[The prepared statement of Dr. Hyman and information referred to follow:]

TESTIMONY OF THE

AMERICAN COUNCIL OF MEDICAL STAFFS
3422 Bienville Street, New Orleans, LA 70119

on S. 1391
A Bill to establish a transitional system of
hospital cost containment

Presented to the Hearings of the

Subcommittee on Health and Scientific Research
of the
Senate Human Resources Committee

June 17, 1977

SUMMARY OF TESTIMONY

OF A.C.M.S.

ON S1391

As privately practicing physicians who attend the sick in hospitals we are obliged to demonstrate the role of the government itself as the major cause of the abnormal rise in the cost of hospitals. The Consumer Price Index shows that the cost of hospitals has risen more rapidly since 1966 when government intervention began with Medicare. Government-run hospitals have always been more expensive than private hospitals, and their wasteful methodology has not allowed updating of their own facilities. Imposing the same government methodology on private hospitals has raised the cost and lowered the quality.

Every facility within the hospital has been burdened with bureaucracy, featherbedding, job descriptions, paperwork, audits, typewriters, and typewriter jockeys, all of which raise the costs of hospitals and divert professionals from the care of sick people to the care of sick paper. HEW will not stem the rise of bureaucracy. Although lauded as successes, audits of hospital utilization and medical audits have actually been failures which have significantly added to costs. The projected cost of a new Federal rationing procedure known as PSRO is great enough to buy a CAT-scanner for every hospital in America in 2 or 3 years. Yet planners would ration that revolutionary new X-Ray technique while spending the money to ration medical care.

Practicing physicians ask the government to lower the costs of hospitals by getting rid of the featherbedding, the paperwork, and the bureaucracy, and not by cheapening drugs, by cheapening medical care, or by rationing medical care. More of the cause is not the cure. If the government is alarmed by the rise in the cost of hospitals, it should stop causing the rise.

C O R R E C T I O N S

Page 2.

Paragraph one, line nine, CHANGE TO: "One out of seven ..."

Paragraph three, lines four to six. UNDERLINE: "This is a real explanation of the abnormal rise in cost our private hospitals."

Page 3.

Paragraph five, line three, ADD: "...imposed by HEW throughout the hospital. The cost of the bureaucracy is spread over all other items. Won't you in this ..."

Page 4.

Paragraph three, SUBSTITUTE THIS PARAGRAPH:

"The most important advance in X-Ray studies in at least 30 years is the Computerized Axial Tomography, the CAT scanner. The apparatus is expensive. Rationing of CAT scanners has been proposed to contain hospital costs. But, by any reasonable estimate, the additional money to be spent on PSRO in 3 years would buy a CAT scanner for every private hospital in America. Let's not deny our patients the wonderful advances such as the CAT scanner, which would shorten hospital stays and help sick people. Instead let's reduce the cost by getting rid of sick paper."

Paragraph four, line six, ADD: "... in this kind of cost containment. This kind of containment is neither equitable nor is it good for the people of our country."

Paragraph five, UNDERLINE: "But, if the Government is alarmed by the rise in cost of Hospitals, it should stop causing the rise.

Testimony of the American Council of Medical Staffs on S. 1391, a Bill to establish a transitional system of hospital cost containment, presented to the Hearings of the Subcommittee on Health and Scientific Research of the Senate Human Resources Committee, on June 17, 1977.

Mr. Chairman, Members of the Subcommittee:

I am Dr. Edward S. Hyman, Vice President of the American CMS. The American Council of Medical Staffs, founded in 1968, is now the second largest medical organization in the United States, and the largest organization representing only privately practicing doctors. Our voting membership is 41,387, comprising 71 Chapters in 32 States, and growing.

I am a privately practicing physician as a specialist in the field of Internal Medicine for the past 23 years, and a research biophysicist. With me is Dr. Wesley N. Segre, also a Vice President of CMS, and a practicing pediatrician for the past 40 years. He is past president of the Louisiana Medical Association, representing the black physicians in Louisiana.

It is necessary that public policy in the field of health care be responsive to the needs of the patient. This is why we are presenting this testimony.

Everyone knows that the cost of hospitals has risen inordinately, and many reasons have been given. As seen in the Consumer Price Index, (Figure 1), the hospital per diem began to rise more rapidly in 1965 when the Federal Government began to move into the nation's hospitals with the Medicare program.

In spite of the information repeated in the popular press, hospitalization in the government's "System" of Hospitals is much more expensive than in the private, so called "Non-System" of hospitals. As an example, before Medicare, the cost of hospitalization in U.S. Veteran's Administration Hospitals was more than three times as high as in a private hospital (Figure 2). Public Health Hospitals were about the same price (Figure 3).

In spite of its much higher cost per stay, the U.S. Public Health Hospital in New Orleans has been unable to keep up with the times, as shown in the photograph (Figure 4).

That hospital would not qualify for Medicare because there are more than 4 in a room. That hospital could not pass inspection by the New Orleans Fire Department. It is not air-conditioned, but every less expensive private hospital in our deep-South city is air-conditioned. When we visited it was nearly empty. Of the 363 patients in the hospital log book, there were only about 50 warm bodies on the wards. 6 out of 7 patients were not there. Some lived as far away as 1,000 miles. They lent their names to the hospital log. They required no food, no medicines, no linens, no nursing, and no other service. 1 out of 7 patients were there. Thus, the 2 employees per patient touted by the AFL-CIO's spokesman in New Orleans was 14 employees per patient who actually lived there. Perhaps that is why they had enough personnel to wash disposable syringes during our visit. Like any Federal Hospital, the floors were highly polished (Figure 4). No one walked on them.

In spite of being more expensive for a patient stay, these government hospitals, like those in England, or Russia (Figure 5) are not capable of using their large revenues for change; for updating; for installing modern plumbing and air-conditioning; or even for partitioning wards into rooms. This is the picture of a mature or overripe "system of hospitals" full of government methodology.

Now, as HEW imposes the methodology of a government hospital onto a private hospital, we may expect the cost of the private hospital to rise and to approach that of a government hospital, and the quality of care in the private hospital to decay to that of a government hospital. This is a real explanation of the abnormal rise in cost of our private hospitals. Let us witness the change.

The abnormal rise in cost of private hospitals began with the feather-bedding of personnel and the extra accounting required by Medicare. A hospital which has 12 technicians in the Biochemistry Laboratory to serve sick patients now has another 12 in the Personnel Office (Figure 6) and 27 more employees in the catacombs of this Medicare Office (Figure 7) to serve sick paper. Each is paid a salary by the hospital. Hospitals now have superfluous personnel at desks (Figure 8) and in the hallway. Healthy young nurses (Figure 9) are taught to sit at a desk and fill out pages of useless paper to expand a chart at the demand of some government agency, or some government-controlled agency such as the Joint Commission on Accreditation of Hospitals.

This costs money and interferes with good medical care. While the nurse treats sick paper, an untrained aide attends the sick patient. There are nursing plans which will never be used. Then there is the nursing audit. But, when the nurse becomes insulated from the patient by untrained assistants, patient care deteriorates. Instead of an oldfashioned, interested nurse, there is a "patient representative" (Figure 10). One half of the rack (Figure 11) for patient's charts is now devoted to a file for rules and regulations. With Medicare, accountants have proliferated. Unplanned administrative cubicles had to be built in the lobby of a new hospital (Figure 12).

A small hospital where all the doctors and one administrator once parked under the oak tree now has 4 parking lots. The versatile employee who

knew what to do was replaced by several untrained employees, each with a job description to limit any potential versatility or usefulness. Then, as problems arose between 2 job descriptions, another job description was created. The hospital became a bureaucracy. Clearly, these expenses are not controlled by the doctors' orders as was claimed by George Meany on November 6, 1975, in the House Ways and Means Committee, and by others.

When the 3 doctors in Hinesville, Georgia noted that the business office of their 17 patient hospital had expanded from 2 to 11 persons since Medicare, and the cost of pharmacy had soared, and the flood of paperwork and audits reached an increase of $11 per patient per day from pre-Medicare days, they asked HEW to turn back the clock, to reduce the featherbedding, and to cut the costs. (Figures 13 & 14). Federal, state and insurance audits has increased from one a year to 57 audits a year!

Of course, HEW said, "No" (Figure 15). "Audits, as you know, are important management tool we need in order to meet our responsibility to the public we serve." This is signed by the Chief of the Program Experimentation Branch, of the Division of Special Operations, of the Bureau of Health Insurance, of the Social Security Administration, of the Department of HEW. What a pedigree! Note that no "open heart surgery" is done in that hospital - the expenses soared not due to expensive technology, but to 57 audits which had diverted all personnel away from patient care.

You are told that new medical equipment like this heart monitor (Figure 16) is so expensive that it makes hospitalization expensive. But, an IBM typewriter costs as much as a heart monitor, and the service contract costs more, and there are many more new typewriters and each typewriter is equiped with a jockey. You are also told that "expensive and unnecessary heart surgery units lay unused and increase costs". But, the decried open heart surgery units exist in less than 10% of all hospitals, and all hospitals are suffering nearly alike from the escalating costs of bureaucracy. Obviously, these heart surgery units are only a small part of the problem.

A hospital pharmacy buys a pill for 10 cents and charges a patient $1 for it. The 90¢ markup is necessary to pay the new typewriter jockey imposed by HEW throughout the hospital. Won't you in this room join with us to lower the cost of that drug by getting rid of the typewriter jockeys, and not by cheapening the drugs or by cheapening the medical care.

CMS is grateful to Dr. Charles McSherry who found, in his New York-Cornell Hospital, that Utilization Review, designed by the bureaucracy to reduce hospital stays, had only discovered 6 patient overstays per 9,500 charts reviewed of the 30,000 admissions in a year, and that it costs $34,212 per patient identified by the process. He projected the nationwide cost of this failure that year to exceed the research budget of any one of the National Institutes of Health as follows:

UTILIZATION REVIEW COSTS vs. NIH RESEARCH FUNDS

Utilization Review (McSherry)	$356,000,000.00
National Cancer Institute	$222,000,000.00
N.I. Alcohol, Drug Abuse, Mental Health	$189,000,000.00
National Heart & Lung Insititute	$179,000,000.00
N.I. Arthritis, Metabolism & Digestive	$117,000,000.00
N.I. General Medical Sciences	$113,000,000.00

In 1969, when the "featherbedding" of hospitals had already exhausted the Medicare money, the heads of Social Security wittingly misrepresented data in a fraudulent press release, and told the press that doctors had overutilized hospital stays. This and the subsequent coverups resulted in an euphemism called Professional Standards Review, or PSRO. In brief, a PSRO is but another set of catacombs with a bureaucratic office force and typewriter reviewing more paper (Figure 17). The very same paper has already been reviewed in the catacombs I showed you in the hospital, and again at the desks of the Blue Cross (Figure 18).

By any reasonable estimate, the additional money to be spent on PSRO in 3 years would easily buy a "CAT" Scanner, the latest and most dramatic advance in x-ray studies in 30 years, for every private hospital in America. Let's not deny our patients the wonderful advances such as the CAT Scanner, which will shorten hospital stays, and help the sick. Instead let's get rid of the sick paper, with its tremendous cost.

If a ceiling of 9% cost rise per year is imposed on hospitals, Medical Care will be sealed in a closed container along with this expanding maligant bureaucracy. The malignancy will smother medical care. States such as Massachusetts, which already collect nearly twice the hospital funds per capita from Medicare as does Louisiana, would be allowed to rise twice as much in this kind of cost containment.

But, if the Government is alarmed by the rise in cost of Hospitals, it should stop causing the rise.

Thank you.

* * * * *

RESCREEN & SQUARE HALFTONES

-5-

TABLE OF FIGURES

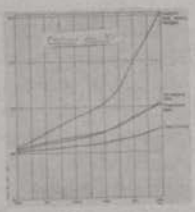

Figure 1

Figure 2

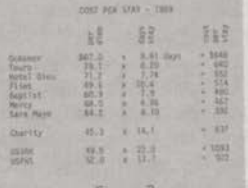

Figure 3

Figure 4

Figure 5

Figure 6

Figure 7

Figure 8

Figure 9

Figure 10

Figure 11

Figure 12

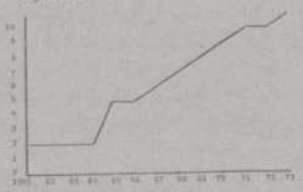

Figure 13

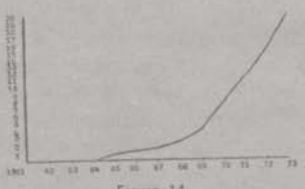

Figure 14

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BALTIMORE, MARYLAND 21235

REFER TO:

IHI-632

JUL 0 3 1974

Frank T. Robbins, M.D.
Masonic Building
Hinesville, Georgia 31313

Dear Dr. Robbins:

After studying your perceptive report about administrative requirements in small hospitals, such as Liberty Memorial, we are very empathetic about the administrative demands our complex society makes on its institutions.

Yet, we do not see how we can possibly meet your request to waive the audits to make life simplier. Audits, as you know, are important management tools we need in order to meet our responsibility to the public we serve.

For example, reimbursement on the basis of cost requires assurance that the amount of cost is correct, that there has been a proper distribution of overhead and other costs, and that the utilization data are not in error. To verify accuracy of the cost reports requires proper audits of the hospitals and other providers. Such audits are necessary to assure equity to both the purchaser and provider of service and in general would contribute to sound management of the program.

But I can well understand that, sometimes, there may be an excess of a good thing. After we read your statement about the large number of audits done at Liberty Memorial, we have asked our Atlanta office to be in touch with you to make sure that we in Medicare, at least, do not trouble you with any more audits than are absolutely needed. We have also asked our Atlanta office to see if they can do something in an operational way that would ease the administrative burden you so well describe.

On the personal side, I thought your report was an exceptionally lucid and nicely organized document that well illustrated your point.

We do regret that, in this instance, we cannot be more helpful.

Sincerely yours,

Glenn J. Martin

Glenn J. Martin, Chief
Program Experimentation Branch
Division of Special Operations
Bureau of Health Insurance

Figure 15

TABLE OF FIGURES

Figure 16

Figure 17

Figure 18

APPENDIX A

THE NEW ORLEANS TIMES PICAYUNE
SUNDAY, MAY 15, 1977

Views of Readers

Bureaucracy Blows Up Hospital Costs

New Orleans.
Editor, The Times-Picayune:

Carl T. Rowan's column (May 2) entitled "Public Hospitals are Cutting Back" gives hard information but faulty conclusions. He summarizes, "Reports from around the country tell of lives endangered and even lost, of patients waiting hours to get prescriptions filled and months to get X-rays, of bureaucratic bungling and hospital entanglements in politics and patronage." That distress is the status of any ripe government-run hospital, and that "bungling bureaucracy and politics" is the cause of the distress, not only in this country but in virtually every country in the world.

Ironically, the cost per patient stay in a public hospital greatly exceeds that in a private hospital. Yet as Mr. Rowan says, "well-to-do go to more comfortable and prestigious private hospitals." And the rise in cost of private hospitals since Medicare in 1965 is closely related to introduction of the government's bureaucracy and politics, and to bungling by the same government methods which paralyze the government hospitals.

But rather than shackle private hospitals with the extra burden of increased bureaucracy, bungling, and politics of some government kind of "cooperative effort" as in Rowan's thesis, or with the expensive bureaucracy necessary to impose President Carter's 9 per cent ceiling on the rise (caused by prior bureaucracy), we should go exactly the other way. We should allow private hospitals to go back to their older, less expensive ways which produced the more desirable medical care, and we should see what we can do to liberate the downtrodden public hospitals from the malignancy of paperwork and politics.

EDWARD S. HYMAN, M.D.

THE WALL STREET JOURNAL, Monday, June 2, 1975 9

Letters to the Editor of the Journal

Strangling the Hospitals

Editor, The Wall Street Journal:

Regarding I. D. Robbins' article "Health Costs—A One-Way Street" (May 8):

Mr. Robbins should be reminded that the cost of running New York City rose about four times as much as the cost of the nation's medical care in the past decade, and that New York City leads the country in medical indigence, and does so with a Medicaid system subsidized by other states where the per capita income is lower. New York's hospitals are probably the nation's most distressed, but perhaps not for the reasons he cited.

Should he compare his cited 138% rise in "wages in the health industry" from 1952 to 1972 (only 4.2% per year) to the 162% rise in per capita income nationwide or to the 152% rise in New York State during the same period, then there would be no need for his derogatory explanations of the "health industry."

He should also be enlightened that his cited 56% increase in hospital personnel, or the 73% rise in a decade reported recently in U.S. News & World Report, is primarily an increase in persons who do not attend the sick, but instead are assistant administrators, insurance clerks, other clerks, personnel officers, quality assurance persons, couriers, typists, auditors, etc. These extra employes are spawned by civic minded businessmen who do not understand medicine but who seem determined to improve and expand the paperwork they think they understand. The same is done by agencies of the government, by agencies controlled by the government such as the Joint Commission on Accreditation of Hospitals, and by "health planners."

The physician or surgeon has no control over this featherbedding and often finds that it interferes with good medical care. The doctor has lost the help of a good nurse because she is now doing a sham called "Quality Assurance." She is replaced by two or more persons each with a Job Description to limit his versatility or usefulness. The physician is limited by a businessman's accounting system which makes it expensive for a patient to sleep in one more night. Thus a patient must have walk-in surgery and leave before nightfall, or perhaps have his appendicitis treated with "ice packs and penicillin."

This cost accounting system is responsible for many square pegs in round holes. If a physician needs a simple hemostat he must open a whole suture tray; if he needs a few pills he must order a unit package; and on and on. But the use of a drug or the extra blood test must be compromised to pay the salary of a typewriter jockey in the Medicare (Papercare) office. Then some civic leader on CBS or NBC discovers that drugs can be purchased cheaper outside the hospital, and he wants to cheapen the quality of drugs to lower the price instead of sequestering the typewriter jockey. As this bureaucracy strangles a hospital, civic leaders delight in employing more administrative personnel to limit admissions, to do "utilization review," or to replace a technologist with two untrained refugees from the welfare system.

All of this destruction is done by "experts" with the opening prayer that this will "lower the cost while raising the quality of medical care." We need less advice from these vicarious virgins describing labor pains and more input from the physicians in the front line.

EDWARD S. HYMAN M.D.
Secretary
American Council of
Medical Staffs

New Orleans

Treating Appendicitis

Editor, The Wall Street Journal:

Mr. Robbins certainly did not pick a very convincing example to bolster his position when he spoke of patients getting ". . . surgery instead of ice packs and penicillin for an appendicitis." (This being intended to illustrate the greed of surgeons.)

The potentially lethal, peritonitis-causing bacteria in appendicitis are almost always E. coli and other gram-negative organisms, against which penicillin is ineffective. The ice packs do not deserve discussion. Appendicitis would kill many young annd otherwise healthy people; surgery is a simple and effective means of treatment.

The article is an eloquent, albeit unintentional, argument in favor of letting the experts in health care make the decisions.

W. LAWRENCE WILDE M.D.

Belmont, Mass.

APPENDIX C

AMERICAN CMS MEMBERSHIP - December 1976

	CHAPTER	NO. OF STAFFS	MEMBERS
I	ALABAMA		
	*1 Northern Alabama	1	32
II	ARIZONA		
	*2 Central Arizona	1	442
III	ARKANSAS (see Gr. Memphis)		
IV	CALIFORNIA (V-6842)		
	3 San Diego Imperial	2	199
	*4 Southern California	50	6,641
V	COLORADO		
	5 San Luis Valley Area	1	17
VI	FLORIDA (R-3135, V-3235)		
	*6 Florida West Coast	6	609
	7 Ft. Lauderdale Area	1	222
	*8 Mid East Florida Area	6	724
	*9 South Florida Area	12	1,680
VII	GEORGIA (V-596)		
	*10 Ctl. Savannah River	2	241
	11 Northeast Georgia Area	1	11
	*12 Northern Georgia Area	1	344
VIII	ILLINOIS		
	*13 Northern Illinois Area	9	1,233
IX	INDIANA (V-227)		
	*14 Northeast Indiana Area	2	77
	15 South Ctl. Indiana Area	1	46
	16 Southern Indiana Area	2	104
X	IOWA		
	17 Black Hawk Area	2	61
XI	KANSAS		
XII	KENTUCKY (V-283)		
	18 Bluegrass Area	1	11
	19 Green River Area	2	109
	20 Northern Kentucky Area	2	163
XIII	LOUISIANA (R-2652)(V-2802)		
	21 Acadiana Area	3	70
	22 Baton Rouge Area	1	215
	23 Ctl. Louisiana Area	1	25
	*24 Greater Monroe Area	3	188
	*25 Lake Charles Area	5	170
	*26 New Orleans Area	35	1,870
	27 Shreveport Area	1	264
XIV	MASSACHUSETTS		
	*28 Merrimack Valley Area	8	751
XV	MICHIGAN (R-3301)(V-5505)		
	*29 Albion Area	1	48
	*30 Greater Detroit Area	48	5,177
	31 Jackson/Hillsdl/Lenawee	7	263
	32 Northern Michigan	1	17
XVI	MINNESOTA		
	33 South Ctl. Minnesota	1	12
XVII	MISSISSIPPI (R-350, V-350)		
	34 Central Mississippi	2	225
	*35 Northern Mississippi	1	9
	*36 Northwest Mississippi	1	12
	37 Southeast Mississippi	3	104
XVIII	MISSOURI		
	*38 Gr. St. Louis (Illinois)	9	1,320
	*39 Mid America KS	2	410
XIX	MONTANA		
	40 Montana Area 2	3	142
XX	NEW HAMPSHIRE		
	41 New Hampshire Area	1	198
XXI	NEW JERSEY (V-1350)		
	*42 Northern New Jersey	7	1,110
	43 Southern New Jersey	2	240
XXII	NEW MEXICO		
	*44 New Mexico Area	4	162
XXIII	NEW YORK		
	45 Nassau-Suffolk	6	1,106
XXIV	NORTH CAROLINA (V-197)		
	46 Clinton-Fayetteville	1	21
	*47 Kinston Area	1	70
	48 Rocky Mount Area	2	105
XXV	OHIO (R-3922)(V-4122)		
	*49 Eastern Ohio Area	6	708
	*50 Mid Ohio Area	17	1,169
	51 North Central Ohio	2	169
	*52 Northeast Ohio	12	1,124
	*53 Northwest Ohio	10	808
	*54 Southwest Ctl. Ohio	1	144
XXVI	OKLAHOMA		
	55 Oklahoma City Area	1	†
XXVII	OREGON		
	56 Portland Area	1	83
XXVIII	PENNSYLVANIA (R-5547)(V-5847)		
	*57 Allegheny Valley Area	10	1,246
	58 Central Penn. Area	1	80
	*59 Delaware Valley Area	25	3,969
	60 Northeast Penn. Area	3	371
	61 Northwest Penn. Area	2	55
	62 South Central Penn.Area	2	126
XXIX	RHODE ISLAND		
	*63 Rhode Island	1	166
XXX	TENNESSEE (ARK & MISS)(V-774)		
	64 East Tennessee Area	1	28
	*65 Greater Memphis Area	2	746
XXXI	TEXAS (R-2547)(V-2846)		
	66 Alamo Area	+	+
	*67 Gr. Houston/Galveston	11	1,338
	68 Lower Rio Grande Area	1	77
	*69 North Ctl. Texas Area	18	1,331
	70 South East Texas Area	1	100
XXXIII	VIRGINIA		
	71 Southwest Area	1	19
	INDIVIDUAL MEMBERS		260
	TOTAL	394	41,387

* = Incorporated Chapter
† = Incorporated, not Affiliated
\+ = No Roster

UTILIZATION REVIEW, CORNELL-NEW YORK HOSPITAL*

31,800 Admissions in a year

9,500 Charts reviewed

6 "Overstays" detected

$34,212 per "overstay" found

*McSherry,C.K., Surgery,80,122,1976

Figure A

UTILIZATION REVIEW vs. N.I.H. RESEARCH FUNDS
(after McSherry)

	$ Millions
UTILIZATION REVIEW (McSherry)	356
NATIONAL CANCER INSTITUTE	222
N.I.ALCOHOL,DRUG ABUSE,MENTAL HEALTH	189
NATIONAL HEART AND LUNG INSTITUTE	179
N.I.ARTHRITIS, METABOLISM, & DIGESTIVE	117
N.I.GENERAL MEDICAL SCIENCES	113

Figure B

COST OF PSRO,

$1.0 to 1.5 Billion per year
(ACMS-1974, IOM-NAS-1977)

COST OF CAT SCANNER,

$225,000 each
(EMI, June 1977)

$$\frac{\$1,000,000,000}{\$225,000} = 4444 \text{ CAT SCANNERS PER YEAR}$$

Figure C

Senator SCHWEIKER. That concludes this hearing on hospital cost containment; the subcommittee will stand adjourned.

[Whereupon, at 2:10 p.m., the subcommittee adjourned.]

HOSPITAL COST CONTAINMENT ACT OF 1977

TUESDAY, JUNE 21, 1977

U.S. SENATE,
SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
OF THE COMMITTEE ON HUMAN RESOURCES,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9:35 a.m., in room 1202, Dirksen Senate Office Building, Senator Edward M. Kennedy (chairman of the subcommittee) presiding.

Present: Senators Kennedy, Javits, Schweiker, and Hayakawa.

Committee staff present: Stuart Shapiro and Robert Wenger, professional staff members; David Winston and David Main, minority.

Senator KENNEDY. We will come to order.

Today is the fourth in this series of hearings on the escalating costs of health care. We have heard from numerous witnesses representing consumers, Governors, hospitals, unions, rate regulators, and doctors. Today we will hear from representatives of the health insurance industry, the American Association of Retired Persons, and the major spokes-organization for those directly involved in implementing the health planning laws—the American Association for Comprehensive Health Planning.

During the last 3 days of hearings, a consensus was reached that health care costs are escalating at rates that are no longer acceptable. Without any intervention, it has been estimated the $139 billion Americans spent on health care in 1976 will grow to more than $230 billion in 3 short years when the average hospital stay will then cost more than $2,000. Each and every witness made suggestions for changing our health care delivery system—some proposed radical change and others only marginal change.

I believe a major overhaul of the way we finance and deliver health care is needed. For too long, we have paid hospitals and doctors whatever they wanted. The costs of a hospital stay has risen 2½ times faster than the Consumer Price Index, and doctors' fees have been going up at similar rates. Even the American Hospital Association acknowledges that it is not just the costs of supplies and equipment that is causing costs to go up. Hospitals continue to add expensive new facilities, personnel, and technology, but few are asking, "Do we really need all this new personnel, laboratory tests, and X-rays?"

Even though we spent nearly three times as much for laboratory tests in 1975 than we did in 1971, there is no evidence that all these extra tests affected the health of the American people.

Tragically we have been funneling so much money into hospitals and doctors to cure illness that we have not had enough to spend on basic

preventive care. Nearly 9 cents of every Federal dollar spent goes to the hospital industry while far less than 1 penny is spent on preventive care and health education. We need to redefine our priorities. Vital programs, such as immunizing children, have been overlooked for too long.

In these hearings we have carefully examined S. 1391, "The Hospital Cost Containment Act of 1977." No one has claimed the bill is perfect, and many have made extremely constructive suggestions. After the hearing today, we will begin the difficult task of redrafting a transitional cost containment program.

As chairman of the Subcommittee on Health and Scientific Research, I am committed to the speedy passage of a program that is administratively simple, does not create a new expensive bureaucracy, and will result in significant savings next year. We can no longer afford to just sit back and watch hospital costs escalate as they have in the past.

I recognize the Senator from New York, Senator Javits.

Senator JAVITS. One of our witnesses today is a very distinguished New Yorker, Morton Miller, vice chairman of the board of the Equitable Life Assurance Society of the United States, one of New York's principal corporations.

I have had a talk with Mr. Miller and know something about the activities he will describe for the committee, and I commend him to the serious attention of every member as I think they have for us an answer on the interlock between the States and the Federal Government on the question of cost containment with respect to hospital care.

I regret very much, Mr. Chairman, that I shall not be able to be here as I am managing the mine safety bill with Senator Williams on the floor, but I will be represented. I wanted the privilege of introducing Mr. Miller and commending him as a New Yorker to the committee.

Thank you.

Senator KENNEDY. Very fine.

Mr. Miller, vice chairman of the board, the Equitable Life Assurance Society of the United States, would you come forward, please?

We will also have Mr. Bernard Tresnowski, executive vice president, Blue Cross Association; Mr. Henry DiPrete, second vice president, group operations, John Hancock Mutual Life Insurance Co.; and Robert J. Kilpatrick, president, Connecticut General Life Insurance Co., represented on the panel.

Mr. Tresnowski.

STATEMENTS OF BERNARD R. TRESNOWSKI, EXECUTIVE VICE PRESIDENT, BLUE CROSS ASSOCIATION; MORTON D. MILLER, VICE CHAIRMAN OF THE BOARD, THE EQUITABLE LIFE ASSURANCE SOCIETY OF THE UNITED STATES; HENRY DI PRETE, SECOND VICE PRESIDENT, GROUP OPERATIONS, JOHN HANCOCK MUTUAL LIFE INSURANCE CO.; AND ROBERT J. KILPATRICK, PRESIDENT, CONNECTICUT GENERAL LIFE INSURANCE CO., A PANEL

Mr. TRESNOWSKI. Thank you very much.

I am Bernard Tresnowski, executive vice president of the Blue Cross Association.

We have prepared a detailed analysis of S. 1391 reflecting our views on the proposed bill. If it is acceptable to the committee, I would ask that the statement be introduced in the record, and I will briefly summarize.

Senator KENNEDY. We will include the entire statement in the record at the conclusion of your testimony.

Mr. TRESNOWSKI. The Blue Cross Association believes that there is a need for enactment of a program to contain health care costs. We believe that such a program should contain two components: (1) a transitional program for limiting inpatient hospital revenues on a class of purchaser basis with positive incentives for hospitals and (2) a national moratorium on new plant capital expenditures.

As for which providers and services should be subject to a transitional revenue limitation program, we share the same concerns others have expressed. If such a program applies only to one segment of the health care delivery system—such as only hospitals or hospital inpatient care services—there is real danger that the program will not achieve effective containment of health care costs generally. Continued high rates of inflation are not restricted to the hospital industry, even though it represents the largest single component of the delivery system. Nor are the underlying causes of health care cost inflation that require corrective action and behavioral change restricted to the hospital industry.

On the other hand, we seriously question whether a transitional revenue program applicable to several or all segments of the health care system could be effectively and equitably designed and administered over a reasonable amount of time.

We share the view of the administration and others that immdiatee action is in order as a transition to longer term reforms. For these reasons, a transitional revenue limitation program that applies only to hospital acute care services at this time appears to be a viable, though far from ideal, course of action.

We believe that if only hospital acute care services are to be contained in the program, the actions and expenditure increases of various providers of non-acute-care services should be closely monitored to determine whether any corrective actions are needed for those segments of the health care industry.

We also believe that the concurrent introduction of a temporary capital expenditure moratorium program should go a long way toward preventing fragmentation and duplication of health facilities and services, whereas a revenue limitation program applies only to hospital acute care services. Such a moratorium would allow time for more fundamental and permanent reforms in the Health Planning Act.

In the design and operation of a transitional revenue limitation program for hospitals, positive incentives need to be provided for hospitals to operate more efficiently. For example, incentives should be established for hospitals to substitute for inpatient care services less costly services, where medically appropriate, and to eliminate, consolidate or convert existing excess operating capacity.

Also, there should be opportunities and incentives for continued innovation and experimentation with a variety of approaches resulting in longer term, more permanent and effective health economic reform.

We firmly believe that the key to improved efficiency and cost effectiveness within the health care delivery system lies with the types of

longer term, permanent cost containment tools that are currently underway—health planning, prospective and other incentive payment systems, utilization review, alternative delivery systems, utilization review, alternative delivery systems such as HMOs or large multi-speciality group practices and innovative health care benefits such as home care and second surgical opinion coverage. We also believe that these tools must be closely integrated. No one tool can be expected to do the whole job, as each deals only with selected facets of the cost problem.

Similarly, we believe that effective design and implementation of these tools is a shared responsibility. Health providers, government, labor and business must all work with us to insure success. Hospital trustees, hospital administrators, physicians, and other health professionals must understand the dimensions of the problem and actively contribute to its solution.

We recognize, however, that these cost containment tools have not been implemented as fast as we would like and that it may be several years before they are effectively operating on a broad scale. The current state of the art is far from well developed in terms of what criteria and procedures work best in implementing these cost containment programs at the State, local, and individual levels.

Hence, our recommendations reflect the combined circumstances of not yet having the basic cost containment tools well developed, tested, and effectively operating on a broad scale, and of rapidly approaching the limit of funds available for health care expenditures in this country. If imaginatively designed, a revenue limitation program may serve not only as an interim measure to alleviate economic pressures while those basic tools evolve, but also as a means of stimulating more rapid and effective development and implementation of those tools.

I must note, however, that there is a potential legal problem under a revenue limitation program. Existing contracts between Blue Cross plans and providers impose obligations and confer rights with respect to payment for subscriber care. There is the potential under a revenue limitation program for Blue Cross plans to be sued for breach of contract by providers if the plans pay less than what is called for in the contract in order to stay under the limit. Or the plans could be taxed on the excess payments if they honor the contract.

Senator KENNEDY. Run that by us again.

Mr. TRESNOWSKI. I wish I could be more definitive. Let me say the lawyers feel very strongly about the constitutional matter of impairment of contracts. I am quick to say that matter is being researched by our attorneys in an attempt to find a way to arrange a revenue limitation program——

Senator KENNEDY. What aspect of the impairment contract are they most concerned about?

Mr. TRESNOWSKI. As you know, we contract with the hospital, and part of that contract defines and describes the reimbursement system. If that reimbursement system calls for the payment of reasonable cost without limitation, that is an understanding between the parties and agreed to.

If a Federal statute now imposes a limitation over and above those contract requirements, apparently that raises the question of the right of the Federal statute to override those privately negotiated contracts.

That matter is being researched. I would say to you that we feel, as I will point out later on, the development of a broader exemption opportunity from the revenue limitation program might offer hope to get out from under that constitutional question.

Senator KENNEDY. Will you give us some ideas and suggestions that your people believe can deal with that problem?

Mr. TRESNOWSKI. Yes; I will.

Senator KENNEDY. We will be glad to ask the Justice Department to work with you.

Mr. TRESNOWSKI. It is a key point, and we will be working with your staff.

The imposition of a transitional capital expenditures moratorium also meets important needs. It can provide some "breathing room" for new State and local planning agencies now in a critical stage of their development to formulate health plans and project review criteria and procedures in an effective manner. Also, it will help to insure that providers of services not covered under a transitional revenue limitation program do not unnecessarily duplicate facilities and services for those subject to the limitation program.

As for the administrative responsibilities, we believe that the detailed administrative functions should be assigned to the medicare intermediaries both to use this available and effective resource and to allow the Secretary to concentrate his resources on program design, policy, and evaluation.

In summary, we view S.1391 as a valuable first step toward formulation of a transitional revenue limitation program. Title I of the bill—revenue limitation—contains several good ideas There are no easy answers to designing a program which is easy to understand, implement and administer, and which is simultaneously flexible and effective in containing health care costs in all the right ways.

We do believe certain aspects of title I are too prescriptive, detailed, and inflexible. For instance, we do not believe that sufficient options and incentives are provided to hospital or third-party payers to further develop, refine, and implement cost containment tools. And we find some provisions unclear and confusing from a conceptual or administrative standpoint.

There are also legal problems that must be addressed. Also, for effective administration, medicare intermediaries should be assigned a major responsibility.

We find title II—capital expenditures limitation—of the act to be provocative, and our initial reaction to many of the provisions of that title are favorable. We believe, however, that title II of the proposed bill is not a transitional program. Title II really suggests some fundamental and permanent reforms to the current system of health planning in the United States. For that reason, we believe that such changes should be given very careful consideration in the context of other changes that are expected to be proposed later this year in congressional hearings on the extension and potential amendment of Public Law 93-641—the Health Planning and Resources Development Act of 1974. That, we believe, is the appropriate time and place for consideration of title II program features. Thank you.

Senator KENNEDY. Mr. Miller.

Mr. MILLER. Thank you, Mr. Chairman.

As you know, Mr. DiPrete, second vice president of John Hancock, is here with me.

We appear today on behalf of the Health Insurance Association of America.

We have a longer formal statement which we ask be made a part of the record. I will summarize our position.

Senator KENNEDY. It will be included in the record at the conclusion of your remarks.

Mr. MILLER. The companies we represent, which provide health insurance protection for over 100 million Americans, have long been intimately concerned with the costs of health care in this country. In that connection, we have lent our active support to community health planning, increased ambulatory care, alternative delivery systems, health education, professional standards review, and a better distribution of health manpower.

As was stated in our testimony of May 17, 1976, before this subcommittee, the rapid escalation of costs during the last several years spread across the entire spectrum of health services—doctor and dentist fees, drug and nursing home charges, and particularly the costs of hospital care—has created a most worrisome situation. The health insurer's suggestions for reducing this problem were spelled out in some detail at that time.

Mr. Chairman, your subcommittee does not need a long recitation from us regarding the reasons for the health care costs escalation we are experiencing or the magnitude of the problem. Through the intervention of third-party payments by Government and private insurance plans, the American public has minimally felt the full impact of rising costs, particularly with hospital costs where third-party financing exceeds 90 percent of total revenues. The prevalence of third-party payments has tended to inhibit the normal operation of supply and demand in the health care field and, together with the rising expectations of the public, has been translated into an almost limitless demand for health care services.

Accordingly, we would like to express our wholehearted approval of the administration's efforts to contain health care costs and, subject to some qualifications, support for the recently announced hospital cost containment program set forth in S. 1391, the Hospital Cost Containment Act of 1977.

There are a number of good features in the administration's proposal. Starting with hospital cost, it focuses on the largest single cost component, where the number of service units is manageable, and the rates of inflation most extreme. Prior cost control measures which dealt with medicare and medicaid costs alone had the effect of turning the savings flowing to the two governmental programs into increased costs for private patients.

The proposed legislation avoids this major problem. The limitations of the bill apply to a hospital's total revenues from all patients equally and not just to reimbursement by the Government under medicare and medicaid. It recognizes the importance of capital expenditures in the cost equation, and it appears to be relatively easy to administer.

On the other hand, however, there are some disadvantages. Some hospitals are more cost effective than others. The imposition of the same revenue limits on all will be unfair to the cost-effective hospitals and overly generous to others. The passthrough of wage increases for

nonsupervisory personnel may weaken the ability of the hospital to bargain at arm's length with their employees. Instead of a blanket provision, it may be preferable for the Secretary to have the authority to grant a waiver for an area where wages are substandard. Furthermore, S. 1391 does nothing to redress the present longstanding imbalance between the lower reimbursement levels of medicare and medicaid and, to a lesser extent, Blue Cross, and the disproportionately higher levels of hospital costs passed on to insurance company and self-pay patients. Such an inequity must be adjusted in the long run.

Finally, S. 1391 is admittedly an interim or transitional program. The President, in presenting his proposal, stated that it

> relied heavily on the initiatives of the private sector—business, unions and insurers working with providers—to pursue innovative techniques for reducing the cost of high quality care.

We accept that challenge.

We believe S. 1391 can be greatly strengthened to move more rapidly and effectively toward a long-term permanent solution for moderating hospital care costs. The National Health Care Act, S. 5 and H.R. 5, introduced by Senator McIntyre and Representative Burleson, and supported by the health insurance companies of America, includes such a plan. It calls for a system of prospective review of hospital operating and capital budgets and the approval of rates for all payors to be carried out at the State level.

Such systems have been in operation in four States, Maryland, Connecticut, Washington, and Massachusetts, and have worked well. We are confident that a substantial reduction in the growth of hospital care costs can be achieved through the mechanism of prospective hospital rate approval and budget review conducted by the States under a Federal mandate and guidelines.

In the two States with the most experience, Maryland and Connecticut, the State Rate Setting Commissions have saved residents $27 million and $18 million a year, respectively.

In order to illustrate the potential of extending this type of program nationwide, we estimate there would have been savings in the order of $1 billion last year had such a program been in operation in all of the States.

The experience to date suggests that, to be successful, such State prospective budget review and rate approval programs must:

1. Have an independent State commission which is solely responsible for reviewing the operating and capital budgets of the institutions and for setting their rates.
2. Establish rates applicable to all payors, as is the case now in Maryland.
3. Institute effective programs of utilization review; and
4. Be closely coordinated with the planning agency responsible for certificate-of-need determination.

The best of prospective hospital rate approval and budget review processes would not be fully effective operating alone. The functions of prospective rate review, certificate-of-need determination and utilization review must be carried out together. Given close liaison with the local planning agencies and involvement with utilization review, the State Rate Setting Commission can be truly responsive to local needs and conditions.

Senator KENNEDY. In the area of utilization review, do you think it ought to apply to all patients?

Mr. MILLER. Yes, indeed.

Senator KENNEDY. How would that be funded? If the Government funds the other under medicare and medicaid, would the insurance companies be willing to fund that?

Mr. MILLER. Yes, indeed.

Mr. DIPRETE. We already are, Senator.

Senator KENNEDY. As I have to leave in a few minutes Senator Schweiker will take over the chair for me. I am most interested in the information you are presenting and hope you will keep me informed.

In terms of the Talmadge approach, you understand generally what is being attempted regarding the grouping of the various hospitals. Do you have any recommendations to us on how we can do that in a temporary and preliminary way?

Mr. DIPRETE. I am Henry DiPrete with John Hancock.

In Massachusetts currently under a Social Security Administration funded program, the rate setting commission is developing methodology on just that, on case mix, on groupings with hospitals, and grouping with interdepartmental likeness between hospitals.

I think they are working on a target for late this summer for concluding the methodology.

Senator KENNEDY. Do you have suggestions about how we can do it at the Federal level in a way that is equitable?

The rate setting commission spent a lot of time trying to get this work out. I am wondering if there is sufficient information available that we can use in this particular proposal?

Mr. DIPRETE. I would suggest that we submit for the record the developments and report of what has happened in Massachusetts. That is transferable. I do not think we will ever have complete equity to satisfy the hospitals on satisfactory grouping, but it is a start.

Senator KENNEDY. From an insurance point of view, you think that is a reasonable way of grouping?

I know you have been very much involved in fashioning that system. Do you think that basic pattern is a reasonable approach for the Federal level?

Mr. MILLER. We are less satisfied with that than with the prospect of rate review approach we have been suggesting.

Senator KENNEDY. I think everyone agrees that this is a temporary measure, and we are trying to make it more equitable. Please excuse me. Senator Schweiker will chair in my absence.

Mr. MILLER. Senator Schweiker and Senator Hayakawa, with your permission, I will continue with my testimony.

Turning to another aspect of our problem, excess bed capacity has clearly been a prime factor in the recent cost inflation. The administration has estimated that we have about 100,000 more hospital beds than we need. Therefore, as part of the long-term control of health care costs, we would propose the following:

a. The certificate-of-need process be strengthened to include all major capital expenditures, regardless of their ownership.

b. Consideration be given to studying the desirability of discontinuing the tax subsidies and loan guarantees which are now available for hospital-related capital investment. Hospitals seeking funds

would then have to turn to normal investment channels. The investors would become more selective in their lending and would have compelling reasons to be concerned over the management of their investments.

c. Clear provisions for decertifying unneeded beds be established under the Planning Act.

d. Funds be appropriated to assist in closing down excess beds or their conversion to other uses and for the retirement of outstanding debt.

We are persuaded that the combined efforts of State prospective budget review and rate approval, when coupled with effective certificate-of-need determination and utilization review, will succeed in effectively constraining the rise in hospital care costs over the long term.

We, therefore, would propose that S. 1371 be amended so that:

One, hospitals in any State that has or institutes a prospective budget review and rate approval system and also has a certificate-of-need program, both of which meet Federal guidelines, should be exempt from the revenue and capital ceiling provisions of titles I and II of S. 1391.

Two, the appropriation of modest funds be authorized to enable States to initiate prospective budget review and rate approval programs that comply with Federal guidelines.

Three, the quality of care and utilization control requirements of Public Law 92–603 applicable to medicare and medicaid be extended to all patients.

Four, the Planning Act, Public Law 93–641, be amended to authorize the decertification of unneeded hospital beds and services.

Five, the appropriation of funds in reasonable amounts be authorized to assist in closing down excess beds or their conversion to other uses.

I would like now, gentlemen, with your permission, to turn to Mr. Robert Kilpatrick, president of the Connecticut General, who would like to tell you more about the favorable experience we have had with respect to our hospital ratesetting and budget review program that has been operating in the State of Connecticut for 3 years.

Mr. KILPATRICK. Good morning, Senator Schweiker and Senator Hayakawa.

I am Robert D. Kilpatrick, president and chief executive officer of Connecticut General Insurance Corp. and chairman of the board of the Insurance Associates of Connecticut.

I want to thank you for the opportunity to appear here today on behalf of the IAC, a trade association of Connecticut-based insurance companies. IAC member companies write about 30 percent of the commercial group health insurance sold in the United States.

Our member companies, as leading members of the Health Insurance Association of America, strongly support the testimony of the HIAA given here this morning.

The IAC companies have long supported the concept that hospital budgets and charges should be subject to some form of public regulation. As supporters of private enterprise, our normal conviction would be to allow marketplace forces to set appropriate levels of price, utilization, and quality of care. However, for some time, we have been convinced

that the marketplace does not operate in the hospital field to encourage efficiency and lower prices, or to control plant expansion.

COMMENTS ON S. 1391

With regard to the pending bill, we believe:

One, the need for immediate action is critical.

Two, for regulation to be effective, it must include revenue from all sources, not just medicare and medicaid. Anything less than regulation of total revenues will simply shift costs, not restrain them. Hospitals must provide full disclosure of financial information in a uniform manner

Three, the proposal for an across-the-board pass through of nonsupervisory wage increases is an enormous loophole and would weaken the bill substantially. HEW estimates that 83 percent of hospital employees and 75 percent of wages would fall into this nonsupervisory category. Moreover, this provision is unnecessary An independent study commissioned by the Insurance Association of Connecticut clearly indicates that most hospital workers earn as much or more than their counterparts in industry. Hospital workers' wages have increased at a rate of 7.9 percent since 1970 compared to 6.5 percent for nonhospital workers. Therefore, we strongly urge the subcommittee to limit wage passthroughs only to those locations where hospital workers' wages are still substandard.

Senator SCHWEIKER. I wonder if you would send us a copy of that study?

Mr. KILPATRICK. We certainly will, Senator. It will be available for the record.

Senator SCHWEIKER. Thank you.

[The information referred to follows:]

THE HOSPITAL COST CONTAINMENT WAGE PASS-THROUGH PROVISION

The hospital cost containment legislation, introduced by the Administration, H.R. 6575, contains a provision (Section 124) that permits hospitals an adjustment of the revenue limit based on actual increases in pay (not fringe benefits) granted to non-supervisory employees. At the end of 18 months the Secretary of HEW would determine if the adjustment should be continued.

In effect, wages of non-supervisory employees are not subject to the general ceiling on revenues and increases above the general ceiling will be reflected in an increase of the ceiling for individual hospitals.

The assumption that appears to underlie this waiver is that hospital personnel continue to earn wages below their occupational counterparts in private non-farm employment. While some skills used in hospitals have no counterpart in other industries, many do, and direct comparisons by geographical area are possible.

This paper describes the nature of the wage pass-through provision, examines data comparing hospital workers' wages with their counterparts in other industries, and examines the implication of the pass-through for the hospital industry and for the cost containment program. The conclusions drawn are:

- The primary rationale for the pass-through -- that the proposed 9% cap would discriminate unfairly against non-supervisory hospital workers whose wages lag behind their counterparts in other industries -- is not substantiated

by the evidence at hand. Hospital worker wages are at least as high as their counterparts, and, if held to 9% would still be increasing at a faster rate than their counterparts.

- The effect of the pass-through would be to undercut hospital industry efforts to improve productivity by making investments in labor-saving procedures and equipment less desirable. The already increasing FTE per patient day ratio could be expected to worsen.

- The 18 month reconsideration provision would create powerful pressures to achieve large wage settlements immediately.

- Higher hospital worker wages would increase wage rates in related programs not subject to the proposed legislation such as nursing homes, thereby creating increased inflationary pressures with direct impact on the federal budget.

- The definition of non-supervisory personnel is unclear and would be difficult to administer. Hospitals do not routinely report their personnel data in this form so new reporting formats will be required.

The Wage Pass-Through Provision

Section 124 provides that in computing the overall hospital revenue increase limit a separate calculation is to be made for the wages of non-supervisory employees. This calculation would work in the following manner:

Assume that hospital A's costs in the base year are distributed as follows: 45 percent for wages of non-supervisory employees and 55 percent for all other costs. Assume that the average earnings of non-supervisory employees have increased 12 percent in the current year; the revenue limit for the hospital is 9%. To compute the overall revenue limit 45% of costs are permitted to increase 12% and the remaining 55% are increased 9%:

$$(.45 \times .12) + (.55 \times .09) = .054 + .050 = .104 \text{ or } 10.4\%$$

While this seems a straightforward process, there are serious problems in defining non-supervisory wages. The definition of supervisory employees, under the Taft Hartley Act (which amended the National Labor Relations Act) is:

> Any individual having authority in the interest of the employer to hire, transfer, suspend, layoff, recall, promote, discharge, assign, reward or discipline other employees or responsibility to direct them, or to adjust their grievances, or effectively to recommend such action, if in connection with the foregoing the exercise of such authority is not of a merely routine or clerical nature, but require the use of independent judgment.

The definition is such that supervisory employees and non-supervisory employees will differ on an individual hospital by hospital basis and in some teaching hospitals physicians other than interns and residents could be regarded as non-supervisory employees. Furthermore, the status of interns and residents is uncertain pending a decision as to whether they are students or employees.

The problem is complicated by the fact that few hospitals routinely report cost data in a form that breaks down personnel in accordance with the definition. Unless rough approximations are permitted in computing the percentage of non-supervisory wages, special reports may be required.

Analysis of Comparable Wage Data

A principal rationale for the wage pass-through has been that without it, the hospital revenue cap would unfairly single out non-supervisory hospital workers whose wages allegedly lag behind their counterparts in other industries. The validity of this rationale rests on two assumptions: that non-supervisory hospital worker wages do, in fact, lag behind their counterparts, and, that the 9% cap would prevent comparability from being achieved or maintained. The evidence suggests both assumptions are incorrect.

As Table 1 shows, wages for hospital workers as a group were considerably behind private non-farm wages in 1955 but that the gap has closed substantially since the mid-1960's*/ closing to 1% in 1972. The gap widened to 3% during the Economic Stabilization Program years of 1972-1974 but by 1975 hospital worker wages were 101% of those in the private non-farm sector.

Table 2 shows the annual rate of increase and demonstrates that with wage rates for private non-farm workers increasing at close to 6% annually, the cap would not prevent hospital workers from improving their relative position.

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*/ This period saw implementation of Medicare/Medicaid and application of the Minimum Wage Law to hospital workers.

TABLE 1

AVERAGE ANNUAL EARNINGS OF HOSPITAL EMPLOYESS AND ALL PRIVATE NON-FARM EMPLOYMENT

	Average Annual Earnings per FTE Hospital Employees	Average Annual Earnings All Private Non-Farm Employment	Hospital Employees As a % of All Private Non-Farm
1955	$ 2,563	$ 3,521	73%
1960	$ 3,240	$ 4,195	77%
1963	$ 3,639	$ 4,600	79%
1966	$ 4,097	$ 5,139	80%
1969	$ 5,380	$ 5,960	90%
1970	$ 5,921	$ 6,212	95%
1971	$ 6,530	$ 6,619	99%
1972	$ 7,062	$ 7,080	99+%
1973	$ 7,388	$ 7,562	98%
1974	$ 7,803	$ 8,031	97%
1975	$ 8,649	$ 8,522*	101%

* Preliminary

Source: Staff Report, Council on Wage and Price Stability, January 1977.

TABLE 2

ANNUAL RATE OF CHANGE IN EARNINGS

	Earnings of Hospital Employees	Earnings of All Private Non-Farm Workers
1955-60	4.8	3.6
1960-63	3.9	3.1
1963-66	4.0	3.8
1966-69	9.5	5.1
1969-70	10.1	4.2
1970-71	10.3	6.5
1971-72	8.1	7.0
1972-73	4.6	6.8
1973-74	5.6	6.2
1974-75	10.8	6.1
1970 - 1975	7.9	6.5

It should be noted that hospital worker wages are not only roughly comparable, but they are increasing at a more rapid rate, 7.9% since 1970 as compared with 6.5% for private non-farm workers. This is of particular concern since, as Table 3 shows, the number of FTE employees per patient day has been climbing steadily. Hence, the combined effect of rapidly increasing wage rates and incentives to substitute labor (without the cap) for other factors (subject to the cap) undercuts the intended effect of the cost containment program.

The figures in Tables 1 and 2 are for all hospital workers and all private non-farm workers. Since the skill mix of these two groups is different a more precise picture of the extent of comparability is shown by comparing specific counterparts. Table 4 shows the ratio of the wage rates for nine categories of hospital workers to the wage rates of their counterparts in other industries for Baltimore, Boston and Dallas for 1975.

These somewhat limited figures show substantial comparability particularly in the Northeastern cities but suggest that there may be considerable geographic variations.

Implications

The wage pass-through provision could be expected to take considerable pressure off hospital administrators in negotiating wage agreements with non-supervisory workers. While pressure on the management side is declining, workers can be expected to press for the maximum possible increases before the Secretary of HEW reevaluates the pass through provision in 18 months. The almost certain result will be higher wage rates for non-supervisory workers than would have been the case without the pass through.

TABLE 3

EARNINGS AND LABOR COSTS

	Average Annual Earnings	Full Time Equivalent Employees Per Patient Day
1955	$ 2,563	2.03
1960	$ 3,240	2.26
1963	$ 3,639	2.41
1966	$ 4,097	2.61
1969	$ 5,380	2.80
1970	$ 5,921	2.92
1971	$ 6,530	3.01
1972	$ 7,062	3.10
1973	$ 7,388	3.15
1974	$ 7,803	3.26
1975	$ 8,649	3.39

TABLE 4

HOSPITAL WAGE AS A PERCENTAGE OF WAGE IN ALL INDUSTRIES - 1975

	Baltimore	Boston	Chicago
General Duty Nurse	97.1	102.0	9.1
Payroll Clerk	101.5	107.7	91.6
Switchboard Operator	116.4	103.7	91.4
Switchboard Receptionist	114.5	104.7	-
Trans. Machine Operator	123.6	110.6	108.6
Maintenance Electrician	82.5	96.9	68.8
Stationary Engineer	96.0	86.0	75.2
Porter	122.4	107.4	89.8
Maid	146.4	117.1	111.3

It is likely that higher rates of increase for non-supervisory worker wages will have an effect on both supervisory wages within hospitals (in order to maintain the desired differential) and on other health care service units wages since they must compete with hospitals for many of the same personnel. These units include doctors offices, nursing homes, home health agencies, visiting nurse associations and state and local government hospitals which, while not covered by the cost containment legislation, nevertheless have a significant impact on inflation in the health care industry generally and therefore on federal expenditures.

The long term effects of the wage pass-through could be significant. Once wages are increased, particularly in a relatively price-insensitive industry they simply become a new and higher base on which new percentage increases are figured. Given the way the pass-through is structured there is an incentive for hospital administrators to increase the work force which is not subject to a cap rather than to seek potentially more cost effective means which would be subject to the cap. This incentive would, for example, make it less desirable to rely on disposable materials that would save labor, than to increase the work force.

Finally, the wage pass-through provision as presently written would create some administrative problems.

There will be difficulties in determining supervisory vs. non-supervisory personnel on a hospital by hospital basis. Errors in sorting personnel could result in cost overruns and fiscal penalties to the hospital.

There will be pressures particularly in the unionized hospitals to reopen contracts before the 18-month period.

It is not clear from the legislation whether increases that occur between the base year and effective date of the legislation can be passed through. If so, pressures will begin now to raise wages and there can be two large increases before the 18-month period after the effective legislative data runs out.

There appears to be an incentive for hospitals to negotiate large increases every other year using the pass-through to raise the overall ceiling in the year of the wage increase and to use the 9% applicable to the non-supervisory wages portion of total costs even though the increase would be mutually zero.

Mr. KILPATRICK. Four, control on capital expenditures, as well as operating costs, is absolutely necessary.

Five, effective utilization review is essential to sensible cost-control programs and should be extended to all patients as part of this bill.

Six, finally, and most importantly, S. 1391 should be amended to require that State prospective budget review and rate approval programs be put in place by a specified date.

The IAC companies have had considerable experience with State regulation of hospital costs in Connecticut. Also, we have closely watched the experience of the regulatory agency in Maryland. In addition, we have recently participated in the Government Research Corporation's initiative to draft a model prospective reimbursement program.

Because each of these efforts has implications for a Federal hospital cost control proposal, I would like to describe them briefly.

CONNECTICUT EXPERIENCE

The Connecticut experience has been especially illuminating. In 1973, the legislature created a commission on hospitals and health care. A majority of its 15 members are consumer representatives. The commission administers the State's certificate-of-need law and reviews all operating and capital expense budgets of health service institutions, including hospitals.

In Connecticut we have seen that a State health care commission can help contain rising costs. The commission has saved Connecticut consumers an estimated $35 million since its inception without adversely affecting the quality of care.

Before the commission was established, Connecticut hospital prices and revenues were rising at or above the national average. After the commission went to work, Connecticut hospital charges for individual services increased about 8 percent in 1975 and 10 percent in 1976, well below the national average of about 15 percent for those years.

Because of increased utilization of services, however, total hospital revenues in Connecticut increased 16 percent in 1975 and again in 1976. This was still below the national average of 20 percent in 1975 and 22 percent in 1976.

The existence of the commission has caused insurers and health care professionals to take a fresh look at the system of health care in Connecticut. Citizen task forces are helping the commission in its planning and ratesetting and in its efforts to assure the efficient delivery of quality care. These groups actively deal with quality care issues in important areas, such as primary care, open heart surgery, and ambulatory surgery.

Of course, Connecticut is not without its problems. The commission has recognized that price control is not necessarily total cost control, and it has been concentrating its efforts on controlling hospital revenues. In that regard, a committee of all interested parties is studying a number of refinements of the regulatory process.

Since 1973, it has also become apparent that legislation was needed to protect hospitals' right of due process, and it also became evident that the makeup of the commission should be changed to enable it to benefit from the expertise of third-party payers. These two changes are

contained in a bill that was recently passed by the Connecticut Legislature and sent to the Governor for her signature.

The point is that the process of State regulation is adjusting and improving. We think such refinements can be incorporated into a Federal program which establishes State prospective budget review and rate approval as a long-term solution.

MARYLAND EXPERIENCE

Now, I would like to describe the Maryland experience.

In July 1974, the State of Maryland Health Services Cost Review Commission set out to implement a statute similar to Connecticut's. The results to date have been positive.

In 1975, the rate of increase for inpatient costs was held to 11 percent, compared to a national average of nearly 15 percent. In 1976, the increase was 12 percent as opposed to 15 percent nationwide; 1976 savings alone total nearly $23 million.

It is particularly encouraging that these savings have been achieved without impairing hospitals' delivery of quality care or adversely affecting their financial stability. As a matter of fact, their financial position improved. From experiencing a combined net loss of nearly $4 million in 1975, Maryland hospitals showed a net gain of over $8 million in 1976.

A key argument in favor of State prospective budget review is that it can be responsive to the varied needs of each individual institution. Experience in Connecticut and Maryland has shown this to be true.

For example, in the first year of Connecticut's program, the average authorized increase in hospital budgets was 8 percent, but the increase granted for individual hospitals ranged from 4 to 27 percent.

The experience in Maryland is even more dramatic. In 1976, approved increases in operating costs ranged all the way from less than 1 percent to 29 percent.

An arbitrary Federal cap on budget increases by its very nature tends to perpetuate the status quo and ignores differences among institutions. It therefore rewards inefficient institutions and punishes the efficient. State hospital commissions like Connecticut's and Maryland's avoid the problem inherent in a Federal price control.

GOVERNMENT RESEARCH CORPORATION PROPOSAL

In addition to observing these positive experiences in Connecticut and Maryland, our companies also have participated in a unique effort to reach a consensus on the ingredients necessary for a system of State regulation that is equitable to hospitals, consumers, and third-party purchasers alike.

This effort was sponsored by the Government Research Corporation. It involved an ad hoc group of representatives of hospitals, employers, unions, health and welfare funds, State regulators, and insurers. This group did an 8-month analysis of prospective budget and rate review as a cost-control device. Because of the conflicting interests of the various institutions involved, the final work product of this group does not necessarily represent a system that all participants as a group would support. But we believe it is a thoughtful,

workable, and effective proposal which I would like to submit for the record of the subcommittee.

The proposal suggests establishment of a permanent system of prospective budget review and rate approval operated under Federal standards, but administered at the local level by State commissions. It calls for annual budget and rate reviews for those institutions that fall outside of established screens, and advocates reviews at least once every 5 years for all institutions.

State commissions would have responsibility for coordinating with health planners and in so doing would exercise certificate-of-need functions. They would also be empowered to decertify and phase out underutilized or inefficient hospital beds and services. The model suggests Federal assistance in meeting costs associated with closing or converting decertified facilities. It also suggests that a critical element of effective hospital cost control is the establishment of utilization review for all patients by the hospitals, either directly or through PSRO's.

ANTITRUST OBSTACLES TO INSURER ACTION

Turning to another area, individual insurance companies have considerable potential to assist in controlling health-care costs. However, Federal antitrust regulations prohibit the industry from pooling data and acting collectively to hold down costs. The public would benefit from a narrowly drawn antitrust exemption that would permit us to barter with providers on acceptable levels of reimbursement. This could create an important moderating influence on cost increases. Such an exemption should also permit insurers to work together to shape benefit packages to include cost-saving features, such as coverage of procedures in outpatient settings.

CONCLUSION

In conclusion, I would like to reiterate our support for the administration's efforts to control hospital costs. The administration bill is an important first step. However, we strongly believe the Nation must make a transition to a permanent system of hospital cost control. Needed is a system that gives equal emphasis to quality care, adequate reimbursement for all legitimate hospital costs, and the public's need for control of the rate of increase in hospital costs.

We believe State prospective budget review and rate approval systems can accomplish this goal. In Connecticut and Maryland it has proved that costs can be controlled without adversely affecting the quality of care. It offers the local expertise and knowledge that a Federal system could never achieve. It makes possible a more sophisticated, in-depth review of a particular hospital operation than could a Federal system. And as a permanent solution it offers the flexibility needed to become an extremely effective regulatory process.

We urge you to take these steps in developing a cost control proposal, and we offer you any assistance we can provide.

Thank you.

Senator HAYAKAWA. Thank you very much.

Mr. Kilpatrick, I would like for you to explain, if you will, please, why you need the antitrust exemption and why you cannot impose cost controls under present circumstances?

Mr. KILPATRICK. I would like to make three points on that Senator.

Senator HAYAKAWA. Please do.

Mr. KILPATRICK. First, without an antitrust exemption, the efforts of any indivudial company would be ineffective. This would be effective only if all companies joined in openly and publicly. This is a very competitive business and there are more than 300 companies in it. Even the largest company has something less than 10 percent of the total share. An individual effort would be ineffective becasue of competitive forces in the marketplace. We simply cannot negotiate with providers, hospitals, doctors, and so forth on a company-by-company basis. There is too much competition.

Second, I would like to believe that without the antitrust exemption, that ethically we simply could not do it.

But the primary point I want to make is no company is large enough alone to negotiate.

The third point I want to make is we need an exemption as a legal matter in order to pool ideas and data. We cannot do that at this moment.

Senator HAYAKAWA. You say no company is large enough to negotiate and that the companies could get together to pool their buying power in such a way as to negotiate; is that what you are saying?

Mr. KILPATRICK. I am saying that would be one part.

If you try to negotiate prospective payments with institutions, for example, it would be ineffective if one company tried to do it alone, or even several companies operated alone, because the forces of competition are so great in the marketplace. This is a terribly competitive business.

Mr. MILLER. Our lawyers interpret antitrust laws to prohibit us from doing that sort of thing in concert. Unless we have some kind of exemption, which would permit us under, perhaps, established guidelines to deal with certain areas of this on a common basis, we suffer from a very distinct impediment in our ability to deal with providers, both hospitals and doctors, in this connection and other providers.

Senator HAYAKAWA. When you say very sharply competitive field, does that mean then that some of the competitors would then drive prices down to the point where other companies cannot survive?

Mr. MILLER. No.

Mr. DIPRETE. Senator, if, in a given hospital, one insurance company only had its insured patients representing 4 or 5 percent of that hospital's total business, it would be difficult for that insurance company to negotiate effectively for cost containment or to put pressure on for containing costs. It is too small a piece of that hospital's total effort.

Mr. MILLER. Look at it from the point of view of hospitals. Suppose there are 300 carriers they have to negotiate with. It would mean each of the 7,000 hospitals would have to undertake negotiations with each of the 300 companies, and that gets to be an enormous task which certainly, from both points of view, from the viewpoint of the companies having to negotiate with 7,000 hospitals and from the viewpoint of each hospital negotiating with 300 companies, is an intolerable burden on both.

Mr. KILPATRICK. If I may make one other point on the same question, sir, and that is that it is necessary to pool data to be effective in cost control. Individual insurance companies have considerable data that is available to monitor costs, control health care costs. But we interpret Federal law at this moment to prohibit the industry from pooling this data. One company cannot exchange data with another.

I think this in itself bars us from using the collective knowledge of the industry to holding down costs.

Senator HAYAKAWA. You say that with 300 insurers and 700 hospitals——

Mr. MILLER. 7,000

Senator HAYAKAWA. 7,000 hospitals?

Mr. MILLER. Yes, sir.

Senator HAYAKAWA. Well, what is the factual situation? Are there now some of these insurance companies much larger than others so they control a very large percentage of the total business?

Mr. MILLER. The largest of the companies barely has 10 percent of the total, and that 10 percent is often concentrated somewhat more highly in one area and less highly in another.

So no one company can deal effectively with the whole of the hospital community countrywide.

Mr. KILPATRICK. Even the largest of the companies have only a small proportion of the market.

Senator SCHWEIKER. One of the first questions I would have is, what protection would there be against abuse if such antitrust exemptions were granted?

Mr. DIPRETE. Senator, perhaps as an example, a very specifically limited piece of enabling legislation, and we would be happy to submit a proposal that would conduct, for example, an experiment, with specific parameters around it, so we can monitor the results of that experiment. This would not be broad legislation applicable to the entire industry or business, but perhaps we could start with an experiment in a cost-containment area and see if that works.

Senator SCHWEIKER. Instead of doing it the way you are proposing, what would be wrong with presenting this information to State commissions and letting them compare it?

They obviously would not be subject to the antiturst laws. The companies would not be acting collusively or collectively if that information was passed on to the State cost control commission.

What disadvantages would there be in doing it that way?

Mr. DIPRETE. If there were State control commissions, if that were in place, I think through the mechanism of Hospital Rate Review Commission, the commission itself would have enough data, information, through budget review process, to make a major impact.

We are dealing in a world that is absent those programs currently.

Senator SCHWEIKER. Your testimony advocates State review commissions, State ratesetting, and prospective review, if I'm not mistaken.

Mr. MILLER. Yes, sir.

There would be another advantage to such a system, it seems to us, in that State commissions could be given the power to collect data of a sort that would be helpful in understanding the costs and utilization that is involved in a particular area.

Senator HAYAKAWA. Are these State commissions effective and operative in all the States?

Mr. MILLER. No. They are operative largely in four States at the present time: Maryland, Connecticut, Washington, and Massachusetts. They are under consideration elsewhere.

A State enabling law is necessary in order to put one of these systems in place, and legislation is moving through several other States, the particular ones I am not familiar with.

Mr. DIPRETE. In California, the Assembly Ways and Means Committee currently has before it a proposal that would do just this thing.

In Colorado, legislation just passed about a week ago, I believe. And maybe 12 or 13 other States have under consideration something. Whether there is a chance for passage in the short run, I do not know.

Senator HAYAKAWA. Further developments that you mentioned to Senator Schweiker just now, you are going to give more narrow definition of the exemption you suggested?

Mr. MILLER. Yes indeed.

Senator HAYAKAWA. You have specific language on that?

Mr. MILLER. We will do our best and as quickly as possible.

Senator HAYAKAWA. Among the proposals is data pooling, is that correct?

Mr. MILLER. And the capacity to negotiate with providers on costs.

Senator HAYAKAWA. This data pooling will be how extensive? What areas?

Mr. DIPRETE. We would like to report back to you on what it is we would like to start with.

Senator HAYAKAWA. How much of this is now being done with health care data consortia being sponsored under the cooperative health statistics system?

Mr. DIPRETE. I cannot speak to that. The only data that we collect is on surgical procedures and that is without the name of the physician. It is only by zip code and the type of procedure and the amount. That is fed into a common data bank and available to the public at large at cost. But it does not make for an effective negotiation with the provider because it is purged of the physician information.

Senator HAYAKAWA. Then having accumulated the data you would be bargaining with the providers?

Mr. DIPRETE. Yes sir.

I think this is similar to the proposal that Interstudy now has under consideration, for which they are being funded by the National Chamber Foundation to explore this even further, forming health care alliances to negotiate effectively with providers.

This is a study that I believe will take place over the next several months to be concluded in months rather than years.

Senator HAYAKAWA. Would Blue Cross then be included as a partner in the bargaining?

Mr. TRESNOWSKI. Senator, I am listening to the testimony presented by the commercial insurance carriers. I, for the record, want it to be clear that we have not seen the statement or the rationale in support of an antitrust exemption, so I cannot speak to that.

Generally, our views are that we would not support such an exemption, although I would like to look at the rationale more carefully. We would not need to support it because, each Blue Cross plan does

contract with hospitals on an individual basis, and as part of that contractual process they negotiate the reimbursement arrangement.

In other words, there is a form of rate regulation in all Blue Cross plan areas.

Senator HAYAKAWA. What about medicare and medicaid?

Mr. MILLER. As being a part of this?

Senator HAYAKAWA. Yes.

Mr. MILLER. I would not think so offhand. The government, at the State and Federal level, have been establishing the prices at which they will reimburse medicare and medicaid patients.

If there would be any need or desire on the part of the Government to be a part of such a program, I do not see any reason why there could not be services and probably medicaid patients.

Senator HAYAKAWA. It is my understanding that the benefits package will be shaped toward cost control.

Mr. MILLER. Yes.

Senator HAYAKAWA. What I would like to ask is why can that not be done now, particularly with added benefits that would be acceptable to both labor and management, if they were cost-effective?

Mr. DIPRETE. That is already being done. That is separate and apart from the discussion on the enabling legislation. That was not to deal with benefits but to deal with charges and costs.

What is being done now is largely reshaping and redesigning of benefit programs to emphasize less expensive outpatient care where the buyer will participate and purchase such coverage.

But most companies—our company at least—have expanded their benefit program to add benefits such as outpatient services, preventive care, preadmission testing, and the like to encourage less expensive facility use.

Senator SCHWEIKER. Mr. Kilpatrick, how long do you think it would take for the States to implement cost control programs?

Mr. KILPATRICK. Senator Schweiker, I will have to make a guess. I can tell you about our experience in Connecticut. I think it would be a lot faster than that, because the public nationally has made this such a high priority issue.

It is my own belief that any legislature in its normal session could pass the necessary legislation, and the system could probably be operational in 6 months thereafter.

We did that in Connecticut, and without having anywhere near the public attention being focused on this issue as it gets today. My belief is that the Federal Government should set a specified date by which each State would be required to have such legislation.

Senator SCHWEIKER. You referred on page 7 of your testimony to a proposal which "suggest establishment of a permanent system of prospective budget review and rate approval operated under Federal standards."

What kind of Federal standards would you suggest?

Mr. KILPATRICK. I think one of the standards would be to have the States make individual judgments about different institutions. I think another standard should be to require inclusion of all costs, not just operating costs, but capital expenditures as well. I think it should require the States to have a systematic process of planning for new facilities, and that they decertify unused facilities—this kind of thing.

We have done a great deal of work, which I will also enter into the record, through the Government Research Corporation, that we believe attempts to propose appropriate standards.

Senator SCHWEIKER. Does your proposal envision a State cap, or a national cap administered by the State, or no cap at all on the States? I am not clear.

Mr. KILPATRICK. My own belief is there should not be a cap on a national basis or a State basis, but that each State should be required to meet some sort of procedural standards, perhaps specified and reviewed by the Department of Health, Education, and Welfare.

I believe a great deal of individual judgment should be left to the States in terms of a cap.

Mr. MILLER. The advantage of the system we propose is that it applies hospital by hospital instead of across the board in a way which would be inequitable for some, and perhaps providing more than necessary for some and less than others.

The prospective budget review and rate commission would look at the situation hospital by hospital and make a judgment as to whether the hospital in aggregate was proposing to use revenues and increase them in a way that was sensible and supportable in terms of the services that particular hospital was providing with the particular population that is served.

Senator SCHWEIKER. So your proposal contemplates that the States set up the commissions and thereby be excluded from the cap?

Mr. MILLER. Yes.

Senator HAYAKAWA. What prevents you now from advising your clients of the high cost doctors and high cost hospitals so they will help you use the lower cost facilities?

Do not your clients still have to pay that part of the bill that is above the indemnity limits?

Would they not want to know how much more they might have to pay if they go to certain providers?

And why do you need to have an exemption from antitrust to do a consumer information program?

Mr. MILLER. Well, there is no need for exemption from antitrust to carry out that type of information program. I would say the best answer lies in the direction of having hospitals and doctors, if you will, disclose the nature of the charges that they will make so that a patient or prospective patient can find out that in hospital X the room charge is so much and in hospital Y the room charge may be something else, and be able to make some judgment.

Patients today can find that out. It takes a little doing.

It seems if there were some requirement which could be suggested as being as fair and easily determinable, these rates be posted and disclosed more adequately for the purposes of the public——

Senator HAYAKAWA. That would be a desirable goal, indeed. Therefore, would you support developing standard formats for health insurance policies, like auto insurance in Massachusetts, with the policies written in English where all can understand it, and then have unit pricing for each part of the policy?

And do you know what I mean by Massachusetts auto insurance?

Mr. MILLER. I am not familiar with the situation in Massachusetts. I think I know what you have in mind, stipulation by the State that

everybody ought to have auto insurance of a specific quantity and quality.

Senator HAYAKAWA. And unit pricing of each part of the policy.

Mr. DIPRETE. The difficulty there, Senator, is that for the most part health insurance provided to the private sector patients through a group insurance vehicle, and that is experience rated for the most part for that particular employer or that particular group, so that unit price is not transferable over to another group whose experience is different.

But rates are on file with each line of coverage by all companies with each insurance department, unit pricing, if you will.

Senator KENNEDY. If we could go back for a moment to some aspects of antitrust as they relate to health. As I am also chairman of the Antitrust Subcommittee there are some points I would like clarified. In the of health you support planning and allocation of resources which runs contrary to the direction we are moving in antitrust. These issues are basic and essential and I would like to know if you have any specific recommendations?

Mr. MILLER. The nature of the problem as we see it is twofold.

One, public, and others perhaps wonder why we do not do more to use the muscle that we have in terms of the payments that we make to hospitals to bargain or to negotiate cost of services with them. And our lawyers tell us that is not possible for us to do in any sort of concerted way. We have to do it on a company-by-company, individual insurance company by company basis. That tends to be impractical because no one company has enough—so large a proportion of all the business to make its impact felt adequately.

On the other side of the same question is that our lawyers tell us they are very definite impediments from an antitrust point of view to our ability to collect and pool in a significant way data with respect to the extent of services and the cost of services among a number of companies, so we might use that data and become more effective in cost control.

Senator KENNEDY. Could you give us some specific recommendations?

Mr. MILLER. We will do that, sir.

Senator KENNEDY. Would it be possible to have your staff work with our Antitrust people on this?

Mr. MILLER. We will work with your staff on this, and we have previously indicated we will supply an initial proposal as soon as possible, and we will indeed do that.

Senator KENNEDY. Are you raising this point as an obstacle that you want to see overcome?

Mr. MILLER. Yes, sir.

Senator KENNEDY. You are willing then to share information with Blue Cross and the others?

Mr. MILLER. That is a different matter.

We are willing to share information with other insurance companies. I cannot speak for the Blues. We would be prepared to share information with them. Now, whether they would be prepared to share information with us is another matter.

Senator KENNEDY. Let me hear from Mr. Tresnowski for a minute.

Mr. TRESNOWSKI. That question was asked while you were out. I have said at that time I have not seen this proposal made——

Senator KENNEDY. What about the conceptual idea?

Mr. TRESNOWSKI. I would have concern about that antitrust exemption. We do not need one.

As you know, each of our plans are separate corporations. They operate under enabling legislation specifically in the State in which they operate. Each one of them now have contracts with hospitals which prescribe the nature of the reimbursement arrangement.

So whether we have 80 percent of the market or 10 percent of the market, we still negotiate with hospitals. That has been our tradition and that is the way we operate without benefit of antitrust exemption.

Senator HAYAKAWA. May I have another question for Mr. Tresnowski?

Senator KENNEDY. Yes.

Senator HAYAKAWA. In your statement you say you favor positive incentives toward cost reduction.

Would those you favor include, for example, bonus payments and conversion allowances as provided for in the Talmadge bill?

Mr. TRESNOWSKI. Yes; as a matter of fact. That is detailed in our statement on page 12 as what we have in mind about the incentives.

Specifically, the Talmadge idea comes up with classification scheme. Within the classification scheme it develops, you might call, a target rate. You can expand that idea to provide an incentive.

In other words, if a hospital can come in under the target rate, that hospital ought to be allowed to keep some difference between that rate and what he came in at. Clearly the incentive is money. That is the kind of thing to motivate the hospital.

We would be supportive of that type of incentive.

Senator HAYAKAWA. You believe there are enough data available to HEW to administer an effective scheme classifying hospitals and payers by type?

Mr. TRESNOWSKI. It depends on the classification scheme. I believe the best one yet developed that takes into account most of the factors is the American Hospital Association's classification system. It accounts for most variables and provides as much similarity as possible within the groupings. You can pick that one.

Several have been mentioned this morning.

I think it depends a lot on what you are trying to get to.

In the case of the Talmadge bill, what they are trying to do is get to the inefficient hospital.

In the case of the Carter administration's proposal, what they are trying to do is reduce the rate of inflation.

What you can do is join those two ideas, put a cap on, reduce the rate of inflation, but build in an incentive such as Senator Talmadge has proposed within the classification scheme. I think the idea is compatible.

Senator HAYAKAWA. Thank you.

Mr. MILLER. May I take this opportunity to comment further on the Talmadge proposal?

Senator KENNEDY. Yes.

Mr. MILLER. We testified before Senator Talmadge, I think last week. We pointed to several deficiencies we say in his proposal. It does not focus on total hospital revenues. It does not take into account outpatient services. It does not take into account so-called ancillary services.

As we understand it, it is based primarily on per diem rates. This has the deficiency that it removes any incentive of the hospital to shorten lengths of stay.

When you get past the first few days, actually the hospital is taking in more revenue through its per diem rate charge than its expenses require. In a sense, it puts the reverse incentive on the hospital to keep the patient in longer in order to obtain more revenue.

At the same time, in focusing only on the room rate, and not outpatient costs, or ancillary costs, there is an opportunity to juggle expenses and allocations among those.

We think the Talmadge proposal has several deficiencies along those lines and so indicated to the good Senator.

I would like, Mr. Chairman, with your permission, to put our testimony with respect to the Talmadge bill in the record.

Senator KENNEDY. Fine. We will make it a part of the record.

Mr. MILLER. You wanted us to continue discussion of the physician service review concept.

Senator KENNEDY. Yes, please.

Mr. DIPRETE. As part of our recommendations, we propose expansion of the PSRO concept to all patients. We have been, by individual company, trying to negotiate with some limited effect with individual PSROs around the country, indicating a willingness to pay for onsite reviews, case by case, or adding it up to the hospital bill.

At Hancock, we have only been able successfully to negotiate with about 18 PSRO's out of approximately the estimated potential of 200. Our impact is very limited.

We feel the PSRO law should be expanded to all patients, and we would be willing to pay for it because effective utilization review has a big payoff.

Senator KENNEDY. That would be very helpful.

Mr. MILLER. We will send you some information as to what we have been doing in these 18 or so areas where some work has been going on.

Senator KENNEDY. That would be most helpful as we will be working on "The Health Planning and Resource Development Act of 1974" later this year.

I appreciate Senator Hayakawa addressing these questions, and I look forward with great interest to your responses.

I want to thank you very much.

Mr. MILLER. Thank you.

[The prepared statements of Mr. Tresnowski and Mr. Miller follow:]

Statement of the

BLUE CROSS ASSOCIATION

on

S. 1391

"THE HOSPITAL COST CONTAINMENT ACT OF 1977"

presented to

SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

COMMITTEE ON HUMAN RESOURCES

UNITED STATES SENATE

by

Bernard R. Tresnowski

Executive Vice President

May 26, 1977

EXECUTIVE SUMMARY

The Blue Cross Association believes that there is a need for enactment of a program to contain health care costs. We believe that such a program should contain two componenets: (1) a transitional program for limiting inpatient hospital revenues on a class of purchaser basis with positive incentives for hospitals and (2) a national moratorium on new plant capital expenditures.

As for which providers and services should be subject to a transtional revenue limitation program, we share the same concerns others have expressed. If such a program applies only to one segment of the health care delivery system -- such as only hospitals or hospital inpatient care services -- there is real danger that the program will not achieve effective containment of health care costs generally. Continued high rates of inflation are not restricted to the hospital industry, even though it represents the largest single compoenent of the delivery system. Nor are the underlying causes of health care cost inflation that require corrective action and behavioral change restricted to the hospital industry.

On the other hand, we seriously question whether a transitional revenue program applicable to several or all segments of the health care system could be effectively and equitably designed and administrered over a reasonable amount of time. We share the view of the administration and others that immediate action is in order as a transition to longer term reforms. For these reasons, a transitional revenue limitation program that applies only to hospital acute care services at this time appears to be a viable, though far from ideal, course of action. We believe that if only hospital acute care services are to be contained in the program, the actions and expenditure increases of various providers of non-acute care services should be closely monitored to determine whether any corrective actions are needed for those segments of the health care industry.

We also believe that the concurrent introduction of a temporary capital expenditures moratorium program should go a long way toward preventing fragmentation and duplication of health facilities and services whereas a revenue limitation program applies only to hospital acute care services. Such a moratorium would allow time for more fundamental and permanent reforms in the Health Planning Act.

In the design and operation of a transitional revenue limitation program for hospitals, positive incentives need to be provided for hospitals to operate more efficiently. For example, incentives should be established for hospitals to substitute for inpatient care services less costly services, where medically appropirate, and to eliminate, consolidate or convert existing excess operating capacity. Also, there should be opportunities and incentives for continued innovation and experimentation with a variety of approaches resulting in longer term, more permanent and effective health economic reform.

We firmly believe that the key to improved efficiency and cost effectiveness withing the health care delivery system lies with the types of longer term, permanent cost containment tools that are currently under way -- health planning, prospective and other incentive payment systems, utilization review, alternative delivery systems, utilization review, alternative delivery systems such as HMO's or large, multi-specialty group practices and innovative health care benefits such as home care and second surgical opinion coverage. We also believe that these tools must be closely integrated. No one tool can be expected to do the whole job, as each deals only with selected facets of the cost problem.

Similarly, we believe that effective design and implementation of these tools is a shared responsibility. Health providers, government, labor and business must all work with us to ensure success. Hospital trustees, hospital administrators, physicians and other health professionals must understand the dimenstions of the problem and actively contribute to its solution.

We recognize, however, that these cost containment tools have not been implemented as fast as we would like and that it may be several years before they are effectively operating on a broad scale. The current state of the art is far from well developed in terms of what criteria and procedures work best in implementing these cost containment programs at the state, local and individual levels.

Hence, our recommendations reflect the combined circumstances of not yet having the basic cost containment tools well developed, tested and effectively operating on a broad scale, and of rapidly approaching the limit of funds available for health care expenditures in this country. If imaginatively designed, a revenue limitation program may serve not only as an interim measure to alleviate economic pressures while those basic tools evolve, but also as a means of stimulating more rapid and effective development and implementation of those tools. We must note, however, that there is a potential legal problem under a revenue limitation program. Existing contracts between Blue Cross Plans and providers impose obligations and confer rights with respect to payment for subscriber care. There is the potential under a revenue limitation program for Blue Cross Plans to be sued for breach of contract by providers if the Plans pay less than what is called for in the contract in order to stay under the limit. Or, the Plans could be taxed on the excess payments if they honor the contract.

The imposition of a transitional capital expenditures moratorium also meets important needs. It can provide some "breathing room" for new state and local planning agencies now in a critical stage of their development to formulate health plans and project review criteria and procedures in an effective manner. Also, it will help to ensure that providers of services not covered under a transitional revenue limitation program do not unnecessarily duplicate facilities and services for those subject to the limitation program.

As for the administrative responsibilities, we believe that the detailed administrative functions should be assigned to the Medicare intermediaries both to use this available and effective resource and to allow the Secretary to concentrate his resources on program design, policy and evaluation.

In summary, we view S.1391 as a valuable first step toward formulation of a transitional revenue limitation program. Title I of the bill (revenue limitation) contains several good ideas. There are no easy answers to designing a program which is easy to understand, implement and administer and which is simultaneously flexible and effective in containing health care costs in all the right ways. We do believe certain aspects of Title I are too prescriptive, detailed and inflexible. For instance, we do not believe that sufficient options and incentives are provided to hospital or third-party payers to further develop, refine and implement cost containment tools. And we find some provisions unclear and confusing from a conceptual or administrative standpoint. There are also legal problems that m must be addressed. Also, for effective administration Medicare intermediaries should be assigned a major responsibility.

We find Title II (capital expenditures limitation) of the act to be provocative and our initial reaction to many of the provisions of that Title are favorable. We believe, however, that Title II of the proposed bill is not a transitional program. Title II really suggests some fundamental and permanent reforms to the current system of health planning in the United States. For that reason, we believe that such changes should be given very careful consideration in the context of other changes that are expected to be proposed later this year in Congressional hearings on the extension and potential amendment of Public Law 93-641 (the Health Planning and Resources Development Act of 1974). That, we believe, is the appropriate time and place for consideration of Title II program features.

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Mr. Chairman, and Members of the Committees, I am Bernard Tresnowski, Executive Vice President of the Blue Cross Association, the national coordinating agency of the 70 member Blue Cross Plans in the United States and Puerto Rico.

I thank you for the opportunity to share with you our thoughts on health care costs; on what generally must be done over the short and longer terms to promote more effective containment of those costs; and on S. 1391 as a means to accomplish that end.

The views I shall present reflect the knowledge and experience gained by the Blue Cross organization through the administration of both governmental and private underwritten health care financing programs.

On the government program side, the Blue Cross Association is a prime contractor to the Social Security Administration for the Medicare program nationwide. Individual Blue Cross Plans are subcontractors to the association for this program. Many of our Plans also administer the Medicaid program in their territories.

On the underwritten business side, the Blue Cross organization serves more than 80 million private members who are significantly affected by the rising costs of health care. In nearly all instances, we provide what is known as "service benefits," that is, full or nearly full payment for covered services, in contrast to "indemnity" or fixed cash benefits paid by many commercial insurance policies.

In 1976, we paid $13 billion in benefits for our subscribers, covering nine million claims for inpatient hospital care and twice that number -- twenty million -- for outpatient and other ambulatory care.

Our Plans have contracts with 6,700 hospitals, covering both inpatient and outpatient services. In addition, 30 of the Plans are involved with 57 health maintenance organizations, mostly the prepaid group practice type, to help give our subscribers a choice of the kind of care they will receive.

We have been most closely identified with hospital coverage. But now, to a significant degree, we also cover diagnostic laboratory and x-ray services, dental care, home health care, prescription drugs, vision care, nursing home care, ambulance service, preventive care and outpatient psychiatric services.

Because of consumer demand for broader benefits, our payments would have gone up over the years even if the cost of care had remained constant. However, costs have increased significantly.

Need for a Transitional Health Care Cost Containment Program

The Blue Cross Association position is that there is a need for enactment of a program to contain costs in the health care delivery system. Walter J. McNerney, President of the Blue Cross Association and representing Blue Cross Plans, believes that a transitional program should consist of two parts: (1) a program to limit inpatient revenues on a class of purchaser basis, and (2) a national moratorium on new plant capital expenditures.

In terms of the first, we believe the inpatient revenue limitation on a class of purchaser basis should distinquish among the various third-party contract payors (charge-based or cost-based contract payors), cost-based payors which technically are not contract payors (e.g., state Medicaid programs), and non-contract charge payors.

In terms of which providers and services should be subject to a transitional revenue limitation problem, we share the same concerns that others have expressed. If such a program is applicable to only one segment of the health care delivery system, such as hospital inpatient care only, it could have the positive affect of shifting care to ambulatory services, however, there is a danger that such a program will not achieve effective containment of health care costs generally. Continued high rates of inflation are not restricted to the hospital industry, even though it represents the largest single component of the delivery system. Nor are the underlying causes of health care cost inflation that require corrective action and behavioral change restricted to the hospital industry.

Not only might expenditure increases in segments of the delivery system not subject to a transitional program more than offset any cost containment gains of such a program, but there is a real potential that current problems of fragmentation and unnecessary duplication in health care delivery at the local level would be increased. On the other hand, we seriously question whether a transitional revenue limitation program applicable to several or all segments of the health care system could be effectively and equitably designed and administered over a reasonable amount of time. We share the view of the Administration

and others that fairly immediate action is in order as a transition to longer-term reforms. For these reasons, a transitional revenue limitation program applicable to hospital acute care services is a viable, though far from ideal, course of action. Concurrent introduction of a new capital expenditures moratorium program should go a long way toward preventing increased fragmentation and duplication of health care facilities and services, where a revenue limitation program would be applicable only to hospital acute care services. Such a moratorium would allow time for more fundamental and permanent reforms in the Planning Act. However, we also believe that if only hospital acute care services are to be contained under a transitional revenue limitation program, the actions and expenditure increases of providers of non-acute care services should be closely monitored to determine whether any corrective actions are needed for those segments of the health care industry.

In the design and operation of a transitional revenue limitation program for hospitals, positive incentives must be provided for hospitals to operate more efficiently. For instance, the program needs to account for the fact that a large number of hospitals in this country are making important strides in containing their costs by improving their operational efficiency, in reaching out to serve the poor and in providing needed, higher quality services to the population generally. The program must be as sensitive as possible to individual hospital differences, in terms of characteristics, levels of performance, needs and community outlook.

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Positive incentives must be provided to hospitals under the program for them to operate more efficiently, to substitute alternative, less costly services for inpatient care services where medically appropriate and to eliminate, consolidate or convert existing excess operating capacity. Also, opportunities and incentives need to be available for continued innovation and experimentation with a variety of approaches that can result in longer term, more permanent and effective health economic reform, such as incentive payment systems, HMOs, utilization review, health education and innovative benefit programs.

With respect to inclusion of our underwritten business payments to providers under such a revenue limitation program, we see a potential legal problem that needs further investigation. Existing Plan-provider contracts impose obligations and confer rights with respect to payment for subscriber care. There is the potential under a revenue limitation program for Blue Cross Plans to be sued for breach of contract by providers if the Plans pay less than the contract calls for to stay under the limit, or to be taxed on excess payments if they honor the contract. This possibility is increased if providers are not subject to an excise tax on excess receipts from a Blue Cross Plan. The constitutionality of a revenue limitation program applied to Blue Cross Plan payments may also be an issue. Contract rights are property which under the 5th Amendment may not be taken away without due process.

Rationale for These Recommendations

By whatever economic yardstick, it is clear that health care prices and expenditures -- including those related to the largest single component, hospital acute care -- are continuing to rise at rates significantly above those being experienced

in other industries and sectors of the economy. A portion of the increase is attributable to the provision of more and better services to more people -- in other words, improved access to higher quality care.

At the same time, while there is no common agreement on what portion of our nation's wealth should be devoted to the delivery of health care services, it is clear that we are not getting the best results for money we're now spending. This is evidenced by the following circumstances:

- More services and new technologies do not necessarily result in better health. Some would argue that we have reached the point of negative returns in our investment in health care services. The environment, housing, personal life styles and other factors appear to affect health status as much or more than the delivery of health care services.

- Services being rendered are not always medically necessary and appropriate; there exist wide disparities in the rates of hospital use from community to community, as well as between certain HMOs and the traditional health care delivery system.

- New medical technologies, such as CT scanning, are often widely introduced in the system without careful evaluation of their efficiencies and cost-effectiveness relative to existing techniques.

- There is considerable evidence in many communities of unnecessary duplication of expensive facilities, equipment and services.

- There are often considerable variations among health care institutions of like size and other characteristics in terms of the number and mix of nurses and other health professionals.

Over the long term, it would appear that the primary solution to the nation's health economic problem rests with a fundamental change in the way we view health and health care. What is needed is a "holistic" approach to allocation of resources toward improvement in health, analyzing the relative costs and benefits of factors and initiatives not only within the health care delivery system, but also external to it (e.g., the environment, housing, personal life styles, nutrition, etc.).

While work in the foregoing area is critical and must begin as soon as possible, there does exist a more immediate economic problem in the health care delivery system that needs to be successfully addressed and resolved in a shorter time. We firmly believe that the key to improved efficiency and cost-effectiveness within the health care delivery system lies with the types of cost-containment tools that are currently underway: health planning, prospective or other incentive payment systems, utilization review, alternative delivery systems such as HMOs or large, multi-specialty group practices, and innovative health care benefit programs such as home care or second opinions in surgery. We also firmly believe that these tools must be closely integrated. No one tool can be expected to do the whole job, as each deals only with selected facets of the cost problem.

Similarly, we believe that effective design and implementation of those tools is a shared responsibility. Health providers, government, labor and business must all work with us to insure success. Hospital trustees, hospital administrators, physicians and other health professionals must understand the dimensions of the

problem and actively contribute to its solution.

We recognize, however, that those cost-containment tools have not been implemented as fast as any of us would like, and that it may be several years before they are effectively operating on a broad scale. The current state of the art is not well developed in terms of what criteria and procedures work best in the administration of these cost-containment programs at the state, local and individual provider level. We are still very much in the developmental/ experimentation stage with these tools, and we should continue to be, before any prescriptive approaches are mandated for broad adoption across the country. There is a tendency to look for simple, permanent solutions -- such as state regulation of hospital rates. There are no simple solutions to this complex health economic problem; the uniform adoption of a single approach now would not only fail to solve the problem, but would undoubtedly worsen it.

Hence, our recommendations presented at the beginning of this statement reflect the combined circumstances of (1) not yet having the basic cost-containment tools well developed, tested and effectively operating on a broad scale; and (2) of rapidly approaching the limit of funds available for health care expenditures in this country. If imaginatively designed, a revenue limitation program may serve not only as an interim measure to alleviate economic pressures while those basic tools evolve, but also as means of stimulating more rapid and effective development and implementation of those tools.

The imposition of a transitional capital expenditures moratorium also meets important needs. It can provide some "breathing room" for new state and local planning agencies, now in a critical stage of their development, to formulate

health plans and service needs and project review criteria and procedures in an effective manner. Also, it will help to insure that providers of services not covered under a transitional revenue limitation program do not unnecessarily duplicate facilities and services of those subject to the revenue limitation program; or that providers themselves subject to the revenue limitation program do not move services into otherwise uncontrolled settings. Both of the transitional programs we recommend must remain in effect until such time as more permanent, effective reforms and programs are ready to be set in place.

Overall Reactions to S. 1391

We view S. 1391 as a valuable first step toward formulation of a transitional revenue limitation program. Title I of the bill contains some good ideas. There are no easy answers to designing a program which is easy to understand, implement and administer, and which is simultaneously equitable, flexible and effective in containing health care costs in all the right ways. We do believe that certain aspects of Title I are too prescriptive, detailed and inflexible. For instance, we do not believe that sufficient options and incentives are provided to hospitals or third-party payers to further develop, refine and implement the cost-containment tools previously discussed. Some provisions we find unclear and confusing from an administrative standpoint. In the remainder of this statement, as well as in technical appendixes attached, our specific comments and concerns are presented in detail.

As stated earlier, we favor the imposition now of a temporary national moratorium on new capital expenditures. Title II of the bill raises important issues and contains general worthy suggestions. We note, however, that Title II of the proposed bill is not a "transitional" program. Its economic impacts would not

be realized over the short term, given the time lags in the incurrence of capital and operating costs associated with capital project approvals. Title II is really suggesting some fundamental and permanent reforms in the current system of health planning in the United States. For that reason, we believe that such changes should be given very careful consideration in the context of other changes that are expected to be proposed later this year in congressional hearings over the extension and potential amendment of Public Law 93-641. That, we believe, is the appropriate time and place for consideration of Title II program features. An attachment to this testimony discusses the types of issues and implications associated with Title II which merit consideration later this year when PL 93-641 is subjected to intensive and substantive congressional hearings.

Our thoughts on the appropriate design and administration of a transitional, national capital expenditures moratorium program are presented later in this statement. First, however, I would like to present our more specific reactions to Title I of S. 1391.

Transitional Hospital Cost Constraint Provisions (Title I)

We have previously noted that Title I, the Transitional Hospital Cost Constraint Provisions, has problems associated with imposing a limitation program on one segment of the economy. Because we believe permanent reforms are needed, particular care must be taken to insure that a transitional cost containment program does not negatively affect the health care system's ability to respond to a longer term program. This is particularly important in the fragmented, technologically changing and complicated health care industry.

To minimize this risk and to insure that there is sufficient latitude to make necessary changes, the legislation in general should be structured to:

- Include only the general characteristics of the limitation program. In addition, the Secretary should be given responsibility to promulgate regulations for specific provisions consistent with the intent of the legislation.

- Require concurrent evaluation of the effects of the transitional program with at least annual reports to Congress. An adequate evaluation should include the impact of the limit on availability of health care services and adjustments made by hospitals to the revenue limit. Reports related to these evaluations should be required in stipulated time frames.

While we believe permanent reforms are needed, recommendation should be made only after careful study. We are concerned that a report to Congress by March 1, 1978, may not provide adequate time for such study. We hope that sufficient time would be allowed for adequate consultation with various parts of the industry.

Even on a transitional basis, a cost-containment program should differ among hospitals more than is possible in this bill. The approach should be as sensitive to

the needs of individual hospitals as possible. The driving force should be incentives rather than penalties, so that the better managed, more cost-concerned providers can channel their efforts into long-term improvements in the hospital sector.

Among the payment features that should be considered in a cost containment program are:

- Comparison by peer groupings: Several classification systems now exist which could be considered for purposes of comparing provider costs/revenues performance.
- Target rates: The predictability associated with the rate and the potential for sharing savings warrants consideration.
- Special incentives/payments to promote initiation of cost containment programs - including specifically merging/consolidating of institutions and/or services, and modification of payment units to include capitation.
- Various methods for the provider to amortize or refund amounts in excess of allowed payment. These may include a phase-in of penalties, offset against future reductions, among others.
- Special consideration for programs which have potential for more effective utilization of existing facilities; for example, the "swing bed" projects currently underway.

In all, a broad range of incentives would have the potential to gain the necessary cooperation of the industry and yield the cost containment results sought.

Class of Purchaser-- We understand that the legislation is intended to provide application and enforcement of the revenue limitation on a class of purchaser basis. We support this basis, but believe that the legislation fails to clearly establish

this intent in its definitions. Furthermore, we believe that the definitions of the various classes of purchaser should more closely conform to current third-party arrangements; that is:

- Contract payors (charge-based or cost-based, including Medicare)
- Other cost-based (e.g., state Medicaid programs)
- Non-contract charge payors

Use of the class of purchaser arrangement simplifies administration and reduces the potential for shifts of payment liability among payer groups.

Limitation Computation -- The limit proposed in the legislation applies to inpatient care revenue only. We favor a shift from inpatient to ambulatory care whenever such shifts are ar least equally effective and less expensive. One possible result of the limit as proposed would be to increase fragmentation in the health care delivery system. Outpatient care could increase without necessarily reducing the level of admissions whenever there is a choice as to when a patient is to be admitted. Physicians may also be encouraged to use hospitals in a different way for elective admissions. As a consequence, total expenditures for heatlh care could rise despite the limit set for hospital inpatient revenues. This would be one of the effects that would need to be studied carefully to determine the need for future application of a limitation program.

The level of the revenue limit over an extended period is another consideration. We urge continuous monitoring of its effects with annual reports and an overall evaluation to the Congress within a reasonable time after two years' experience. Our concern is that over time, the basic formula (Section 112) reduces the limit to that allowed for general prices by the GNP deflator, with no allowance for technological change.

With hospitals limited to base-period revenues adjusted by general level prices, funds may not be available for financing use of significant and costly technological developments appropriate for acute hospital inpatient care. Moreover, the depreciation component implied within the revenue limit may not generate the funds needed to replace existing equipment. One possible source of funds would be savings generated by increased efficiency and productivity. Where hospitals are already at a reasonably high level of efficiency, this potential is limited. For other hospitals, the potential gain from improved efficiency and productivity is not known.

The limit formula identified as "adjusted inpatient hospital revenue increase limit" provides for an adjustment based on "total hospital expenditures" (Section 112(b)(i)(A)(i)). Various hospitals will have different proportions of inpatient and outpatient "expenditures". If both inpatient and outpatient revenues are used, the formula will tend to penalize hospitals with less outpatient activity, regardless of their inpatient efficiency and needs. Moreover, the provision of total expenditures in a formula that is applied each year might encourage expenditures for outpatient care without a corresponding reduction in admissions, thus reducing the effectiveness of the limit. This formula, to be consistent with the intent of the bill, should consider only inpatient hospital expenditures.

Several provisions of the bill relative to the calculation of base-period revenue need clarification and/or expansion. Base-period revenue may be affected by events which occurred during the latter part of that year, but affect costs and revenues for full years thereafter. A capital improvement during the base-year will be a cost factor in the revenue determination (for cost and charge payers) for all months thereafter for the life of the improvement. Similarly, any wage settlement during the year will affect cost and revenue calculations for all months thereafter.

Without adjustment, these costs will not be adequately reflected in the cost levels allowed by the proposed bill. An unusually cold winter may have had a similar impact on costs in the base year, but would have no effect on any month thereafter. These one-time costs should not be part of the allowed levels in subsequent periods.

The bill does not affect new hospitals until after two years of operation. Our experience shows that newly constructed facilities may have charges 50% above those of other facilities in the same geographic area. Without adequate revenue controls for new hospitals or a moratorium on new plant capital expenditures, the bill may unintentionally encourage new hospital construction within capital construction limitations. Provisions should be added so the special problems of new hospitals are considered. Clarification and definition also need to be provided for treatment of cost/revenues of replacement hospitals.

The formula that provides the bridge between the allowable base-year revenue and the period covered by the limit (Section 111(a)(1) makes no allowance for developments which occurred after the close of the base year but before the start of the limit program. Examples already given of capital improvements and wage settlements are also relevant here. A hospital may have made these commitments without knowledge or anticipation of a federal limit on revenues. Its financial commitments will have increased by amounts not provided for by the base-year calculations or by the formula that allows for revenue escalation from the base period to October, 1977.

Reimbursement on a per-admission basis (Section 102(b)) may adversely affect appropriate hospital utilization and the cost-containment potential may not be realized to the extent anticipated. For example, it may foster shorter stays (e.g., overnight observation) and diagnostic admission cases which can just as effectively be handled on an outpatient basis. It could also discourage such outpatient trends as ambulatory surgery.

A per admission form of reimbursement may change a hospital's case mix after the base-period calculations. Hospitals could prefer cases which require lower intensity of care rather than the more complex cases, thereby decreasing cost per admission without changing revenue. Hospitals adversely affected may not be able to detect these trends early enough for corrective action.

A combined admission and patient days measure, with the corridor in effect, would appear to be an effective deterrent to these practices.

The bill provides an adjustment for allowable revenues when there are signficant changes in volume. Significant changes are those that exceed specified limits for large and for small hospitals (Section 113(1)). The adjustment is applicable to total hospital inpatient revenue presumably in the same way as the "adjusted hospital revenue increase limit" (Section 112). The general description of the program provides (Section 102(b)) for a limit "on a per admission basis" for cost payers (Section 102(b)(1)) and charge payers (Section 102(b)(2)). There are thus two limits, one by class of purchaser and another by total hospital inpatient revenues. Where there are different changes in relative volume among various classes of payers, the two limits may not produce consistent allowable revenue limits. We have included examples of this effect in our technical comments attached to this statement. Additional consideration must be given as to how the inconsistencies can be equitably resolved.

We favor classifying hospitals by bed size rather than by admissions (Section 113) for purposes of adjustments for volume. This avoids giving more favorable treatment to larger hospitals with low occupancy over smaller hospitals with higher occupancy rates. The distinction by hospital bed size also allows hospitals to know their category at the beginning of the year and could also provide incentives

to hospitals to decertify beds if they wish to benefit from the small hospital provisions of the bill.

Where the hospital accounting year does not coincide with the limitation period, the bill provides for an allocation of the two federally determined limits on the basis of calendar days (Section 111(b)). This will be inequitable if there is significant variation in volume during the year. Hospitals in resort areas are particularly subject to the variation. An allocation of the limits should be permitted on the basis of volume in the base year with the exercise of that choice available for any hospital.

Flexibility/Exceptions:-Exemptions. -- We have previously noted the need for increased flexibility to avoid inequities in applying the limitation. Where the limitation is computed on an overall formula basis, as in this bill, such flexibility can only be achieved through an exception/exemption process. This is not provided for in the legislation.

The inclusion of options and incentives would probably reduce the incidence of exception requests. In addition, the exemption provisions, per se, should also be broadened. Wherever any group of hospitals or a particular class of purchaser can assure compliance with the overall provisions of the revenue limit, they should be eligible for exemption. This would permit greater flexibility within the context of local programs for hospitals to develop programs necessary to comply with the limitations. Furthermore, it may also stimulate interest in mergers and consolidations needed to organize more effectively health care delivery.

The exemption process now recognizes experiments approved under specific provisions of the Social Security Act. We favor broadening the provisions for experimentation,

so that development of innovative payment programs are encouraged. This is necessary to help provide the flexibility needed to identify the programs and incentives which have the greatest potential for long-term cost-containment impact.

Where an exemption is granted, it is important that each affected third party is also granted appropriate coverage under that exemption.

The requirement for implementing recommendations under the operational reviews provided in the bill (Section 115(c)) must be carefully considered. What is required there is measurement of the quality of hospital management and performance. Unfortunately, there are no widely accepted yardsticks for evaluatinghospital management. Nor is the process certain or scientific. If these operational reviews are not done well by properly trained objective hospital analysts, they could add more cost than efficiency. We suggest that the focus of such review be to stimulate development of criteria and standards for evaluating hospital performance. We believe the benefit to the individual hospital under review would be increased if the contents of the report were reviewed by a panel of hospital administrators for their comments before implementation.

The solvency test currently required may be too severe and not as objective as it may appear to be . Current asset ratios can vary during the year and over the years and do not adequately reflect longer term financial needs. Further, hospitals may be given doubtful incentives to shift financing from long term to short term debt, a shift that may improve their chances for an exception but not necessarily improve hospital administration.

We prefer to have the exception granted on the basis of its validity rather than imposing a separate financial need requirement. However, if financial need must be

demonstrated, it would need to be evaluated on an individual hospital basis.

This bill and changes we suggest can generate a large number of appeals. The programs should not deliberately discourage appeals; they may reveal how the program is working and help avoid inequities.

Administration. -- With the changes we have suggested, we believe that this cost containment program is administratively feasible. However, as with any new payment program, administration can be expensive and require a long lead time. Medicare, at its inception, resolved its problems by giving the Secretary authority to use existing capability in the private sector.

Similar authority should be included in this legislation. We believe that the Medicare intermediary system, developed in response to the intitial Medicare challenge, can perform a substantial administrative role in any national payment or cost containment program. The role could be much broader than was set forth when this legislation was announced.

Augmenting the responsibilities currently assigned to the intermediary system would be appropriate because:

- its functions in Medicare closely parallel those required under this and similar legislation
- the system is operational and well established
- its performance has been cost effective
- it is familiar with and to providers at the local level
- the incremental cost of administration of the new program would be lower because of the opportunity to share facilities, processes and personnel
- providers would prefer an administrative agent who has a demonstrated record of effectiveness in dealing with hospitals.

The categories of activities required in the administration of a limitation or other program are the same as for Medicare: receipt and processing of data; evaluation of data; communication and consultation. Medicare intermediaries are required to make judgments regarding reasonableness of cost incurred, prudence of certain management acts under the "prudent buyer concept" and compliance with Medicare rules. Intermediaries have developed audit staffs with substantial reimbursement expertise to carry out these responsibilities.

As Medicare intermediaries, Blue Cross Plans receive Medicare cost reports from providers and have established desk review procedures to complete an initial review of that data as to its completeness and accuracy in accordance with Medicare requirements. Similar procedures and expertise would be required to administer the cost containment program.

These strengths are of considerable value in assessing and processing provider submissions and could also be used to evaluate data submitted in support of exception requests.

The Blue Cross Association carries out an intermediary appeal process where the provider has an opportunity to present its case before a group that is independent of the original decision. These procedures have been in place for ten years, are well established and, with some modification and expansion, could form the basis for exception reviews.

Blue Cross Plans have provided important consultative services to providers in the area of fiscal records, utilization review and other activities.

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We have commented on the need for flexibility in the proposed legislation. While such flexibility will increase administrative complexity, the intermediary system has the capacity to cope with the problems. It deals with individual circumstances in relating to each provider and to the various kinds of providers currently in Medicare.

Assigning detailed administrative functions to intermediaries would permit the Secretary to concentrate his resources on general public policy matters; evaluation of program impact and its conformance with policy intent; and evaluation of the program administrators.

Transitional National Moratorium on New Capital Expenditures (In Lieu of Title II)

We strongly support the concept of capital expenditure limitations since they are critical to achieving a short-to-long-term effect in the battle to control rising costs. Capital structure in many ways dictates the level of use, efficiency and total costs of health care services. The presence of capital limitations can stimulate critical "affordability" decision-making, i.e., seeing the relative value of all needed services and evaluating the cost/benefit trade-offs among needed services by state and local health planning agencies.

Title II of S.1391 attempts to address a number of the key issues that must be considered in developing a capital expenditure limitation program; however, we do not feel that enactment of this Title is appropriate at this time.

First, the potential economic benefits of the capital limitation program proposed in Title II would not be realized over the short term, but rather over the long term, because the operational results of capital decisions are not immediately felt. Title II is therefore not a "transitional" program in the same sense as a transitional

revenue limitation program. What is really proposed in Title II are provisions for long term, permanent reform in the current system of health planning.

Second, while we believe that the ideas contained in Title II for permanent reform are provocative and exciting, we also recognize that because of their far-reaching implications, they should receive careful consideration in congressional hearings expected to be held later this year when potential amendments to PL 93-641, the National Health Planning and Resources Development Act, are introduced. As mentioned earlier, an attachment to this testimony contains our comments on the specific provisions of Title II which we will expand for the upcoming amendment hearings on PL 93-641.

As an alternative to the enactment of Title II of S.1391, we recommend that a transitional national moratorium be imposed on new capital expenditures under the Medicare and Medicaid programs until a more permanent capital limitation program is developed in PL 93-641 amendment hearings.

A transitional moratorium has a number of benefits. First, it allows planning agencies necessary additional time to establish effective state or local health planning structures. We feel these agencies are in a critical stage of development. The local and state level health plans now being developed will provide important guidance to decision makers under any future capital expenditure limitation program developed.

Second, a transitional moratorium will help to prevent further health services fragmentation through the debundling of hospital services that may result from the application of revenue limitation only to hospital acute care services.

Third, the Secretary must activate the National Council on Health Planning and Development, develop the section 1501 guidelines and provide the necessary leadership to implement the Health Planning Act.

From our perspective, the key provisions of a transitional capital expenditure moratorium include expansion of Section 1122 of the Social Security Amendments of 1972 to include, as covered capital expenditures, major equipment acquisitions, regardless of location, e.g., both Part A and Part B participating providers; and, the extension of Section 1122 review authority to all states, regardless of whether or not states are currently participating in the Section 1122 review program.

In states that have entered into a Section 1122 review agreement with the Secretary, the Designated Planning Agency would have the responsibility to administer the transitional moratorium program, including the granting of exceptions. Exceptions in such states should be granted for capital expenditures approved by the DPA prior to the date of enactment of the transitional moratorium. After the date of enactment of the moratorium program, exceptions may be allowed for capital expenditures necessary to eliminate or prevent imminent safety hazards as defined by federal, state or local fire, building or life safety codes or regulations; or to avoid non-compliance with state or voluntary licensure or accreditation, if the health services for which the capital expenditure is proposed are needed, as determined by the Designated Planning Agency.

The moratorium program shall also be applied in states that have not entered into a Section 1122 review agreement with the Secretary. In such states, Medicare intermediaries would monitor capital expenditures made by participating providers and report violations of the moratorium program to the Secretary.

In such states, the Secretary, or his designee, should administer exceptions to the moratorium program. Exceptions would be granted for capital expenditures that have been obligated or approved by an existing state certificate-of-need program

prior to the date of enactment of this program; or, have been determined to be needed by an existing conditionally or fully designated state health planning agency or health systems agency and are necessary to eliminate or prevent imminent safety hazards.

The Secretary would be required to establish procedures governing both the review of exception requests and appeal of exception decisions.

Reimbursement penalties under Medicare and Medicaid for unauthorized capital expenditures should be high enough to discourage any violations of the transitional capital expenditure moratorium program.

Finally, for the purposes of any revenue limitation program that may be enacted, such as Title I of S. 1391, any grounds for exception to the revenue limit program should be consistent with the requirements of the foregoing proposed amendments to the Section 1122 review program.

We feel that a transitional capital expenditure moratorium program of the type we suggest satisfies the transitional cost containment objectives contained in S. 1391. We are not completely satisfied with the enforcement provisions as they relate to participating Part B providers, but we would be pleased to work with congressional staff on this issue.

We appreciate the opportunity to appear before you to present our views on this most important matter.

BLUE CROSS ASSOCIATION

Technical Comments - S. 1391

Title I

Sections 102(b), 111 and 112(b)(1) - Scope of Program

The purpose stated in the introduction of the bill, is "to constrain the rate of increases in total acute care hospital inpatient costs." The program may not achieve effective containment of total health care costs. Continued high rates of inflation are not restricted to the hospital segment of the industry. Moreover, emphasis on inpatient costs only may increase fragmentation and unnecessary duplication of health care services elsewhere. A revenue limitation on inpatient care only could be considered in the context of a transitional program. A concurrent evaluation program becomes even more essential to determine the need for mid-stream adjustments and to use the learning experience in the design of a permanent program to improve the efficiency in delivery of health care services.

One point to be considered in the evaluation is the possible shift of services from an inpatient to outpatient basis. Hospitals may increase outpatient services as well as outpatient charges which would not be controlled; and, the non-hospital based facilities may provide services previously provided on a hospital inpatient basis.

A different problem arises from limiting controls to only inpatient payments is the impreciseness in allocating costs between those services which are provided for both inpatient and outpatients for cost payers.

One of the components used in the calculation of the allowed revenue limit is the average annual rate of increase in hospital expenditures (Section 112(b)(i)). This expenditure compenent does not specify inpatient or outpatient segments,

although the limit is imposed on inpatient services only (Section 111). The calculation of hospital expenditures for inpatient care only may be difficult because of data limitations. The use of total expenditures to measure change of inpatient expenditures gives a slight upward tilt to allowable revenue limits, because of greater growth rate of outpatient care over inpatient care expenditures.

RECOMMENDATION:

Potential "debundling" of service and inappropriate use of hospital resources may require eventual imposition of revenue limitations on other sectors of the health care system. A concurrent evaluation program is indicated, as noted above.

Because total inpatient expenditures are difficult to isolate, it would be more practical to use total hospital expenditures as a proxy for measuring change of inpatient expenditures. The upward tilt in allowable revenues resulting from use of the substitute would be very small in nearly all cases. The cost of refining the estimate probably would not be justified by the change in the limit calculation.

BLUE CROSS ASSOCIATION

Technical Comments - S. 1391

Title I

Section 102(b)--Per Admission Revenue Formula

The use of a per-admission revenue formula as the measure for reimbursement suggests a possible impact on:

1) inpatient/outpatient facilities utilization,

2) case mix, and

3) utilization review programs.

Up to the lower limit of the admission adjustment corridor (Section 113), the per-admission-reimbursement formula may provide an incentive for inpatient hospital utilization.

The per-admission formula offers hospitals a financial incentive to admit more short-stay cases and patients requiring minimum level of care. Hospitals which have need to maximize revenues without an equal increase in costs will prefer admissions with below average costs. These admissions may come from potential outpatient surgical cases, cases of diagnostic work-ups, or play-it-safe cases of overnight observation. Effective review of the medical necessity of such admissions is indicated.

If revenue for a T&A on an outpatient basis is $500, and allowable inpatient reimbursement formula specifies revenue at $1,000 per admission, the hospital may elect to have the T&A's done on an inpatient basis, up to the lower end of the corridor provided in Section 113 (94 percent). Where admissions are declining,

hospitals may curtail or delay introduction of ambulatory surgery programs so as to maximize total reimbursement from inpatient and outpatient services.

The same formula also has the possibility of shifting workloads to an outpatient basis, where no revenue controls exist. Uncontrolled charges for specific outpatient services could result in hospitals with outpatient capability electing to perform pre-surgery work-ups, as an example, on an outpatient basis. Admission revenues may not be affected but outpatient revenues would rise. Though more outpatient use is generally desirable, in the absence of total revenue controls, expenditures for health care may increase unnecessarily.

The intent of the per admission formula is to reduce overall inpatient hospital costs. Anticipated results will not be realized unless:

1) effective review of the medical necessity of admissions is in place, and
2) the reimbursement formula decided upon addresses the total revenue problem all hospitals face.

Instead of maximizing revenues, hospitals in trying to comply with the provision of the bill may seek to reduce costs which are in part, subsidized by other services in the hospital. Another result could be a shift of high cost-per admission cases to other hospitals with higher average revenue per admission - a kind of regionalization, but one probably associated with higher costs for the community, and not necessarily related to efficacy. The case mix could change at each hospital, possibly to the advantage of each, without constraint on total expenditures.

The possible adverse impact of the per-admission reimbursement program on existing utilization review programs should be noted. The Federal Government's

Professional Standards Review Organization (PSRO) Program is expected to be implemented in all areas of the country by January 1, 1978. This program is mandatory for Medicare, Medicaid and Title V admissions; private sector experimentation to date is extremely limited. The PSRO program utilizes both admission review and continued stay review as a means of controlling the medical necessity of admissions and length of stay. Evaluation to date is limited; evidence available appears to indicate only a limited accomplishment in the control of unnecessary admissions. Moreover, under the PSRO program, hospitals may make their own reviews, under a delegated status, although monitored by PSROs. Delegated hospitals make their own determinations of medical necessity of admissions and their determinations are binding on Medicare and Medicaid intermediaries for payment purposes. Under S. 1391 , the hospital incentive to control admissions up to the lower limit of the corridor provided by Section 113 could be adversely affected by the admission reimbursement formula. The willingness of private carriers to work with the PSRO program, and accept as binding hospital determinations of medical necessity, may be seriously weakened.

The role of the PSRO and other private review efforts concerned with retrospective claims review, profile and pattern analysis, and pre-admission certification, need to be examined for potential effectiveness when carried out simultaneously with the admission-review formula.

RECOMMENDATION:

Michigan Blue Cross and Blue Shield has proposed an alternative method to measure changes in volume. That method would average the percentages changes in admissions and length-of-stay.

The combination would not completely eliminate the incentives associated with the admission reimbursement formula but reduce it by about one-half. That reduced incentive, combined with the provisions that place a limit on total reimbursement so that it will be the same for all volume within the 94% - 102% corridor, may effectively minimize the incentives for unnecessary medical admissions. The problems associated with inpatient-outpatient services, case mix, and the role of the PSROs would still remain. The overall system under either method should still be subject to careful evaluation.

BLUE CROSS ASSOCIATION

Technical Comments - S. 1391

Title I

Section 102(b) - Total Revenue by Class of Purchaser, on a Per Admission Basis

For a typical patient covered by a third party payer, more than one payer may be obligated to pay the hospital bill. For example, patients covered by Medicare may have parts of their hospital bill paid by Medicaid and Blue Cross, in addition to their own personal payments. Thus, the hospital could have four sources of payments for a single admission. Each third party and the hospital would have one admission but there could be a total of four admissions when all third party records are combined for one patient.

Revenue per hospital admission could be calculated easily but revenue per admission by class of purchaser is an ambiguous term if not defined clearly. The example below shows four possible interpretations, without regard to the cost or charge basis of payment by each class of purchaser.

	Total	Medicare	Medicaid	Blue Cross	Other
Patient A	$1,000	$800	$100	$ 50	$ 50
B	1,050		900	100	50
C	1,060			900	160
D	1,040				1,040
Total	$4,150	$800	$1,000	$1,500	$1,300
Number of patients		1	2	3	4
Number of primary patients		1	1	1	1

Average Revenue Per Admission Calculation

	Total	Medicare	Medicaid	Blue Cross	Other
Interpretation 1		$800	$1,000	$1,050	$1,300
Interpretation 2		800	500	350	325
Interpretation 3					
Primary		800	900	900	1,040
Supplementary - Computed Separately			100	150	260
Interpretation 4		1,000	1,050	1,060	1,040

Interpretation 1 would be total revenues for each class of purchaser divided by the number of patients classified by their primary third party payer.

Interpretation 2 would be total payments (including settlement adjustments) for each class of purchaser divided by the number of different patients in each class of whom any part of the bill was paid.

Interpretation 3 would separate the payments (including settlement adjustments) for each class of purchaser into 2 parts, that for which the payer had primary patient responsibility and the rest which were supplementary payments for patients who were primary to another payer.

For the primary patient category, for each class of purchaser, an average per admission would be computed by dividing total primary revenue by the corresponding number of primary patients. For the supplementary category, there could be a choice of several options. One would calculate supplementaries per admission as a percent of the revenue per admission of the primary category to which most supplementaries relate. Another less desirable calculation would compute supplementaries as a percent of primary payments in the same class. A third

would calculate the average supplementary per patient receiving supplementary coverage.

Interpretation 4 would require that, for each primary class of purchaser, the total inpatient revenue, defined as inpatient cost or charges in accordance with that purchaser's reimbursement contract/formula, be divided by the number of inpatient admissions for that purchaser. A similar aggregate calculation using imposed charges would be made for patients not covered by cost/contract arrangements. (Total imposed inpatient charges, less imposed inpatient charges for services covered by all other classes purchaser.)

In the example above, category A is primary Medicare with $1,000 per admission, category B primary Medicaid with $1,050 per admission; category C primary Blue Cross with $1,060 per admission and category D charge payors. The average allowable revenue from each of these third party payers under contractual arrangements would be the total allowable cost, or charges, in accordance with their particular reimbursement formulas.

An example involving Medicare will help illustrate Interpretation 4.

Assume for the base period a Medicare patient that was in a hospital for a stay which included covered Medicare benefits and remained as medically necessary after his Medicare benefits had been exhausted and had also used private duty nurses not covered by Medicare. His hospital bill might look like the following:

Total Imposed Charges		$ 1,600
Less charges for stay after Medicare benefits exhausted and benefits not covered by Medicare		500
Charges imposed for services covered by Medicare		1,100
Contractual Allowance -- excess of imposed charges over Medicare reimbursement		100
Total Medicare reimbursement allowable for covered services (revenue).		1,000
Less deductibles & Co-insurance paid by:		
Medicaid	100	
Blue Cross	50	
Other	50	200
Net Medicare liability		800

The average allowable revenue from Medicare according to its formula, for calculation of the limit, would be $1,000. Medicare, would actually pay $800, representing $1,000 reimbursement, less $200 for deductibles and co-insurance paid by Medicaid, Blue Cross and the patient, as shown by the example above. The $200 would not be a part of the Medicaid or Blue Cross average revenue per admission calculation (as it was included it Medicare). Assume that the allowable limit for Medicare in the year under limit is 10% above the amount due in the base period. For the patient in the example, the limit amount allowable for Medicare reimbursement (revenue) would be $1,100 and not $880.

The $500 imposed charges not covered by the Medicare allowable revenue of $1,000 in the base period could be treated differently. The charge could be considered a separate admission for the class of purchaser actually reimbursing or paying

for this portion of the stay. This option may be useful whenever the "not covered" amounts are large enough or cover an excess of a specified number of days allowed by the contract with the primary third party payer. For smaller amounts, the amount not covered by Medicare could be included with the other third party payer, without adding to the admission divisor, on the assumption that small amounts occur frequently and their impact will average out over time.

In summary, for this example, if the items covered by but not reimbursed by Medicare are relatively small in dollar amounts, and if the total of these amounts and the amounts for non-covered services is small, there is no need to go the exception route of considering these amounts as equivalent to another admission for calculating average charge per admission.

Where the total amount is large, the addition of an admission, for purposes of calculating the average charges per admission, may be an option. In general, interpretation 4 works best where the uncovered amounts are relatively small or where criteria for adding the equivalent of a separate admission can be clearly satisfied.

Each cost/contract payer, like Medicare or Blue Cross, would have no incentive to pay more per admission than required by the terms of its agreements. The difference between the allowable cost and the amount paid by the primary payer would represent deductibles, co-insurance and non-covered services, and would be a collectible from other parties, but without specific controls as the overall calculation is controlled on the third party payers. These amounts are generally well defined (as shown in Interpretation 3) and no payer would have incentive to pay more than that defined as the supplementary amount.

The selection of the method to be used may be influenced by the availability of the data and the cost of records to be maintained in order to permit necessary calculations.

RECOMMENDATION:

The bill should permit calculation of revenue limits per admission on the basis of primary payer calculations (interpretation 4) or on primary and supplementary payments by class of purchaser basis (interpretation 3) to permit use of a more flexible methodology than would be permitted in S. 1391. The choice of methodology would be determined by the Secretary on the basis of availability of information and feasibility of implementation, cost considered.

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BLUE CROSS ASSOCIATION

Technical Comments - S. 1391

Title I

Section 102(b) and Section 111(a)--Maximum Hospital Revenue Allowable

This bill is not clear whether the hospital revenue limitation is to be on (a) total impatient revenue, without regard to class of purchaser, or (b) on a total revenue derived from the imposition of a single limit revenue by class of purchaser.

Whenever there are shifts of admissions among classes of purchasers, it is not mathematically possible or administratively feasible to have a revenue limitation by class of purchaser that is equal to the revenue limitation based on total hospital revenues, unless all cost and charge payers pay the same amount per admission. Shifts to purchasers with lower payments per admission would yield less than allowable hospital revenues. A shift of admissions to purchasers who pay more per admission would result in the hospital having more revenue than allowed. Numerical examples will help illustrate this point.

Assume a 10% limitation on increase in revenues, and base year data as shown.

	No. of Adm.	Revenue Per Admin.	Total Revenue
Medicare	100	$1,000	$ 100,000
Medicaid	100	1,000	100,000
Blue Cross	100	1,100	110,000
Other	100	1,100	110,000
	400		$ 420,000

Maximum allowable hospital revenue in with 10% limitation is $462,000.

CONDITION 1 - No shift among classes of purchases

	No. of Admissions	Allowable Revenue Per Admission	Total Allowable Revenue
Medicare	100	$1,100	$110,000
Medicaid	100	1,100	110,000
Blue Cross	100	1,210	121,000
Other	100	1,210	121,000
	400		$462,000

Total revenue of $462,000 is same as the hospital limitation; all classes of purchasers are in compliance.

CONDITION 2 - Shift to purchasers with lower revenue per admission

	No. of Admissions	Allowable Revenue Per Admission	Total Allowable Revenue
Medicare	110	$1,100	$121,000
Medicaid	110	1,100	121,000
Blue Cross	90	1,210	108,900
Other	90	1,210	108,900
	400		$459.800

Total revenue of $459,800 is below hospital maximum; hospital and all classes of purchasers are in compliance, but hospital has less revenue than permitted.

CONDITION 3 - Shift to purchasers with higher revenue per admission

	No. of Admissions	Allowable Revenue Per Admission	Total Allowable Revenue
Medicare	90	$1,100	$ 99,000
Medicaid	90	1,100	99,000
Blue Cross	110	1,210	133,100
Other	110	1,210	133,100
	400		$464,200

Total revenue of $464,200 is above hospital maximum; all classes of purchasers are in compliance but hospital is not (strictly) in compliance. Not clear who has overpaid and who should receive refunds.

RECOMMENDATION:

Revenue limit should be revenue per admission by class of purchaser, not total hospital revenues. In instances illustrated by condition 2, the hospital should not be allowed to request an exception to obtain revenues equal to maximum allowable. In instances illustrated by condition 3, the hospital should not be requested to refund revenue above its allowable limit, or be penalized in any way for excess receipts over limit set for the hospital. One may argue that to the extent hospital patient-mix and costs are related to payment source, stratification by payment source reflects, in an imprecise way, shifts in costs.

BLUE CROSS ASSOCIATION

Technical Comments - S. 1391

Title I

Section 102(f) and 117 - Exemptions for Hospitals in Certain States

Hospitals would be exempt from the provisions of the bill if they are in states which have requirements consistent with the revenue limitations of the bill. Unless the Governor or Chief State Executive certifies to certain conditions, no hospital in a state would be exempt. Groups of hospitals within states could not qualify.

These restrictions unnecessarily limit the possibility of cooperative efforts of groups of hospitals, states and payers from developing programs which could contain costs and revenues and satisfy the intent of this bill. Hospitals which are exempt are not necessarily eligible for volume adjustments. The bill does not explicitly provide for exceptions or appeals for hospitals exempt under a state-wide approved program.

RECOMMENDATION:

Groups of hospitals in a geographic area should be eligible to qualify for exemption if the intent of the revenue cap provision are met, subject to risk by the institutions. In addition, a third-party payer should be permitted to request an exemption on its payment programs if it can demonstrate that the intent of the revenue limitation can be met. Criteria should be established to evaluate the impact of exempt programs, and to use the evaluation in the design of a permanent program to contain health care costs.

BLUE CROSS ASSOCIATION

Technical Comments - S. 1391

Title I

Section 115 - Establishment of Exceptions

Section 115(a) grants the Secretary authority to grant exceptions from the limits established under the bill to the extent that the Secretary is satisfied that the evidence provided by the hospital supports the exception and that the other conditions of this subsection are met.

The bases for exceptions are limited to specific circumstances and require meeting certain need criteria. The bases, broadly defined as "changes in admissions ... changes in capacity or in the character of inpatient services..." are subject to various interpretations and to that extent the exceptions process may be counterproductive to the application of the limit. Equally important however, is that the bill does not provide for other exceptions where unusual circumstances can be documented.

The inadequacies of the solvency test, as a condition for qualifying for an exception, may result in failing to provide relief where it is needed. Thus, the bill fails to link the question of a hospital's relative efficiency within a community nor adequately provide for the efficient hospitals. Furthermore, the solvency test could result in changes in financial practices such as shifting from long-term debt to short-term debt status. The bill does not state how the solvency ratio will be adjusted over a number of years, and is unclear whether the hospital's ability to meet the solvency test in one year would be applicable in future years. The current ratio for a hospital will vary during the year, and to that extent, the calculation of the current ratio may be affected.

The provision for an operational review of hospitals which are granted an exception is ambitious, administratively difficult and costly. The bill does not specify who will pay for the operational review. Also, the operational review will be relevant to current performance and may not relate to the year for which the exception was given. Currently, there is only limited capability or expertise to perform these operational reviews.

The centralization of the administrative process for granting exceptions may be ineffective because of the lack of familiarity with the hospital's environment and the local factors impacting on the need for an exception. The Medicare intermediary is well acquainted with its providers and has available a considerable data base from which to evaluate requests by the hospital. The intermediary's audit function provides onsite audits for the Medicare program and would be able to expand these audits to verify changes in capacity, character of inpatient service or major renovations and replacements of plant as well as conditions relative to other exception bases.

RECOMMENDATIONS:

The bases for exceptions should not be extensive; but the Secretary should be granted the latitude to promulgate any bases for exception considered necessary. The Secretary should prospectively promulgate these exceptions along with specific criteria for evaluation. Examples of permissible categories could include unusual energy costs and large changes of input prices which were not anticipated, such as the recent trends in malpractice insurance premiums. Specifically excluded should be exception requests related to nebulous, non-quantifiable areas such as intensity and technological improvements.

In relation to operational reviews, it would be necessary to carefully define the competence required to perform such reviews. It would be necessary to define efficiency and how this would be measured. The current state of the art is not well advanced. Careful consideration should be given to the cost of performing these reviews. This will be substantial if it is necessary to use consulting firms to (a) develop necessary criteria, (b) test the criteria, and (c) implement the reviews. It is likely that substantial training would also be involved and that different professional expertise would be required.

The intermediary process should be utilized to handle exceptions. The intermediaries' knowledge of hospitals in the local setting make this an important vehicle to resolve many exception requests (using pre-determined criteria) at the local levels. The Secretary's resources would then be utilized on monitoring performances in this area.

In any event, additional criteria need to be published, but not in the law, so that all parties clearly understand the circumstances under which an exception may be granted.

With regard to replacement, renovation of an existing facility, or to meet life safety regulations, the criteria for an exception on these bases should have the explicit approval of the appropriate planning agency.

OTHER CLARIFICATIONS REQUIRED

Section 115(a)(1) The phrase "costs of providing inpatient hospital services" needs to be clarified or referenced to a definition of such costs.

The only uniform definition of inpatient costs would be the inpatient costs ascertained in accordance with the principles of Title XVIII. An alternative

approach would be to compare the hospital's inpatient revenue, as defined under section 102(b).

Section 115(a)(1)(A) "Changes in admissions" should be clarified to read "changes in the number of admissions."

Section 115(a)(1)(B) This subsection refers to "changes in... the character of inpatient services...." This phrase is different from section 114(b) which refers to change in the "elements" of inpatient services. The same phraseology should be used in both sections. The subsection also refers to "increased inpatient costs per admission." This phrase should be consistent with the "costs" used in section 115(a)(1). It appears that it is a calculation for the total inpatient costs and total admissions, rather than by class of purchaser.

Section 115(a)(2) The reference to "revenue otherwise allowable" should be referenced to section 102(b). The phrase "(taking into account all other available resources)" needs clarification. Does this include funded depreciation, restricted endowments, pension funds, investments and other capital assets? Or, does it include income from the above sources even if restricted, and also including tax support, charity support (donations from United Fund, for example) and income from non-patient care resources? We recommend that this definition be limited so that, to extent possible, necessary exceptions are funded from current revenues received through operations.

Section 115(a)(3) This subsection states that "...changes in... service available ... have been found to be needed under section 1523(a)(5) of the Public Health Service Act..."

It would appear that the "elements of services" referred to in section 114(b), "change in character of inpatient services" referred to in section 115(a)(1) and the "change in services" referred to in section 115(a)(3) are all referring to the same "change in service," at least for this title. The three sections should be referenced to a new definition in section 121 to clarify the matter.

BLUE CROSS ASSOCIATION

Technical Comments - S. 1391

Title I

Section 115(e) - Appeals

Section 115(e)(2) provides for the setting up of a special board of the Provider Reimbursement Review Board (PRRB) for the purpose of hearing appeals under the bill. The PRRB subcommittee would be an adversary hearing, more expensive for the hospital and fiscal intermediary than the existing intermediary appeals mechanism, and would be able to rule against the general instructions promulgated by the Secretary. The intermediary, under Medicare, is required to have hearing officers who are knowledgeable in the hospital reimbursement field and who have not been involved in the decision process.

RECOMMENDATION:

Use the existing Medicare intermediary appeal process where approval is not granted through the exception review process. Section 115(e)(1), 115(e)(2) and 127 would need to be suitably amended.

OTHER CLARIFICATIONS REQUIRED

Section 115(e)(1) The reference to the amount of $25,000 needs clarification to explain whether it refers to the revenue of a class of purchaser or to the total inpatient revenue of the hospital.

Section 115(e)(2) This subsection would be appropriately placed as a subsection of section 127. In addition, additional staff support should be explicitly provided for in the bill.

BLUE CROSS ASSOCIATION

Technical Comments - S. 1391

Title I

Section 116--Enforcement

Penalties are provided for the contract class of purchaser reimbursing hospitals in excess of the appropriate limit. Penalties are also imposed on hospitals for receiving reimbursement in excess of the limit if not corrected subsequently through use of an escrow account.

The bill singles out one class of private purchasers of inpatient hospital care to be heavily penalized for making payment in excess of the allowed limit. To subject only contract payers to a 150% tax on payments deemed excessive may raise some legal questions as to the validity of penalty.

The bill requires that any amounts collected from charge payers in excess of the limits promulgated by the Secretary shall be placed in escrow. No provision has been made for:

1) certifying the correctness of the necessary calculations to determine the amount to be held in escrow,
2) making reports necessary for monitoring the function,
3) setting the time span which it must be held,
4) noting who would qualify as an escrow agent, or
5) identifying the application of interest earned on the account.

Subsection (c) is inconsistent with subsection (d)(1) which refers to "average charges per admission billed for inpatient services", whereas subsection (c)

refers to "payment for inpatient hospital services". While the latter phrase may also be intended to cover revenue from cost payers, the combination causes confusion.

RECOMMENDATION:

The escrow concept may not be necessary to provide for reductions of revenue where non-compliance has been noted. Hospitals could be required to establish the necessary accounting (i.e. set up a liability account) for the amount of excess. This amount would be written off in the subsequent period as revenues from non-contract charge payors are reduced by the required percentage.

This recommendation would greatly simplify the process and meet the objectives of the escrow account - to contain payments when necessary through offsets to excess revenues.

BLUE CROSS ASSOCIATION

Technical Comments - S. 1391

Title I

Section 118 - Exemptions for Hospitals Engaged in Certain Experiments or Demonstrations

Hospitals may be excluded from the revenue limitations of the bill if they are in experimentation/demonstration projects pursuant to Section 402 of the 1967 Social Security Act Amendments or to Section 222 of the 1972 Social Security Act Amendments. The projects must be "consistent with the purposes of this title", to qualify for exemption from the revenue limitation provisions. There are no provisions in the bill for experiments other than those so authorized by these sections of the Social Security Act Amendments.

There is no provision for the continuation of experimental or demonstration programs which are evaluated to be successful, as measured by the revenue limitations proposed by the provisions of this bill. Moreover, the exemption for experimentation applies only to hospitals and not to any major payer which would still be subject to the revenue limitation requirement. This inconsistency is detrimental to the development of innovative payment schemes.

RECOMMENDATION:

The bill should provide for the continuation of existing experiments on a permanent basis whenever they are evaluated to be successful. New experiments should be encouraged and authorized by the bill. Such experiments would examine the feasibility

of using various incentives for hospitals and payers to accomplish, on a voluntary and permanent basis, the intent of this mandatory limitations program. Such experiments should be monitored concurrently to identify problems and feasible alternatives to a mandatory program. In any experiment, enforcement and penalties applicable to major payers should be consistent with the treatment extended to hospitals.

BLUE CROSS ASSOCIATION

Technical Comments - S. 1391

Title I

Section 121(a)--Definition of Hospital

Not all hospitals are included in the definition of hospitals and, therefore, some hospitals are excluded from limitations of revenue and capital expenditures under the bill.

The exclusion of these hospitals creates inequities in the application of the planning requirements and the payment limitations among payers. The federal and HMO exclusion does not consider the effect of these institutions on the health care system. The exemption of these hospitals from the program could impair effective capital expenditure planning, and introduce dissonance in the hospital personnel wage structure of an area. The applicability of the payment limits for payers to these federal hospitals, such as Blue Cross, Medicaid and Medicare who may supplement federal benefits, is not clear. Although the administration's proposed Fiscal Year 1978 budget proposes to limit the health care cost within the Veteran Administration's system, it is not clear that the resultant control over expenditures for admission is similar.

The bill inadequately defines new hospitals. Distinctions are not made between mergers, replacements, relocations, change in ownership or corporate identities, and increased capacity due to consolidation and/or acquisitions. Any of these developments may have an affect on the revenue base used for this program, which

if not adjusted, would not be comparable to the revenue generated by current operations. Mergers between institutions often result in less aggregate costs and the program should not be counter-productive to these developments.

RECOMMENDATION:

All hospitals should be covered by the bill. Clarification of the bill's intent is needed for merged facilities. New hospitals should be included under the program and their revenue limits by class of purchaser should be based on allowable revenue per admission of peer hospitals (as defined by the Medicare program) with allowance for special problems of newly-opened facilities.

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BLUE CROSS ASSOCIATION

Technical Comments - S. 1391

Title 1

Section 124 - Exemption of Non-Supervisory Personnel Wage Increases from Revenue Limit

This section provides an alternative method for calculating the revenue limit for each hospital. A hospital may elect to have a limit that allows for wage increase for non-supervisory personnel to be reflected in the limit to the extent that those wages are a percent of total inpatient costs. The provisions of this section are not clear with regard to:

(a) effective date

(b) definition of wage

(c) wage increase computation

(d) limit of impact of the exemption

The effective date can be read in two ways:

(1) The effective date is the same as for other parts of the bill, related to revenue limits, until March 31, 1979 when the Secretary may decide the extent to which the wage pass through provision is to be applicable.

(2) The exemption will not be effective until after March 31, 1979, and then "only to the extent the Secretary so determines."

Employees are defined in the bill, but "regular wages" are not. It is not clear that "regular wages" include all fringes, including pensions and retirement provisions, regardless of vesting, for example.

The wage increase computation may be affected by the time of the year a wage change, however, defined, occurred in the base year. An increase that occurred at the beginning of the base year will have a different impact on the calculation than an increase that occurred late in the base year. Similarly, an increase that occurs late in the accounting year, for which a limit is calculated, will have a different effect. The wage adjustment as phrased in the bill provides for an adjustment for wage increases in the year of the increase but makes no provision for a cumulation of increases or the impact of the increase in subsequent years. Although the intent seems clear, differences may arise over the mechanics of the computation, and with different limits that would result.

The limit of the impact of the exemption is not specified. In cases where the wage increase is equal to the basic limit formula allowance, the alternative calculation would not be of significance. Theoretically, however, a hospital could grant a 20% or 30% increase in wages that would be applicable to half of its total inpatient hospital cost. The exemption would result in a limit of 15% or 20%, assuming a 10% allowable limit under the basic formula. (50% of 20% + 50% of 10% = 15%; 50% of 30% + 50% of 10% = 20%).

It is not clear from the other sections of the bill that such increases are intended, but there are no restrictions on the limits of the wage-pass-through.

RECOMMENDATION:

The definition of wages; the wage computation based on wage changes during the base year, and years of revenue limit; and the effective date should be stated clearly. The discretion of the Secretary should be related to criteria or guidance by the Congress, particularly with regard to impact on expenditures in specific instances.

BLUE CROSS ASSOCIATION

Technical Comments - S. 1391

Title II

Limitation on Hospital Capital Expenditure

The bill provides for the addition of a new section 1504 to P.L. 93-641, the National Health Planning and Resources Development Act of 1974. As proposed, section 1504 authorizes the Secretary, DHEW, to establish a national capital expenditure limit, apparently convering all hospital capital expenditures, not to exceed $2.5 billion; a national ceiling for the supply of hospital beds, not to exceed the ratio of 4.0 beds per 1,000 population; and a national standard for the rate of occupancy, which may not be less than 80 percent.

With respect to these provisions, we recommend that the following types of questions be fully addressed in upcoming amendment hearings on P. L. 93-641:

Do existing state and local planning agencies have the capacity to effectively administer a capital expenditure limit program?

Could such a program actually be an aid to such agencies and providers to perform their planning functions more effectively?

If at this time, should it apply to just hospitals, or hospital acute care, or be extended to include all health care facilities -- perhaps even major equipment expenditures, e.g., CT scanners in physician offices?

What are the potential impacts, positive or negative, of application of such a limit to only selected providers or services?

Regardless of the extent of provider coverage under a capital limitation program, should the limit apply only to capital expenditure dollars, or also to bed-to-population, occupancy rate, or other limitation standards on a state or health services area basis.

One primary concern we have in the development of a capital limitation program is the extent to which such a program will distort the overall provision of health services. For example, if a limitation program were to apply only to hospital capital expenditures, one might reasonably expect fragmentation of hospital service delivery through a dysfunctional debundling of hospital services, i.e., the provision of traditionally hospital-based services under other free-standing auspices to avoid the limit.

Capital Expenditure Dollar Limits - The level of such limits should be sufficiently high to allow reasonable levels of introduction of new medical technology, as well as replacement of needed plant or equipment. The derivation of the hospital capital expenditure limit of $2.5 billion contained in the bill is not known to us; however, we recommend that capital expenditures in non-health sectors of the economy, in relation to the book value of existing assets, be evaluated for possible use in the determination of reasonable capital expenditure limits generally.

Bed to Population Ratio Ceilings and Occupancy Rate Standards - The establishment of bed to population ratio ceilings and occupancy rate standards should be carefully examined to determine if such constraints allow necessary flexibility to health planning agencies in the administration of a capital expenditure limitation program on a health service area basis. Also, it may be necessary to establish multiple occupancy rate standards to reflect differences between large vs. small hospital groupings or urban vs. rural hospitals. Similarly, bed to population ratios might be developed by type of bed.

Incentives for Reduction of Excess Capacity Section 201 of the bill contains a provision which allows an increase in a state's capital expenditure limit for the undepreciated assets associated with the closure of all, or part of, an acute care hospital subsequent to a finding of "in appropriateness" by the state agency. With regard to this provision, we recommend that any capital limitation program also provide incentives for the voluntary closure of all or part of a hospital. We strongly feel that any future limitation program should be flexible and establish voluntary incentives for improved efficiency. We note also that such incentives to voluntary closure should be coupled with payment provisions for interest and depreciation similar to those proposed in Senator Talmadge's Medicare and Medicaid Administrative and Reimbursment Act.

Definitions The modifications to the definitions of "hospital" and "capital expenditure" contained in Section 201 for the purpose of federally approved certificate-of-need programs warrant further consideration, specifically with respect to the exclusion of federal hospitals from the definition of "hospital" and the exclusion of capital expenditures for major equipment purchases of setting, from the definition of "capital expenditure."

First, while federal hospitals serve specifically defined segments of the population drawn from large geographic areas, their effect on the planning and need determination decision-making of HSA and state agencies may, in some cases, be substantial. We can find no valid reason to exclude such hospitals from certificate-of-need controls.

Second, we believe that hospitals serving HMOs are provided with sufficient "special consideration" under certificate of need programs, as set forth under Sections 122.310 and 123.411 of the Final Rules governing Capital Expenditures Review, Certificate-of-Need and New Institutional Health Services published in the Federal Register on January 21, 1977.

Consideration should be given to amending the definition of "capital expenditure" to include major equipment expenditures, regardless of equipment location. The problem of potential unnecessary proliferation of expensive medical equipment, i.e., CT scanners in non-hospital settings must be addressed.

Tax Exemption for Certain Bond Income Section 204 amends Section 103 of the Internal Revenue Code of 1954, such that tax-exempt interest payments from certain government obligations would lose their tax-exempt status in certain circumstances. Such an amendment requires careful consideration. We understand than an 1895 Supreme Court decision held that income from state and local bonds is constitutionally immune from federal taxation; thus, Section 204 of Title II may be unconstitutional.

STATEMENT OF THE

HEALTH INSURANCE ASSOCIATION OF AMERICA

ON

HOSPITAL COST CONTAINMENT ACT OF 1977
(S. 1391)

Presented by

MORTON D. MILLER

Before The
SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
of the
COMMITTEE ON HUMAN RESOURCES
UNITED STATES SENATE

June 21, 1977

My name is Morton D. Miller. I am Vice Chairman of the Board of Directors of The Equitable Life Assurance Society of the United States. With me is Mr. Henry A. DiPrete, Second Vice President, the John Hancock Mutual Life Insurance Company. We appear today on behalf of the Health Insurance Association of America.

The companies we represent, who provide health insurance protection for over 100 million Americans, have long been intimately concerned with the costs of health care in this country. In that connection, we have lent our active support to community health planning, increased ambulatory care, alternative delivery systems, health education, Professional Standards Review, and a better distribution of health manpower.

As was stated in our testimony of May 17, 1976, before this subcommittee, the rapid escalation of costs during the last several years spread across the entire spectrum of health services -- doctor and dentist fees, drug and nursing home charges, and particularly the costs of hospital care -- has created a most worrisome situation. The health insurer's suggestions for reducing this problem were spelled out in some detail at that time.

Mr. Chairman, your subcommittee does not need a long recitation from us regarding the reasons for the health care costs escalation we are experiencing or the magnitude of the problem. Through the intervention of third party payments by government and private insurance plans, the American public has minimally felt the full impact of rising costs; particularly with hospital costs where third party financing exceeds 90% of total revenues. The prevalence of third party payments has tended to inhibit the normal

operation of supply and demand in the health care field and, together with the rising expectations of the public, has been translated into an almost limitless demand for health care services.

Accordingly, we would like to express our wholehearted approval of the Administration's efforts to contain health care costs and, subject to some qualifications, support for the recently announced hospital cost containment program set forth in S. 1391, The Hospital Cost Containment Act of 1977.

There are a number of good features in the Administration's proposal. Starting with hospital cost it focuses on the largest single cost component, where the number of service units is manageable, and the rates of inflation most extreme. Prior cost control measures which dealt with Medicare and Medicaid costs alone had the effect of turning the savings flowing to the two governmental programs into increased costs for private patients. The proposed legislation avoids this major problem. The limitations of the bill apply to a hospital's total revenues from all patients equally and not just to reimbursement by the government under Medicare and Medicaid. It recognizes the importance of capital expenditures in the cost equation; and it appears to be relatively easy to administer.

On the other hand, however, there are some disadvantages. Some hospitals are more cost effective than others. The imposition of the same revenue limits on all will be unfair to the cost effective hospitals and overly generous to others. The pass-through of wage increases for non-supervisory personnel may weaken the ability of the hospital to bargain at arms length with their

employees. Instead of a blanket provision, it may be preferable for the Secretary to have the authority to grant a waiver for an area where wages are substandard. Furthermore, S. 1391 does nothing to redress the present longstanding imbalance between the lower reimbursement levels of Medicare and Medicaid and, to a lesser extent, Blue Cross, and the disproportionately higher levels of hospital costs passed on to insurance company and self-pay patients. Such an inequity must be adjusted in the long run. Finally, S. 1391 is admittedly an interim or transitional program.

The President in presenting his proposal stated that it "relied heavily on the initiatives of the private sector -- business, unions and insurers working with providers -- to pursue innovative techniques for reducing the cost of high quality care." We accept that challenge.

We believe S. 1391 can be greatly strengthened to move more rapidly and effectively toward a long-term permanent solution for moderating hospital care costs. The National Health Care Act, (S. 5 and H. R. 5) introduced by Senator McIntyre and Representative Burleson and supported by the health insurance companies of America, includes such a plan. It calls for a system of prospective review of hospital operating and capital budgets and the approval of rates for all payors to be carried out at the state level.

Such systems have been in operation in four states, Maryland, Connecticut, Washington and Massachusetts and have worked well. We are confident that a substantial reduction in the growth of hospital care costs can be achieved through the mechanism of prospective hospital rate approval and budget review conducted by the states under a federal mandate

and guidelines.

In the two states with the most experience, Maryland and Connecticut, the State Rate Setting Commissions have saved residents $27 million and $18 million a year, respectively. In order to illustrate the potential of extending this type of program, nationwide, we estimate there would have been savings in the order of $1 billion last year had such a program been in operation in all of the states.

The experience to date suggests that to be successful such state prospective budget review and rate approval programs must:

1. Have an independent state commission which is solely responsible for reviewing the operating and capital budgets of the institutions and for setting their rates;
2. Establish rates applicable to all payors, as is the case now in Maryland;
3. Institute effective programs of utilization review; and
4. Be closely coordinated with the planning agency responsible for certificate-of-need determination.

The best of prospective hospital rate approval and budget review processes would still not be fully effective operating alone. The functions of prospective rate review, certificate-of-need determination and utilization review must be carried out together. Given close liaison with the local planning agencies and involvement with utilization review, the State Rate Setting Commission can be truly responsive to local needs and conditions.

Turning to another aspect of our problem, excess bed capacity has clearly been a prime factor in the recent cost inflation. The Administration

has estimated that we have about 100,000 more hospital beds than we need. Therefore, as part of the long-term control of health care costs, we would propose the following:

a) The certificate-of-need process be strengthened to include all major capital expenditures, regardless of their ownership.

b) Consideration be given to studying the desirability of discontinuing the tax subsidies and loan guarantees which are now available for hospital related capital investment. Hospitals seeking funds would then have to turn to normal investment channels. The investors would become more selective in their lending and would have compelling reasons to be concerned over the management of their investments.

c) Clear provisions for decertifying unneeded beds be established under the Planning Act; and

d) Funds be appropriated to assist in closing down excess beds or their conversion to other uses and for the retirement of outstanding debt.

We are persuaded that the combined efforts of state prospective budget review and rate approval when coupled with effective certificate-of-need determination and utilization review will succeed in effectively constraining the rise in hospital care costs over the long term.

We therefore would propose that S. 1391 be amended so that:

1. Hospitals in any state that has or institutes a prospective budget review and rate approval system and also has a certificate-of-need program, both of which meet federal guidelines, should be exempt from the revenue and capital ceiling provisions of Title I and II of S. 1391;
2. The appropriation of modest funds be authorized to enable states to initiate prospective budget review and rate approval programs that comply with Federal guidelines;
3. The quality of care and utilization control requirements of P. L. 92-603 applicable to Medicare and Medicaid be extended to all patients;
4. The Planning Act (P. L. 93-641) be amended to authorize the decertification of unneeded hospital beds and services; and
5. The appropriation of funds in reasonable amounts be authorized to assist in closing down excess beds or their conversion to other uses.

Mr. Chairman, with your permission, I would like to submit for the record a more detailed exposition of what we would propose.

Thank you.

The full text of the HIAA statement follows:

Provisions of a System Offering a Permanent
Equitable Solution to Containing Hospital Care Cost Increases

In order to moderate the rate of escalation in hospital costs under a

permanent equitable reimbursement system, savings can be achieved in one of or a combination of the following ways:

1. Provide incentives for improved efficiency in hospital departmental operations;
2. Restrict increases in capital expenditures to those projects which are consistent with community needs as determined by the appropriate planning agency;
3. Establish incentives for merger, conversion and, where necessary, closure of under-utilized facilities and services;
4. Establish incentives for utilization of inpatient and outpatient services only where medically necessary; and
5. Establish incentives for quality assurance which would discourage unnecessary treatment, and identify and eliminate physician practices which increase vulnerability to medical malpractice litigation.

Consequently, the Congress must consider not only establishing intelligent regulation of hospitals, but it must also strengthen the planning process.

Weaknesses of S. 1391

The bill in its present form has the following defects:

A. The proposed limitations on operating and capital costs are arbitrary and bear little relationship to an individual institution's actual budgetary needs. Hospital expenses increased 20% nationwide in fiscal 1976. The Connecticut Commission on Hospitals and Health Care's experience illustrates the flexibility in an annual budget review system permitting

hospitals increases in total income, for example in 1975, with approved individual increases ranging from a low of 4% to a high of 24%, the average increase was 13.5%.

B. It will freeze current inpatient utilization patterns at present levels when there is an urgent need for intensified monitoring and evaluation by the medical staff of physician utilization practices. Hospital occupancy levels were running at about 75% nationwide in 1975. Recent studies indicate we have from 20% to 30% more acute care hospital beds than are currently medically necessary. We will not be able to achieve the economies resulting from reduced bed availability unless and until existing utilization patterns are modified. Furthermore, the requirement of the present bill to maintain occupancy levels at 80% of capacity as the basis for approval of increases in capital expenditures will be counter-productive because it will stimulate increased utilization some of which may not be medically justified.

C. Current price differentials between the amounts paid for hospital care by the government and by private sector patients will be continued at the present percentage level but expanded in terms of absolute dollars. As a result of this practice, the private sector patient is already paying a subsidy of more than $2 billion per year for similar services.

D. The pass through of wage increases for non-supervisory personnel will provide little incentive for the management of the institution to restrain union demands. We urge that such a significant piece of hospital costs not be exempt from control. Any wage pass throughs should be limited to hospitals which have demonstrated that their wages are below wage levels

generally in their geographic area.

E. The absence of any requirements for justifying increases in out-patient revenue without concurrent decreases in in-patient utilization may invite abuse of out-patient services.

F. No incentives are provided to promote merger or conversion of existing under-utilized facilities and services.

G. The bill provides little or no incentive for the establishment of new state regulatory commissions as a more sensitive and equitable permanent solution to the problem of rising hospital costs.

H. The bill does not provide adequate safeguards to assure that the program will in fact be a temporary measure, nor does it assure that more permanent solutions will be offered.

State Waivers with Respect to S. 1391
and with Respect to Any Permanent Solution

We strongly support the exemption of hospitals in states with existing hospital cost control commissions from federal controls. We equally support the concept that where a state enacts legislation in the future which requires hospitals to submit their operating and capital expenditure budgets to review and approval by an appropriately constituted state agency, it should be exempt from any temporary federal program such as S. 1391. However, this should be done under federal guidelines.

The present bill recognizes that to be effective, hospital cost control legislation must focus on the total revenue of the institution. The dilemma we currently face is that we have failed to establish a process which permits

separation and support for the factors which are legitimately inflating costs from those based on wasteful practices which may be corrected. Existing state commissions have recognized the need to resolve this issue and should be encouraged to continue their efforts in addressing the problem. This proposed modification in the current bill should serve to permit the development and comparison of additional experience under the federal "CAP" concept with state operated prospective hospital budget review systems.

In establishing the guidelines under which this state waiver would be granted, we have considered the experience of the state hospital cost control commissions now in place in Connecticut and Maryland drawing upon their best features and correcting for their weaknesses. It is significant that in both cases, the commissions have slowed the cumulative rate of escalation, in contrast with the national average, by twelve points over a three year period in Connecticut, and seven points over a two year period in Maryland. It should be noted that a 1% reduction in the rate of escalation in hospital costs nationwide results in savings in excess of $500 million. The Maryland program is also unique because it is the only state where the federal government has agreed to pay commission-approved rates under the Medicare program.

The present multimillion dollar subsidy on the private sector patient that results from existing price differentials must gradually be eliminated. However, we realize this cannot be achieved overnight and, therefore, a practical compromise on this point is necessary to bring the Medicare and Medicaid programs under any state operated budget review system.

Accordingly, the guidelines should be initially drawn so the federal

and state government would not pay amounts in excess of the federal "CAPS" for both operating and capital expenditures, if the state budget review and approval process permitted an aggregate statewide increase of a greater amount. Under such circumstances, the differences would continue to be absorbed, as it is currently, by the private sector patients, recognizing that the latter will benefit from a slowing down of the overall rate of escalation in hospital income.

We applaud the Administration for including limits on capital expenditures as well as on operating budgets. However, we feel the state exemption should also apply to federal limitations on capital expenditures where the state has enacted both Prospective Budget Review and Certificate of Need legislation and where the planning process, as contemplated by P. L. 93-641, is in operation.

Objectives of the State Waiver Programs

Qualified state programs should incorporate the following objectives:

A. Assure that a hospital's total costs are reasonably related to total services;

B. Assure that aggregate rates are set in reasonable relationship to aggregate costs;

C. Assure that rates are set equitably among all purchasers of care without undue discrimination;

D. Assure the continued operation of financially stable, efficient and effective hospitals;

E. Provide "positive" and "negative" incentives to contain the rate of increase in the costs of all payors of services rendered by all institutional health care providers without impairing the quality of care. Total costs, not just unit prices, should be contained;

F. Set a mandatory prospective revenue basis applicable to all payors through a methodology which is efficient, and does not unnecessarily restrict the institution's management prerogatives;

G. Encourage the optimal use of health resources by phasing out under-utilized or inefficient institutional beds and services, and by reinforcing cost-consciousness in health planning, utilization review and the introduction of new technology; and

H. Encourage improved institutional management, budgeting and efficiency.

Guidelines to be Met to Qualify for the State Waiver

Based upon our experience we believe such guidelines should include consideration of the following:

1. In order to maximize the effectiveness of the program it must include all hospitals in the state and the care rendered to all patients; both the beneficiaries of governmental and private sector financed programs.

2. Each state should establish either a full-time commission appointed by the Governor or a rate-setting agency under the direction of a single full-time commissioner. A state

commission should be appointed by the Governor for staggered terms of no less than four years. Members of the commission should have a basic understanding of the delivery and financing of health services in the state. They should not, during their term of office, be otherwise employed by the state, employees or officials of a local government or a health care institution, nor should they engage in the delivery and/or financing of health services in the state.

3. A representative policy board made up of one-third providers, one-third consumers, and one-third purchasers of health care should be appointed by the Governor for staggered terms. The objectives of the policy board is to establish a check against domination of the commission's activities by the commissioners, the commission staff, the Governor, or any other particular interest group while also providing a meaningful resource for the work of the commission.

The policy board should be authorized to:

a. Review and comment on regulations for approval of hospital rates and budgets;

b. Review and comment on rules and regulations regarding uniform accounting and reporting;

c. Review and recommend approval or disapproval of the

commission's annual budget;

d. Provide advice on the integration of state rate approval with certificate-of-need, utilization review, and other state regulatory functions;

e. Report to the commission, Governor, the state legislature and other appropriate agencies of the state on the program's effectiveness, recommended modifications and continuation; and

f. Review and recommend approval or disapproval of the regulations under which the commission itself functions.

4. The commission should be charged with the coordination of both the state's certification of need law and the review of all operations of institutional services, including operating and capital expenses. The commission should also approve budgets and gross operating revenues on an annual basis. If the administration of the certificate-of-need and budget review programs are located in different state agencies there should be close coordination between the programs in order for them to be effective.

The evaluation of the financial impact of proposed new facilities and services by the rate review authority must be considered in the certification of need process. The effectiveness of any certification of need agency in allocating new capital expenditures or promoting relocation, merger and closure of facilities and

services will depend in great part on fiscal sanctions of the budget review mechanism. Therefore, in evaluating increased capital expenditures, the commission should approve costs only for those facilities and services which have been approved by the appropriate planning agency.

5. In order for the commission staff to appropriately analyze hospital budgets and rate requests on a comparable year-to-year and hospital-to-hospital basis, it is necessary to establish a system of uniform financial recordkeeping. Institutions should be required to follow the uniform system of cost and revenue accounting developed under Section 1533 (d) of P. L. 93-641 or any other system reviewed by the policy board and used as the basis for the commission's budget review and approval process.

6. There should be a uniform definition of "Full Financial Requirements" which will be the basis for equal payment for equal services by all patients. "Full Financial Requirements" includes the cost of unreimbursed care for the indigent and bad debts on both an in-patient and out-patient basis.

Because of the wide discrepancy between the amount paid by many state Medicaid programs and the private sector patient for the same services, the state implementing legislation should permit it to avail itself of the same maximum allowable

increase limitation which the Federal Government is allowed for its costs under Medicare and Medicaid. Thus, the state (as well as the Federal Government under Title XVIII and its participation under Title XIX) would be required to fund its share of Medicaid payments based on the rates approved by the program either under Federal or state agency administration subject to a maximum allowable increase. Any excess would be charged to all non-governmental patients by means of a surcharge on the approved rates for the following year.

Because of the assured financing, both short and long range, this definition would enable the hospital to increase the availability of out-patient services to the indigent and medically indigent population, particularly in the inner cities where care is now needed.

7. In the evaluation of increased operating cost, the commission's guidelines should define both comparative and normative standards of reasonableness to which the institution should adhere in supporting increases.

8. In supporting cost increase due to volume changes, e.g., utilization or intensity of services, the guidelines should require the institution to file with the state rate setting agency a quality assurance plan for all patients which provides for routine monitoring of appropriateness of the confinement, and

the duration, and the quality of care rendered. By extending the PSRO program to all patients this requirement would be satisfied.

In addition, the system should clearly identify additional revenues generated by increased volume and establish a methodology for separating fixed and variable costs associated with such service volumes. The amount of reimbursement for the fixed cost component associated with the additional revenues should be used to reduce the hospital's financial requirements for the following year.

9. The guidelines should give the state agency the option of either requiring each institution to submit its budget and rates annually for review and approval or establishing a quadrennial review of all institutions with a special review of institutions who request increases in excess of a predetermined limit in a given year. Review of rates alone does not provide an opportunity to review hospital costs during the hospital's budgeting process. The state agency must also have the authority to reconcile a hospital's budgeted costs, revenues and volume of services with actual experience.

10. The guidelines should permit an institution to petition the state agency for an emergency rate increase during the period between budget reviews where it can show costs have

been inflated due to factors beyond the institution's control (e.g., reduction in expected occupancy levels, malpractice insurance, fuel costs, etc.). Once an institution has submitted its budget to review and received approval, it should be encouraged to generate surpluses due to improved efficiency or productivity. The surpluses so earned should be disposed of on a basis consistent with management prerogatives. Expenditures of such surpluses should be accounted for in subsequent accounting periods and should not call into question the tax exempt status of hospitals.

11. There should be an appropriate administrative and judical appeals process; and finally
12. The legislation may make provision for a differential where the action of the patient, or a prepayment plan or insurance company on the patient's behalf, results in demonstrable savings to the institution; e.g., a patient paying the full bill at discharge reduces the hospital's normal credit collection and operating costs. The criteria for the differential should be established by the state agency, depending on the circumstances involved, and should be available without regard to third party sponsorship or lack thereof.

FINANCING

S. 1391 should be amended to provide one-time development grants to assist states in establishing budget review and approval agencies. Such

grants should be on a graduated per capita scale, e.g., 70 cents for each of the first 500,000 of the state's population; 50 cents for the second 500,000; 30 cents for the third 500,000; and 10 cents for each of the balance of the state's population with a minimum grant per state of $500,000.

The continuing operating costs of the agency could be financed by an assessment against the health care institutions in the state.

FEDERAL ADVISORY COUNCIL ON HOSPITAL COST CONTAINMENT

We also propose that S. 1391 be amended to create an advisory council to assist the Executive Branch and Congress in evaluating the experience under competing reimbursement systems and make recommendations for improvement in cost containment programs as that experience develops.

A council, with balanced representation of providers, third-party purchasers and consumers active in the planning process, would be responsible for monitoring the ongoing operation of the program and would make an annual report to the Secretary of DHEW and the appropriate congressional committees on the program's effectiveness including recommendations for modification of the program.

The report should:

1. Measure the effectiveness of the programs in reducing hospital cost increases and identify the factors which have caused the reduction;
2. Assess the program's impact on improved efficiency in determining the quality of institutional health care services, the utilization of such services, and support for the planning process.

CONCLUSION

It is well recognized that one of the fundamental reasons for spiraling hospital costs is the excess of hospital facilities. The experience gained from the current planning process does not indicate that the law, as it now exists, will have a significant impact on the problem of excess hospital capacity. We strongly urge the Congress to consider an amendment to the National Health Planning and Resources Development Act, P. L. 93-641, which will authorize Health Systems Agencies to recommend the merger of or the closing of excess facilities. Congress should authorize the appropriation of up to 500 million dollars per year to assist in closing down excess beds or their conversion to other uses, and for the retirement of outstanding debt on such facilities.

We believe that the present planning law and the professional standards review organization's efforts will be severely limited in their impact unless they are coordinated with prospective budget analysis. The bill must spell out clearly the need for interaction between these processes.

The medical staffs, administration and governing boards of hospitals should have an interest and concern for the institution's ability to obtain future revenue increases and its ability to deliver high quality care. The bill, therefore, should establish common management objectives that can be achieved through the interaction, coordination and cooperation of regulators, planners and quality assurance experts.

The debate on whether controls will be more effective if they are administered by the federal government or state government is unending.

However, we believe that with incentives for experimentation with the state control process, we can determine whether the private sector working with government can influence the establishment, and help shape and refine a state regulatory process which will produce a reasonable response to the pressure for public accountability in the delivery of health care services. We believe the modifications we have enumerated will produce an effective cost control program.

Senator KENNEDY. Our next witness is William Hiscock, executive director, Central Maryland Health System Agency, Inc., American Association for Comprehensive Health Planning.

STATEMENT OF WILLIAM McC. HISCOCK, EXECUTIVE DIRECTOR, CENTRAL MARYLAND HEALTH SYSTEM AGENCY, INC., AMERICAN ASSOCIATION FOR COMPRENHENSIVE HEALTH PLANNING, ACCOMPAINED BY LAURA McDOWALL AND DAVID CALKINS

Mr. HISCOCK. Good morning, Mr. Chairman. I am here representing the American Association for Comprehensive Health Planning.

Senator KENNEDY. I am familiar with the organization.

Mr. HISCOCK. I want to commend you, sir, for the consciousness raising last week when you attended our convention.

Senator KENNEDY. It was a good meeting of influential people who are going to have a very substantial impact on how we are going to deal with this health issue in terms of both cost of quality and working with Congress to help us meet our responsibilities to the American people.

It is a pleasure for me to have a chance to join with the group and I look forward to hearing your testimony today.

Mr. HISCOCK. Thank you, sir.

I am accompanied by Ms. Laura McDowall, a member of the board, a member of the board for Northern Virginia Health Systems Agency, and a member of the State Health Coordinating Council, and also Mr. David Calkins of our staff.

Before I begin, sir, in April the association adopted a policy statement on capital control options, which is a longer statement, and with your permission, I would like to submit it for the record.

Senator KENNEDY. It will be printed in its entirety at the conclusion of your remarks.

Mr. HISCOCK. Thank you, sir.

I am director of the Central Maryland Health System Agency in Baltimore. I am here in behalf of the Legislative Review Committee of the Association.

The American Association for Comprehensive Health Planning represents the interests of those involved in health planning and resources development at the State and local levels, including consumers, providers, governmental bodies, and professional health planners. The membership of our organization includes health systems agencies, HSAs, State health planning and development agencies, SHPDAs, and a broad cross section of business, industry, labor, and universities, as well as several hundred individual members.

AACHP worked closely with Congress in the development of Public Law 93–641, the National Health Planning and Resources Development Act of 1974, legislation which was a dramatic step by the Federal Government to structure an orderly system for planning and developing health facilities and services, as well as obtaining balanced distribution of health manpower.

As you know, Public Law 93–641 replaced several previous Federal health authorities with overlapping activities, programs which had not provided uniform approaches to the problems being separately addressed. These programs were ones with which we all became

familiar: the comprehensive health planning efforts, regional medical programs, and the experimental health services delivery system activities.

During the 2 years since this significant new program became law, AACHP has monitored its implementation and served as a principal forum for the resolutions of problems encountered during the effectation of this complex program.

The association has been active in the appropriations process, striving to work with Congress to assure that the objectives of the formulators of Public Law 93–641 could be met through adequate funding. As well, we have addressed ourselves to the several issues involved with the preparations necessary to renew this important legislation.

Mr. Chairman, AACHP applauds the commitment of the administration to strive for control of rapidly escalating hospital costs. This escalation is not only causing health care services to be unaffordable to individuals at all levels of society but is severely affecting Federal, State, and local governmental budgets. There is no need for us to repeat the various statistics which portray the magnitude of the problem for they are well known to the members of the subcommittees.

AACHP actively supports the proposal for cost containment, and especially appreciates the dual approach, namely, to control both revenues as well as capital expenditures. Without such control measures, continued increases of this magnitude jeopardize the availability of quality health care for all Americans and delay any serious consideration for a national health insurance program.

We concur with the administration's assessment of the factors which stimulate this upward spiral in hospital costs, in particular:

The increased demand for services, largely a result of the Government financing programs, medicare and medicaid, as well as increased private health insurance coverage.

A method of payment for medical services utilizing a third-party insurance mechanism which shields both the consumer and provider from the impact of the full cost of treatment at the time of utilization.

The nature of the reimbursement system, which is primarily based on retrospective costs incurred, offers little incentive to restrain costs at the time services are provided.

The uneven distribution and mix of health resources—facilities, services, and manpower.

The introduction of high-level medical technology which is heavily capital and labor intensive.

The excess capacity in the medical care system, especially hospital beds, which means that the consumer must bear the burden of paying for the fixed costs of underutilized facilities and equipment.

Today, we wish to direct our remarks specifically to features of title II of the proposed legislation, which involves controls on capital expenditures and the effects of such controls.

AACHP believes that any hospital cost control legislation enacted must be supportive of the principles of the certificate of need and ratesetting processes for facilities and services embodied in Public Law 93–641.

Further, any hospital cost containment legislation must build upon the integrity of the functions and relationships established under Public Law 93–641 between the Federal, State, and regional levels.

Much of the success of the administration's proposal is directly dependent upon preserving and further developing appropriate and strong linkages between the statutory authorities of health systems agencies and the goals of this program. In point of fact, Public Law 93–641 already provides the supervisory mechanism by which the succiss of this program can be assured.

The relationship between cost containment and Public Law 93–641.

In view of this, I believe it appropriate to take a minute or two to comment on the relationship we see between containment of hospital cost increases as proposed in title II and Public Law 93–641

As you know, a major contributing factor to the rate of increase in hospital costs is capital investment. Unnecessary capital expenditures are doubly inflationary. Not only must the public bear the constuction, development, and financing costs of unnecessary facilities, but it must also pay the significantly increased annual operational costs generated by them.

Thus, while regulation is undertaken to control the present level of health care cost inflation, other efforts should be made to achieve compatible basic changes in the health care system: Unnecessary expansion of facilities and services should be prevented, excess capacity in the health care system should be reduced, unnecessary utilization of facilities and services should be reduced, cost-containment incentives should be built into the structure of the health care system, effective and efficient alternatives to inpatient facilities and services should be developed, and the public must be educated as to the relationship between the availability and use of medical care services and costs.

Thus, a strong systemwide planning program is necessary to address these concerns so that medical care resources are developed according to regional and community needs while, at the same time, addressing imbalances in the distribution and mix of services and facilities. Whitout an aggressive planning program, operating cost limitations can inadvertently entrench the existing system, foreclosing efforts to improve it.

A major advantage of linking the two programs is that it would effectively involve wide public participation in the national effort to contain the rise in health care costs. This is important because cost-containment efforts will ultimately force the making of highly unpopular decisions, and this can best be accomplished by maximizing citizen involvement, understanding, and support. This is precisely the current role of planning services.

Several requirements must be considered if the two functions are to be integrated successfully: Complementary guidelines, standards, and criteria at the Federal, State, and local levels; clear delineation of functional relationships; adequate fiscal and manpower support for both functions; and compatible systems of data acquisition and utilization.

Mr. Chairman, we strongly support what we understand to be the four principal ingredients of title II. Specifically:

1. AACHP supports the establishment of a national capital expenditures ceiling. While we cannot confirm the accuracy of a ceiling placed at $2.5 billion, our experience suggests that only a relatively low ceiling will allow us to achieve the rationality required. We believe the $2.5 billion suggestion by the administration to be generous.

2. AACHP supports utilization of existing mechanisms and processes for decisionmaking within adopted cost ceilings, as authorized in Public Law 93–641.

3. AACHP supports establishment of national supply guidelines, tied to the requirements of Public Law 93–641. We accept the suggested maximum of 4 beds per 1,000 population and the 80-percent occupancy factor as general guidelines. Applications of such "standards" as a ratio of 4 beds per 1,000 population, coupled with the 80-percent occupancy reqnirements, is a reasonable step in the right direction. We support both of these provisions, but we wish to stress that both must be viewed from a national perspective. They are desirable, and certainly attainable, national health planning goals. Care must be taken to insure, however, that the 4 beds per 1,000 population "ceiling" does not, in fact, become a "floor," and likewise that the 80-percent occupany "floor" does not, in fact, become the norm.

The health care delivery system in more than one-fourth of the Nation already functions more efficiently than the guidelines specify. Great care must be taken to avoid laxity or retrogression in areas that are functioning relatively efficiently. I would point out that the old Hill-Burton occupancy norm, which many people felt was too lax, stipulated an average occupancy factor of 85 percent.

4. AACHP supports provisions for denial of full Federal reimbursement for unapproved projects.

Although we support S. 1391, and commend the administration for submitting it, we do believe that title II could be improved. Based on our experience, we urge you to consider amending title II as follows:

1. The capital expenditure program should apply to all hospitals, without exclusion for sponsorship; Federal Government hospitals, health maintenance organization hospitals and similar institutions ought not to be exempted if we truly wish to achieve both cost containment and coordinated utilization of existing resources.

2. Certificate of need authorities must be strengthened if cost containment is to work. Containment of expenditures is possible only if certificate of need authorities include all expensive equipment in the range of $150,000 and above, regardless of location. Without this inclusion, planning, service delivery and capital expenditure computations become distorted. At the same time, certificate of need authorities must provide explicitly for decertification and/or conversion of facilities and services, including projects in progress. It is the key to the success of such a program that these authorities include appropriate planning and review processes, appeal mechanisms, and reimbursement and/or capital relief measures for institutions relinquishing or converting facilities or services. Such authorities are appropriately fixed with the several States in their respective SHPDA's. A great deal of Federal guidance will be necessary to assure success.

3. We strongly urge that the legislation incorporate provisions for incentives to convert facilities, as well as for the elimination of unnecessary facilities and/or services.

4. We urge adoption of provisions for inclusion within the ceiling of capital expenditures for modernization of nonconforming facilities and for code compliances.

5. We urge the inclusion of provisions for discontinuation of FHA loan guarantees, tax-free bonding authorities or any other incentives

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for capital formation for unapproved facilities and equipment. We are concerned, in addition, that title II appears to exclude any considerations for expansion of facilities through acquisition. We believe acquisitions are another form of inflationary capital expenditure. Section 1122 of Public Law 92–603 provides for the review of capital expenditures for acquisitions; absence of this consideration in the proposed cost containment program appears inconsistent with existing Federal policy.

6. We urge that provisions be included requiring that certificate-of-need approvals by HSA's and SHPDA's must be consistent with health facilities plans, State health plans, and national guidelines. Explicit national guidelines should be published under the authority of Public Law 93–641, placing a moratorium on the construction or conversion of facilities which would result in additional bed capacity in areas with a bed/population ratio of more than 4 per 1,000 and an occupancy level less than 80 percent.

Extreme caution must be used, however, to insure that unnecessary capacity is not created in areas under that ceiling. An appropriate exceptions process should be established based on criteria of the Secretary of HEW. This process would include the State and area-wide health planning mechanisms.

In addition to these specific recommendations, we cannot help but wonder why only acute care facilities have been addressed by the administration's proposal. While hospital costs are, in fact, a major aspect of our Nation's expanding health care costs, they certainly are not the only part of substance. The costs of care in long-term care facilities, particularly nursing homes, are substantial. We suggest that these areas be examined for possible inclusion under this program.

The American Association for Comprehensive Health Planning is pleased to have had the opportunity to appear before this subcommittee.

As we have explained, we strongly advocate the utilization of health planning organizations and processes for allocation decisions, Further, we support the concept that a program such as this, which will require highly unpopular decisions, can only succeed if built upon citizen awareness and participation embodied within Public Law 93–641.

Mr. Chairman, based upon our experience, cost containment can work, if control mechanisms are appropriate. We believe we have presented recommendations here today which, when combined with adequate revenue controls, will curtail our hospital costs expansion problem. We further believe that the basic mechanisms for implementing such a program already exists, as described by Public Law 93–641.

Picking up on one of your comments as you introduced the legislation April 26, we believe consideration must be given for the practical workload which such a program would impose upon our Nation's HSA's and SHPDA's and, consequently, the adequate authorizations and appropriations which would be necessary to give State and local agencies the resources necessary to successfully carry out the program.

Such authorizations and appropriations would obviously be nominal when compared to the savings available through administration of an effective revenue and capital expenditures cost containment program.

Thank you for your thoughtful consideration of our presentation.

We would be pleased to answer any questions which you may have.

Senator KENNEDY. Thank you very much for your testimony.

There are just a few areas I would like to go over with you. One is that Blue Cross today calls for a moratorium on hospital construction to give HSA's some breathing room to develop their State medical facility plans and to get their house in order.

How do you react to this?

Mr. HISCOCK. There is a backlog—I come from an urban area—and some of the institutions in the city require a capital investment for replacement. I think that backlog could cause some problems, particularly in our urban settings.

Ms. MCDOWALL. In northern Virginia we would welcome such a moratorium. There have not been any acute beds built there since there has been a health planning agency. But I think nationwide it would cause some problems, particularly in areas where there are old facilities.

Senator KENNEDY. You do not feel that with an exceptions policy you would have sufficient flexibility to be able to do it?

Would there be any sense in trying to work out something on this level if there were some criteria that would permit discretion in urban areas or areas where the facilities are old?

Mr. HISCOCK. I think that would be the approach.

Senator KENNEDY. Would you give us some help on that and see if something can be done?

Maybe we could fashion an exception policy for urban areas.

You are going to have important monitoring responsibilities in the dumping area in the exception process, and in the distribution of information from various hospitals. All of that is additional responsibility for you. What will you need in terms of resources to be able to deal effectively with these new responsibilities?

Mr. HISCOCK. Again, sir, after we inventory our membership I would like the opportunity to submit some precise information in that regard. But I can see, No. 1, that it would be a separate tracking system for this set of facilities. I see some additional staffing, and the new process will produce some additional hearings.

Senator KENNEDY. As your organization represents both the local and the State level, where do you think the monitoring should take place?

Mr. HISCOCK. I think the functional relations of the State agencies and the areas are really being well defined, better defined every day.

In the areas, we are slightly closer than a State agency in terms of what is coming in the pipeline in advance. The State has a good feel for the whole statewide operation. The allocation of cap, for example, would require interaction between area and State agencies. I do not think you can put it in one place.

I think each of us influences others in statewide policy.

Ms. MCDOWALL. Our experience in Virginia has been very similar to what Mr. Hiscock is speaking of in Maryland. These functional relationships are working that we are working on now.

Senator KENNEDY. When you submit your information on costs, additional resources, and the language you are giving us in terms of the exceptions policy, would you also give us something more definitive in terms of allocations of responsibility between local and State agencies? I think that is very important.

It is a tough issue, but we would like to get your information so that we can better work with you. Thank you very much.

Mr. HISCOCK. Thank you very much.

[The prepared statements of Mr. Hiscock and the American Association for Comprehensive Health Planning follow:]

AMERICAN ASSOCIATION FOR COMPREHENSIVE HEALTH PLANNING

TESTIMONY OF

WILLIAM McC. HISCOCK
EXECUTIVE DIRECTOR, CENTRAL MARYLAND HSA, INC.
BALTIMORE, MD

AND
MEMBER, AACHP LEGISLATIVE COMMITTEE

BEFORE THE
SENATE HUMAN RESOURCES SUBCOMMITTEE ON HEALTH
AND SCIENTIFIC RESEARCH

June 21, 1977

Chairman Kennedy and distinguished members of the Subcommittee, the American Association for Comprehensive Health Planning (AACHP) is pleased to have this opportunity to appear before you this afternoon to testify on S. 1391, the Hospital Cost Containment Act of 1977.

I am William Hiscock, a member of the AACHP Legislative Committee and Executive Director of the Central Maryland HSA, headquartered in Baltimore, Maryland.

The American Association for Comprehensive Health Planning represents the interests of those involved in health planning and resources development at the state and local levels, including consumers, providers, governmental bodies and professional health planners. The membership of our organization includes Health Systems Agencies (HSAs), State Health Planning and Development Agencies (SHPDAs), and a broad cross section of business, industry, labor and universities, as well as several hundred individual members.

AACHP worked closely with Congress in the development of Public Law 93-641, the National Health Planning and Resources Development Act of 1974, legislation which was a dramatic step by the Federal Government to structure an orderly system for planning and developing health facilities and services, as well as obtaining balanced distribution of health manpower.

As you know, PL 93-641 replaced several previous federal health authorities with overlapping activities, programs which had not provided uniform approaches to the problems being separately addressed. These

programs were ones with which we all became familiar: the comprehensive health planning efforts, Regional Medical Programs, and the experimental health services delivery system activities.

During the two years since this significant new program became law, AACHP has monitored its implementation and served as a principal forum for the resolutions of problems encountered during the effectation of this complex program. The Association has been active in the appropriations process, striving to work with Congress to assure that the objectives of the formulators of PL 93-641 could be met through adequate funding. As well, we have addressed ourselves to the several issues involved with the preparations necessary to renew this important legislation.

Mr. Chairman, AACHP applauds the commitment of the Administration to strive for control of rapidly escalating hospital costs. This escalation is not only causing health care services to be unaffordable to individuals at all levels of society, but is severely affecting federal, state, and local governmental budgets. There is no need for us to repeat the various statistics which portray the magnitude of the problem, for they are well known to the members of the Subcommittees.

AACHP actively supports the proposal for cost containment, and especially appreciates the dual approach, namely, to control both revenues as well as capital expenditures. Without such control measures, continued increases of this magnitude jeapordize the availability of quality health care for all Americans and delay any serious consideration for a national health insurance program.

We concur with the Administration's assessment of the factors which stimulate this upward spiral in hospital costs: in particular,

- the increased demand for services, largely a result of the government financing programs, Medicare and Medicaid, as well as increased private health insurance coverage;
- a method of payment for medical services utilizing a third-party insurance mechanism which shields both the consumer and provider from the impact of the full cost of treatment at the time of utilization;
- the nature of the reimbursement system, which is primarily based on retrospective costs incurred, offers little incentive to restrain costs at the time services are provided;
- the uneven distribution and mix of health resources (facilities, services, and manpower);
- the introduction of high-level medical technology which is heavily capital and labor intensive;
- the excess capacity in the medical care system, especially hospital beds, which means that the consumer must bear the burden of paying for the fixed costs of underutilized facilities and equipment.

Today, we wish to direct our remarks specifically to features of Title II of the proposed legislation, which involves controls on capital expenditures, and the effects of such controls.

AACHP believes that any hospital cost control legislation enacted must be supportive of the principles of the certificate of need and rate setting processes for facilities and services embodied in PL 93-641. Further, any hospital cost containment legislation must build upon the integrity of the functions and relationships established under PL 93-641 between the federal, state and regional levels. Much of the success of the Administration's proposal is directly dependent upon preserving and further developing appropriate and strong linkages between the statutory authorities of Health Systems Agencies and the goals of this program. In point of fact, PL 93-641 already provides the supervisory mechanism by which the success of this program can be assured.

THE RELATIONSHIP BETWEEN COST CONTAINMENT AND PL 93-641

In view of this, I believe it appropriate to take a minute or two to comment on the relationship we see between containment of hospital cost increases as proposed in Title II and PL 93-641. As you know, a major contributing factor to the rate of increase in hospital costs is capital investment. Unnecessary capital expenditures are doubly inflationary. Not only must the public bear the construction, development and financing costs of unnecessary facilities, but it must also pay the significantly increased annual operational costs generated by them.

Thus, while regulation is undertaken to control the present level of health care cost inflation, other efforts should be made to achieve compatible basic changes in the health care system:

- unnecessary expansion of facilities and services should be prevented;
- excess capacity in the health care system should be reduced;
- unnecessary utilization of facilities and services should be reduced;
- cost containment incentives should be built into the structure of the health care system;
- effective and efficient alternatives to inpatient facilities and services should be developed; and
- the public must be educated as to the relationship between the availability and use of medical care services and costs.

Thus, a strong system-wide planning program is necessary to address these concerns so that medical care resources are developed according to regional and community needs while at the same time addressing imbalances in the distribution and mix of services and facilities. Without an aggressive planning program, operating cost limitations can inadvertently entrench the existing system, foreclosing efforts to improve it.

A major advantage of linking the two programs is that it would effectively involve wide public participation in the national effort to contain the rise in health care costs. This is important because cost containment efforts will ultimately force the making of highly unpopular decisions and this can best be accomplished by maximizing citizen involvement, understanding, and support. This is precisely the current role of planning agencies.

Several requirements must be considered if the two functions are to be integrated successfully:

- complementary guidelines, standards, and criteria at the federal, state, and local levels;
- clear delineation of functional relationships;
- adequate fiscal and manpower support for both functions;
- compatible systems of data acquisition and utilization.

Mr. Chairman, we strongly support what we understand to be the four principal ingredients of Title II. Specifically:

1. AACHP supports the establishment of a national capital expenditures ceiling; while we cannot confirm the accuracy of a ceiling placed at $2.5 billion, our experience suggests that only a relatively low ceiling will allow us to achieve the rationality required. We believe the $2.5 billion suggested by the Administration to be generous;
2. AACHP supports utilization of existing mechanisms and processes for decision making within adopted cost ceilings, as authorized by PL 93-641;
3. AACHP supports establishment of national supply guidelines, tied to the requirements of PL 93-641. We accept the suggested maximum of 4 beds per 1,000 population and the 80 percent occupancy factor as general guidelines. Applications of such "standards" as a ratio of 4 beds per 1,000 population, coupled

with the 80 percent occupancy requirement, is a reasonable step in the right direction. We support both of these provisions, but we wish to stress that both must be viewed from a national perspective. They are desirable, and certainly attainable, national health planning goals. Care must be taken to ensure, however, that the 4 beds per 1,000 population "ceiling" does not in fact become a "floor," and likewise that the 80 percent occupancy "floor" does not in fact become the norm. The health care delivery system in more than one-fourth of the nation already functions more efficiently than the guidelines specify. Great care must be taken to avoid laxity or retrogression in areas that are functioning relatively efficiently. I would point out that the old Hill-Burton occupancy norm, which many people felt was too lax, stipulated an average occupancy factor of 85 percent;

4. AACHP supports provisions for denial of full federal reimbursement for unapproved projects.

RECOMMENDATIONS

Although we support S. 1391, and commend the Administration for submitting it, we do believe that Title II could be improved. Based on our experience, we urge you to consider amending Title II as follows:

1. The capital expenditure program should apply to all hospitals, without exclusion for sponsorship; Federal Government hospitals,

Health Maintenance Organization hospitals, and similar institutions ought not to be exempted if we truly wish to achieve both cost containment and coordinated utilization of existing resources.

2. Certificate of need authorities must be strengthened if cost containment is to work. Containment of expenditures is possible only if certificate of need authorities include all expensive equipment in the range of $150,000 and above, regardless of location. Without this inclusion, planning, service delivery and capital expenditure computations become distorted. At the same time, certificate of need authorities must provide explicitly for decertification and/or conversion of facilities and services, including projects in progress. It is the key to the success of such a program that these authorities include appropriate planning and review processes, appeal mechanisms, and reimbursement and/or capital relief measures for institutions relinquishing or converting facilities or services. Such authorities are appropriately fixed with the several states in their respective SHPDAs. A great deal of federal guidance will be necessary to assure success.

3. We strongly urge that the legislation incorporate provisions for incentives to convert facilities, as well as for the elimination of unnecessary facilities and/or services.

4. We urge adoption of provisions for inclusion within the ceiling of capital expenditures for modernization of non-conforming facilities and for code compliances.
5. We urge the inclusion of provisions for discontinuation of FHA loan guarantees, tax-free bonding authorities or any other incentives for capital formation for unapproved facilities and equipment. We are concerned, in addition, that Title II appears to exclude any considerations for expansion of facilities through acquisition. We believe acquisitions are another form of inflationary capital expenditure. Section 1122 of PL 92-603 provides for the review of capital expenditures for acquisitions; absence of this consideration in the proposed cost containment program appears inconsistent with existing federal policy.
6. We urge that provisions be included requiring that certificate of need approvals by HSAs and SHPDAs must be consistent with health facilities plans, state health plans, and national guidelines. Explicit national guidelines should be published under the authority of PL 93-641 placing a moratorium on the construction or conversion of facilities which would result in additional bed capacity in areas with a bed/population ratio of more than 4 per 1,000, and an occupancy level less than 80 percent. Extreme caution must be used, however, to ensure that unnecessary capacity is not created in areas under that ceiling. An appropriate

exceptions process should be established based on criteria of the Secretary of HEW. This process would include the state and areawide health planning mechanisms.

In addition to these specific recommendations, we cannot help but wonder why only acute care facilities have been addressed by the Administration's proposal. While hospital costs are in fact a major aspect of our nation's expanding health care costs, they certainly are not the only part of substance. The costs of care in long-term care facilities, particularly nursing homes, are substantial. We suggest that these areas be examined for possible inclusion under this program.

CONCLUSION

The American Association for Comprehensive Health Planning is pleased to have had the opportunity to appear before this Subcommittee. As we have explained, we strongly advocate the utilization of health planning organizations and processes for allocation decisions. Further, we support the concept that a program such as this, which will require highly unpopular decisions, can only succeed if built upon citizen awareness and participation embodied within PL 93-641.

Mr. Chairman, based upon our experience, cost containment can work, if control mechanisms are appropriate. We believe we have presented recommendations here today which, when combined with adequate revenue controls, will curtail our hospital costs expansion problem. We further

believe that the basic mechanisms for implementing such a program already exists, as described by PL 93-641./ At the same time, we suggest that consideration be given for the practical work load which such a program would impose upon our nation's HSAs and SHPDAs and, consequently, the adequate authorizations and appropriations which would be necessary to give state and local agencies the resources necessary to successfully carry out the program. Such authorizations and appropriations would obviously be nominal when compared to the savings available through administration of an effective revenue and capital expenditures cost containment program.

Thank you for your thoughtful consideration of our presentation. We would be pleased to answer any questions which you may have.

AMERICAN ASSOCIATION FOR COMPREHENSIVE HEALTH PLANNING

July 1, 1977

The Honorable Edward M. Kennedy
431 Russell Senate Office Building
United States Senate
Washington, D. C. 20510

Dear Senator Kennedy:

On June 21, 1977 the American Association for Comprehensive Health Planning (soon to be the American Health Planning Association) testified before the Senate Human Resources Subcommittee on Health and Scientific Research on S. 1391, the Hospital Cost Containment Act of 1977. As a follow up to that testimony and in response to questions from Members of the Subcommittee, we respectfully submit the following.

As we indicated in our recent testimony, we strongly support 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 straight forward 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 truely to develop an effective planning structure for resources allocation. For these reasons, we believe Title II to be clearly preferable to a moratorium.

We do believe, however, that Title II should be strengthened in a number of respects to ensure that the desired results are obtained. Title II currently provides too much discretion to the Secretary of HEW with regard to appropriate minimum occupancy standards and supply ceilings. This discretion could be used to permit inappropriate new hospital bed construction.

As currently written, the bill contains no mechanism for reallocating the annual state hospital capital expenditure limit among health service areas. Such a mechanism must be provided if uniformity and equity of treatment is to be assured. Otherwise, excess capital expenditures could be concentrated in individual health service areas even though the state as a whole did not exceed its allocation. We have suggested an amendment which would provide such a mechanism. We believe it will decrease the likelihood of a grossly unequal distribution of hospital capital expenditures between health service areas.

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Essentially, we are proposing that the same formula used by the Secretary to determine state allocation also be used by the states to determine the allocation for each health service area (or portion of a health service area) within the state. Expenditures in excess of a health service area's allocation would be permitted (so long as the state allotment was not exceeded). However, approval would be required by the HSA in which the expenditure was to be made, as well as comments by HSAs whose allocations would be diminished. Where disagreements exist, the Statewide Health Coordinating Council (SHCC) would make the determination.

On another subject, we also believe that new additional financial resources will be needed by state agencies (SHPDAs) and HSAs to carry out the new functions required by S. 1391. This is particularly important as full funding has never been supplied for the functions already required under P.L. 93-641, and because agencies are not being paid for Section 1122 review. Moreover, as you know, P.L. 93-641 cut off a useful source of private funds by prohibiting health planning organizations from contributing to planning efforts, further accentuating the need for full federal funding. Due to the importance and necessity of additional financial resources that will be required, the Association is preparing a recommended funding level (with supporting justification and rationale) as it relates to S. 1391 and will be sending you those recommendations in the immediate near future.

We are enclosing for your consideration a series of amendments which we believe would substantially strengthen Title II of the proposal. These amendments cover the following points:

1) Inclusion of Federally Owned Hospitals. We have included federally owned hospitals within the sphere of Certificate of Need. We can see no justification for excluding such hospitals.

2) Control of Federal Assistance for Hospitals. We have added a provision requiring any federal department or agency providing financial assistance for hospital capital expenditures to obtain the approval of HEW. There are a number of programs operated outside of HEW which provide assistance for hospital capital expenditures. Such expenditures must be coordinated with the requirements of Title II.

3) Limitation on Use of Investment Tax Credit. Title II uses the tax laws to insure that non-profit hospitals do not receive tax exemption for capital expenditures which are inconsistent with Title II. However, for-profit hospitals may still receive an investment tax credit for such expenditures. Our amendment would eliminate the credit in such cases.

4) Strengthening of Occupancy and Supply Standards. As written the Secretary could modify the occupancy and supply standards at his discretion. We have amended this language to insure that the standards specified in the law are treated as minimum requirements. Without restrictions such as the ones we propose there is a substantial danger that some areas will actually be permitted to relax existing standards.

5) Coverage of Acquisitions. The existing language exempts acquisitions. This loophole would permit the maintenance of excess capacity through turn-key arrangements.

6) Conversion Allowances. We have added authority to the area development funds to encourage conversions or closure of hospitals. Such incentives are necessary if excess capacity is to be reduced.

7) Coverage of Equipment Regardless of Location. We have added authority to cover equipment commonly used in hospitals regardless of location. Otherwise the limitations imposed by Title II will simply serve to encourage free-standing centers for expensive equipment.

8) Certificate of Need to be Consistent with the State Health Plan. We have required all certificate of need determinations to be consistent with the state health plan. This is not the case under existing law or Title II.

9) Decertification of Facilities. We have added authority to decertify existing facilities. This authority is necessary if existing excess capacity is to be reduced.

10) Federal Review of 1122 Determinations. We have provided authority for the Secretary to reverse an approval of a capital expenditure under Section 1122. Currently he can only reverse a disapproval, except where timely notice has not been granted.

11) Reallocation of Cap to HSAs. We have added language requiring a reallocation to HSAs of the state allotment under the cap. Expenditures above the cap in any health service area could be approved (as long as they didn't exceed the state cap) but only if all affected HSAs agree. Where an affected HSA objects, the SHCC would be given authority to resolve the dispute.

We hope our comments are useful and look forward to working with you toward the enactment of strong and effective legislation.

Sincerely,

Bernardo Benes, LLB
President

William C. Kopit
Counsel

Anthony T. Mott
Chairman, Legislative Committee

Enclosures
cc: Dr. Stuart Shapiro

AMERICAN ASSOCIATION FOR COMPREHENSIVE HEALTH PLANNING

(Proposed Changes and Amendments to 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

(3) (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 Federal hospital 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 determination includes expenditures for the expansion of the services of such 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.

"(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."

Senator KENNEDY. We have a final witness, Mr. James M. Hacking from the American Association of Retired Persons and the National Retired Teachers Association.

I can tell you from firsthand information that they are a very effective and wonderful group, and I enjoy working closely with them

STATEMENT OF JAMES M. HACKING, AMERICAN ASSOCIATION OF RETIRED PERSONS AND NATIONAL RETIRED TEACHERS ASSOCIATION, ACCOMPANIED BY RALPH W. BORSODI, CONSULTANT

Mr. HACKING. Thank you, Mr. Chairman. With your permission, I would like to have my full statement included in the record.

Senator KENNEDY. It will be printed in its entirety.

Mr. HACKING. I will proceed with my summary statement, but first I would like to introduce, on my left, Mr. Ralph W. Borsodi, a retired economist and one of our consultants.

I am an assistant legislative counsel for the 11 million member National Retired Teachers Association and American Association of Retired Persons.

I would begin my statement by pointing out what should be obvious. The elderly care a great deal about access to and the cost of health care.

While medicare and medicaid have facilitated access, the programs' payment procedures—like those for private insurance—have contributed to a cost spiral that will, if things remain unchanged, ultimately defeat the ease of access originally gained.

Even before medicare, hospital costs had demonstrated a tendency to rise at rates higher than prices in general. The use of third-party payment procedures by Government programs and private insurers only made matters worse. The patient, the Government, and the private insurance companies all fail to raise any kind of a restraining hand against rising costs.

Since 1973, our associations have been pressing for reimbursement reforms. We have also been advocating a restructuring of an overly hospital-centered health care delivery system. The ultimate way to control the rate of increase in hospital costs is to provide facilities and types of care that are less costly alternatives to highly specialized care in the acute-care hospitals. The fact that hospitals are not competitive does not preclude the fostering of product competition.

Unfortunately, the national dependence on the hospital as the keystone of the health structure is not changing.

In fiscal 1976, 40 percent of the $139.3 billion spent on health was spent on hospitals. The more resources we pour into hospitals, the less we have to stimulate alternatives.

We shall not burden the subcommittee with a description of how things work in the health sector or what it is currently costing, or what it is expected to cost in the future if things remain unchanged. We all know that medicare/medicaid reimbursement reform and health care delivery restructuring have been largely a matter of debate, rather than action. We would, however, like to enumerate what we see as the inevitable consequences if the status quo continues.

First, health care will absorb even more of our GNP despite the fact that, in terms of health status and life expectancy, we have reached a point of diminishing returns.

Second, the proportion of Government budgets allocated to the existing medicare/medicaid programs will grow, compete against and perhaps, crowd out—or be crowded out by—other priorities.

Third, the financial viability of those programs will be seriously impaired—unless taxes are continually increased.

Fourth, increasing numbers of elderly persons, even with medicare/medicaid protection, will be priced out of the health care market and denied access to needed care.

Finally, prospects for any significant expansion of medicare/medicaid protection will diminish and the goal of national health insurance will become increasingly remote.

The realities of the situation are that unless we get control over the spiraling costs of existing programs, not only will we not go forward to expand them and achieve the goal of comprehensive health care protection for all our citizens, but we will end up going backward.

For us, the choice is simple. Either we drastically cut the rate of inflation in the health sector now and thereby contain the spiraling costs of medicare and medicaid—without merely shifting those costs onto the beneficiaries—or we face the growing prospect that medicare and medicaid benefits will be cut. The only ones who can benefit from a perpetuation of the status quo are the providers of health care services.

Because we felt health care inflation to be so serious, we urged the Ways and Means Health Subcommittee last August to cap hospital costs and doctor fees until effective reforms could be implemented. We welcome the administration's legislative proposal. It contains many of the things we recommended a year ago—notably caps on cost increases for all classes of patients using hospitals. If cost containment is to be effective, it must be a general restraining hand that cannot be subverted by bookkeeping tricks.

We endorse S. 1391, subject to the following comments:

First, any formula for determining allowable annual increases in hospital costs, plus exceptions granted, should not result in an annual increase in hospital costs which represent price rises more than 50 percent higher than rises recorded for goods and services in the general economy, and we think 3 years is enough time to bring hospital price inflation in line with the general index of prices.

Second, we are opposed to broad exemptions in advance under the bill for any class of expenditure; an initial rate of increase in annual hospital costs 50 percent higher than that of the general economy provides ample leeway for the hospital industry to brake their costs without injury to any interests.

Third, we would encourage the shift of controls from the Federal Government to State hospital control boards or agencies, subject, however, to Federal oversight and review.

Fourth, since hospitals in some areas have been overbuilt, it is not enough to discourage overbuilding from this point on. Incentives should be provided to eliminate unneeded beds as other community health facilities become available.

The imposition of controls will buy time, but the time they buy must be used wisely. The stick of controls will have to be supplemented by a carrot. Hospital administrators are going to have to be provided with incentives to make savings.

We all know that hospital personnel per patient has been rising and that more sophisticated equipment is being used in diagnosis and treatment. There is merit in the claim that cost increases in the hospitals partly reflect what the economists call an increase in the inputs to the cost flow.

The Council on Wage and Price Stability attributes the larger part of the rise in cost per patient day to the changing character of hospital care. The weight of the evidence is that costs are not closely controlled in institutions where there is neither compulsion nor incentive to conserve funds.

We hope that the Congress would not use the time a controls program will buy to develop a "reform" program that would rely exclusively on budget controls and cost regulations. Because budgets tend to rise unless those who control know as much about the expenditures as those who spend, we believe that budgeting techniques have serious limitations. We would urge that any reform program that is developed rely to the extent possible on the pricing system.

If medicare dropped its allowable cost formula and became a charge payer for the bulk of the ordinary care in hospitals, a basis for competition would be introduced. While physicians would no longer be completely free to place their patients in the most expensive hospital in town, far more unpalatable restraints on their freedom of action may be in the wings, if exploding costs in health care are not brought under control.

Additional competition could be introduced into the hospital sector by converting the insurance payers from cost reimbursers to charge reimbursers for common treatments.

It is not in the public interest that the insurance industry reimburse hospitals, particularly where there is a surplus of beds available, without regard to economics. The better run hospital should get the business.

We have suggested that competition be used to help cut down on the costs of hospitalization and that hospitals should not be sheltered from the ordinary workings of the market place.

But we want to reiterate our support for the development of less-costly alternatives to acute-care hospitals. However, to date, we have been trying to achieve diversification through laws, regulations, planning agencies, and various boards.

Our associations believe that this central planning approach to the helath care industry will bring slow results and high costs. We would urge that competitive and substitute prices be promoted so that health facilities will be developed by private initiative which will represent less expensive, and more convenient, facilities than the large institutions favored today.

There is one other opportunity which the Hospital Cost Containment Act provides and on which we urge this subcommittee to capitalize. That is disclosure. The disclosure requirements of section 125, part B, of the bill appear to us to be inadequate to expose the abuses of public funding which have come to light year after year.

If more than 50 percent of the income of an institutional provider is obtained from third-party payers, the public, it seems to us, as a majority partner is entitled to the fullest disclosure. We feel that a provider falling in this category should publish, or make available, a schedule of compensation of all kinds made to its highest paid employees.

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Hospitals and other institutional providers should provide a detailed conflict-of-interest statement for any members of their controlling or administrative staffs who are in a position to influence purchasing, leasing, and contracting.

Conflict-of-interest statements should list investments, holdings, and family ties for such parties with concerns doing business with the provider.

Finally, some sunshine should be thrown on the outside billings of anesthesiologists, pathologists, and radiologists who practice in hospitals.

This concludes my statement, Mr. Chairman. I appreciate having had the opportunity to present it.

Senator KENNEDY. On page 6 of your testimony, you talk about a reform program and you say

> We would urge that any reform program that is developed rely to the extent possible on the pricing system. If medicare dropped its allowable cost formula and became a charge payer for the bulk of the ordinary care in hospitals, a basis for competition would be introduced. While physicians would no longer be completely free to place their patients in the most expensive hospital in town, far more unpalatable restraints on their freedom of action may be in the wings, if exploding costs in health care are not brought under control.

Would that not work to the disadvantage of the elderly?

Some doctors cannot move the patients around given the realities of the situation at the present time.

If you eliminate that, wouldn't the elderly be stuck with higher bills?

Mr. HACKING. I should not think so.

What I am saying there is not meant to be applied across the board.

Today, as far as we can see, the physician simply refers the patient to the hospital that he is affiliated with. He puts all his patients there. It may be that the particular surgical procedure that he is contemplating is something that is quite standard and something which could be performed quite adequately in a more efficiently run and less costly hospital in town.

Obviously, this could not be done in every case. But to the extent that it can be done, you are making a cost savings.

Senator KENNEDY. Is not the reality of the situation that the doctor's flexibility to move patients around is very limited?

Mr. HACKING. We think that flexibility should be expanded. That might be a very nice alternative.

Senator KENNEDY. I agree with that.

But we are talking about the realities of today. It is very limited. I agree that in a perfect world, that would be desirable. But whether it is realistic is another question.

Mr. HACKING. Procedures could be developed by the third-party payers. They could insist that they are not going to pay the bill, wherever the bill comes from and whatever the amount is——

Senator KENNEDY. Well, whatever group that is negotiating the contract—the union, or somebody else—they will go to another insurance company that will pay it?

Has that not been the practice?

Mr. HACKING. I would agree that is the way the world works today. Doctors do not want the world to change. They have made it quite

evident that they oppose any kind of change, and are opposed to any kind of regulation. They are doing well the way the things work.

What we are saying is that something has to be done to change the way things work; and we would prefer to see the pricing system used to the extent possible. It may not be possible, as you suggest, but we would like to see it used because the alternative—evermore centralized government control and regulation—is not particularly pleasant.

Senator KENNEDY. Your suggestions offer the tightest controls of any of the witnesses that we had.

What percentage would you say for a cap?

Mr. HACKING. Let me ask our economic consultant to comment on that.

Mr. BORSODI. We think that 9 percent is a good target.

Senator KENNEDY. You support the 9 percent?

Mr. BORSODI. Yes, we do. We would like to see the present 15-percent-a-year rate brought down—price inflation in hospital costs should be brought down promptly to the general level of price inflation.

Mr. HACKING. I would like to add to that. Last year, when we were testifying before the Ways and Means Health Subcommittee, we suggested a somewhat different approach or formula. We suggested taking the service component of the CPI, minus the medical service factor providing an additional 2- or 3-percent increment, some arbitrary figure. Over the course of a period of years, that incremental factor would be reduced by 1 percent a year until you get down to an allowable rate of increase which would not exceed the rate of increase in the service component of the CPI.

But the administration's proposal is quite adequate for us. It is just a different formula.

Senator KENNEDY. In terms of inflation in the area of hospital policy, what do you feel is the best indicator to use?

Mr. HACKING. The one the administration proposes to use—the GNP deflator—is the most broad and perhaps, therefore, the most reliable. I do not think we have any strong leanings one way or the other.

Mr. BORSODI. We do not have any strong preference.

Senator KENNEDY. What about the cost of care in the nursing home area?

Do you think there is fat in the nursing homes at this time? If we start controlling nursing homes would the quality of nursing care suffer?

Mr. HACKING. Let me take the first parts of your question first.

I am sure there is a good deal of fat in any institution or institution setting where virtually all costs are reimbursed through third-party mechanisms. I would say that ever since the economic stabilization program expired in 1974, we have advocated reimposition of controls as a short-term measure, and wanted such controls to apply to all institutions, including nursing homes.

But to the extent that that is done, you would not be dealing with just 6,000 providers—but with many times that number, and that would make the burden of administering a controls program that much greater. We really cannot complain. The administration has singled out hospitals as the way to begin. We might wish to broaden it, but we will take what we can get at this point.

Now, as to the last part of your question as to quality of care—will quality of care suffer? We do not think it should.

But the term "quality of care" is one of the most illusive of concepts. Organized medicine raises this as a means of scaring people. I do not know if I can define quality of care. Is it the number of CAT scanners or the number of cardiac units we have per capita?

What we do know is that the term "quality of care" is always used when someone is coming in to oppose some kind of change. They say, "We've got to keep things the way they are or quality will suffer." While I cannot define what quality of care is, I do know the absence of quality when I see it. There have been many nursing home scandals in the last ten years that demonstrate that sort of thing. The news media reveals an institutional scandal that exposes the absence of quality of care.

Nonetheless, we have difficulty dealing with it the concept.

Senator KENNEDY. Do you have any definition of what quality of care is?

Mr. HACKING. No, but we do know nonquality.

Senator KENNEDY. We thank you very much for your testimony.

[The testimony of Mr. Hacking follows:]

STATEMENT

of the

NATIONAL RETIRED TEACHERS ASSOCIATION

and the

AMERICAN ASSOCIATION OF RETIRED PERSONS

on the

HOSPITAL COST CONTAINMENT ACT OF 1977

before the

SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

of the

COMMITTEE ON HUMAN RESOURCES

U.S. SENATE

June 21, 1977

I am James M. Hacking, Assistant Legislative Counsel, for the 10.7 million member National Retired Teachers Association/American Association of Retired Persons. I would begin by pointing out that there are a total of 22.4 million elderly persons 65 years of age or older today. The over 65 group represents one out of every ten persons in the United States. In addition, persons age 55 to 65 years old share many of the health concerns of the over 65 group. The 55 year old and over population in the United States now totals 42.2 million, or nearly one out of every five persons. Two of the most important concerns of the older population are access to health care and the cost of health care.

There is no doubt that Federal legislation dating back to 1965 has greatly increased the access of the elderly and the poor to health care.[1/] However, Congress was overly generous to health care providers when it determined the method under which these providers, especially hospitals would be reimbursed. The "reasonable cost" formula for reimbursement of hospitals under Medicare disregarded the procurement safeguards of the Federal Government, dating back to the colonial days. Cost-plus reimbursement procure-

1/ "Effects of Medicare and Medicaid on Access to and Quality of Health Care", Avedis Donabedian, Public Health Reprots, July-August, 1976.

ment without renogotiation is a hand into an open Treasury.

Hospital costs prior to Medicare and Medicaid had already demonstrated a pronounced tendency to rise at rates higher than prices in general. Between 1950 and 1965 the Consumer Price Index (CPI) showed an increase in the costs of semi-private hospital rooms of 2 1/2 times, whereas the general level of prices rose over the same period only by one-third. The Federal Government's method of reimbursing costs by blank check to the hospital providers under Medicare has been adding gasoline to the older inflationary fires. Third party payments now make up 91 per cent of the income of hospitals. Under third party payment procedures, the patient, the government and the private insurance company all fail to raise any kind of a restraining hand against rising costs. Indeed, the government has been using as intermediaries for their disbursements the same insurance companies who are doing private business with the providers; these intermediaries have no incentive to be tough with the providers for the purpose of conserving public funds. The organization and purpose of hospitals may greatly vary; most, however, were organized to serve communities rather than to exist as carefully run businesses. The consequences of pouring money into hospitals under these circumstances should not surprise any of us.

Since 1966, the post-Medicare period, charges for the semi-private room took off for the statosphere with annual increases averaging 14.8 per cent through June 1971. Phases I through IV of the Economic Stabilization Program that existed between August 1971 and April 1974, restrained the rate of increase as measured by the CPI to 5.7 per cent annually. After the controls were lifted in December 1974, the charges for semi-private rooms resumed their rocketing course with annual price increases again averaging around 15 per cent.[2/]

Since 1973, our Associations have been pressing for reforms in the methods under which the Federal Government reimburses hospital care. We have also been working to restructure what has been called the delivery system of the health care industry. That delivery system is overly centered on the acute-care hospital.

Our Associations strongly believe that the preferable way to control the rise in hospital costs is to create a variety of health care facilities throughout the urban and rural areas of the country so that the demand on acute-care,

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2/ Table IV, The Problems of Rising Health Care Costs, Staff Report, April 1976, Council on Wage and Price Stability.

high-cost, in-patient hospital facilities is greatly lessened. The promotion of health maintenance organizations, intermediate and long-term care facilities, community health centers, smaller clinics of all kinds, and home health care should tend to lower costs by creating alternatives to highly specialized care in the acute-care hospitals. The fact that hospitals are not competitive does not preclude the fostering of competition in the health sector of the economy as the ultimate means of dampening inflation. The type of competition we have in mind is the product competition that would result from encouraging the growth and expandion of alternatives to costly in-patient hospital care. We recognize that there will never be an orderly, competitive market for health care, but the promotion of a variety of health care facilities can only tend to take price pressure off hospitals with respect to in-patient and out-patient facilities. At the same time, these varied facilities will tend to complement the differing health care needes of the elderly and other age groups in the population.

Unfortunately, since Phase IV controls expired in 1974, there has been little change in the national dependence on the hospital as the keystone of its health structure. Thirty-nine per cent of the nation's health bill was spent on hospitals in 1974. In fiscal 1976, the U.S. Dept. of Health

Education and Welfare estimates that 40 per cent of the $139.3 billion spent by the nation on health was spent on hospitals.[3/]

Also, since 1974, reform of the Medicare and Medicaid disbursement systems has been mostly a matter of debate rather than action. Our Associations have been urging that the Federal Government at least limit their liabilities for Medicare payments within the limits of prospectively set budgets, and rates for hospitals and all other institutional providers.

In the absence of real payment reform, per capita health care expenditures were $638 in 1976, up from $495 in 1974, with the government meeting about 40 per cent of the bill.[4/] Of course, the public ultimately bears all these costs via taxation.

Including the years of controlled expenditure, health expenditures for Americans have increased by an average of 12 per cent a year since 1965. The 1976 expenditure of $139.3

3/ Research and Statistics Note. No. 27, Dec. 22, 1976. U.S.Dept. HEW,SSA., Division of Health Statistics.

4/ Research and Statistics Note.-No. 27, Dec. 22, 1976. U.S. Dept. HEW, SSA., Division of Health Statistics.

billion is 3 1/2 times the expenditure of $38.9 billion 11 years ago. Over this period, hospital expenses have quadrupled and physicians' fees have tripled. What is so alarming is that for the two year period 1975 and 1976, national health expenditures grew at an annual rate of 14.5 per cent. For the health care expenditure component of the total national health bill, some 78 per cent of the increase is due to price; the remainder of the increase is attributable to population growth and to changes in inputs to the system. When we keep in mind that the larger part of the increase in national health expenditure is a price increase, it can be seen that price increases in this sector are very much larger than general increases in consumer prices for the same two years. (The CPI increased at an annual rate of 7.0 per cent during 1975, and 4.8 per cent during 1976.)[5/]

If nothing effective is done soon to remedy the problem, the highly inflationary trend in the health sector will continue and bring with it increasingly serious consequences.

First, health care will consume an ever increasing proportion of our gross national produce (GNP). Health spending as a portion of GNP has grown from 5.9 per cent in fiscal 1965 to 8.6 per cent in fiscal 1976.

5/ Social Security Bulletin of April 1977, "National Health Expenditures, Fiscal Year 1976", and Bureau of Labor Statistics.

Second, the proportion of federal and state budgets allocated to cover the cost of the present level of Medicare/Medicaid benefits will continue to grow, compete against, and perhaps, crowd out (or be crowded out by) other priorities.

Third, the financial viability of the Medicare/Medicaid programs will be seriously impaired (unless taxes are continually increased). Indeed, the 1976 Hospital Insurance Trustee's report projected that the trust fund, as a percentage of a year's disbursement, could decrease steadily over the next ten years and be completely exhausted in the mid 1980's.

Fourth, increasing numbers of elderly persons, even with Medicare/Medicaid protection, will be priced out of the health care market and denied access to needed care. The Social Security Administration has computed that in 1967, Medicare's first year of full operation, the average bill for an aged person was $532, of which 31.8 per cent was paid by Medicare. By 1975, the average bill had doubled to $1,052 of which 40.3 per cent was paid by Medicare. The program had picked up 9 per cent more of the tab, but in the meantime, the health bill had doubled. The elderly person is responsible for meeting the difference out of his own pocket or through some type of supplementary insurance.

While the Medicare/Medicaid programs were designed to extend to the elderly a large measure of relief from medical bills, the excessive and chronic inflation that has continued for the last decade in the health sector has defeated this laudable objective. Out-of-pocket health care expenses for the elderly were $390 in 1975, up 65 per cent from 1966 outlays of $237.[6/]

The 1960-61 consumer expenditure survey (used to revise the consumer price index every ten years) found that medical expenditures consumed 10.2 per cent of the average elderly family unit's budget; the new 1973 consumer expenditure survey (taken long after the advent and expansion of the Medicare/Medicaid programs) found that medical expenditures still consume 10.2 per cent of the elderly family unit's budget - despite the programs.

Finally, prospects for any significant expansion of Medicare/Medicaid protection will diminish and the goal of national health insurance will become increasingly remote. For years our Associations have urged the addition of an out-of-institution drug benefit under Medicare, a catastrophic protection feature and other Medicare and Medi-

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6/ Table page 25, Part I, Developments in Aging: 1976, Report Special Committee on Aging, U.S. Senate.

caid program benefit expansions. However, the realities of the situation are that unless we get control over the spiraling costs of the programs we already have, not only will we not go forward to expand them and achieve the goal of comprehensive health care protection for all citizens, but we will end up going backwards.

For us, the choice is simple: either we drastically cut the rate of inflation in the health sector now and thereby contain the spiraling costs of Medicare and Medicaid (without merely shifting those costs onto the beneficiaries) or we face the growing prospect that Medicare and Medicaid benefits will be cut. The only ones who can benefit from a perpetuation of the status quo are the providers of health care services.

Our Associations felt that the consequences of continued uncontrolled health care inflation were so grave that we urged the 94th Congress to create legislation to cap hospital costs and doctor's fees until effective reforms could be introduced to moderate rates of inflation. We are pleased that the Administration has come forward with its proposal (S. 1391) for it contains many features of our recommendations of a year ago - notably that caps be placed on cost increases for all classes of patients using hospitals. It has always seemed highly inequitable to us that private

patients not insured under private or government health plans or programs should have heavy costs shifted to them as a result of containment measures. If cost containment is to be meaningful and effective, it should be a general restraining hand and not a containment that can be subverted by bookkeeping tricks. We are pleased to give our endorsement to S. 1391, subject to the following comments:

First, we believe that any formula for determining allowable annual increases in hospital costs, plus exceptions granted, should not result in an annual increase in hospital costs which represent price rises more than 50 per cent higher than rises recorded for goods and services in the general economy. We would like a target of 3 years within which price inflation in the hospital sector would be brought down to the general index of prices.

Second, we are opposed to broad exemptions in advance under the bill for any class of expenditure, whether or not those exemptions are for wages or for malpractice suit insurance, or for any other type of expenditure. These simply invite cost increases and thus could defeat the purposes of the bill. An initial rate of increase in annual hospital costs 50 per cent higher than the general economy provides ample leeway for the hospital industry to brake their costs without injury to any interests. What is needed is a cap to hospital costs, - and not a hair-net.

Third, we would encourage the shift of controls from the Federal Government to State Hospital Control Boards or Agencies. We believe that attempting to control the costs of some 6000 plus hospitals out of Washington, D.C. for an extended time will be decreasingly effective. Controls should be de-centralized as rapidly as possible to the States which are familiar with the institutions within their boundaries and which are able to meet with unique conditions in an expeditious manner. However, the Federal Government must remain responsible for reviewing the effectiveness of state administration.

Fourth, we should face the fact that hospitals in some areas have been overbuilt, with the consequence that the country is carrying an expensive type of unused capacity. It is not enough to discourage over-building from this point in time. Incentives should be given to hospital managements to cut down on unneeded beds in an orderly manner. In New York State, where they are compelled to exercise economies, surplus beds have been reduced by what has been called the "meat-axe" approach. We are concerned that the public will suffer where other community health facilities are not substituted for eliminated hospitals.

Fifth, the imposition of the new controls provides an opportunity to reform compensation procedures for all hospital services from a retrospective to a prospective budgeting

basis with rate setting. Severe financial penalties cannot be the long-term answer to containing hospital budgets within targeted limits for increases. Hospitals are run by people. The stick will eventually have to be supplemented by a carrot. Savings should be shared with hospital staff, thereby creating a powerful incentive to make the savings.

Sixth, with the reservations expressed, we believe that the controls under S. 1391 are an improvement over the Phase IV regulations of the Economic Stabilization Program. However, the Phase IV regulations apparently gave us only temporary relief, following which hospital costs advanced at higher rates than ever before.[7/] This has been

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7/ Some economists have disputed the efficacy of the ESP in its application to the health sector. For example, Professor Paul Ginsberg of Duke University, in an analysis of the impact of the economic stabilization program on hospitals, asserts that, while the program did restrain hospital employee wage levels somewhat, the structure of the program was such that it did nothing to change the trend toward substantial increases in factor inputs per admission or per patient day.

Moreover, he asserts that focus on the CPI gives a misleading impression of what really happened to hospital costs during the control period. The problem is the use of charge data from the Consumer Price Index instead of data on revenue per unit of output. With the extensive use of third-party cost reimbursement, charges are paid only by a minority of patients. Thus, a series of charges is an imperfect indicator of revenues. This may have been the case for ESP. From 1971 (2d quarter) to 1973 (2nd quarter), semi-private room charges increased at an annual rate of 5.8%, while inpatient revenues per inpatient day increased at a 9.3% annual rate. Hospital charges were much easier to monitor than revenues from reimbursement of costs and this is the proper cause of this large discrepancy.

explained as a catch-up process. We believe that attempting to control the costs of providers of services to the government through specifying the character of the budgetary controls of the provider only creates the illusion of controlling costs. Basically, this is an approach of government to controlling the costs of its own operations; we know that the costs of government march upwards inexorably year after year. We all know that we cannot shoot hospital managements if they exceed their budgets. We cannot, also, shut down the hospitals by punishing financial penalties, if there are no alternatives to their medical facilities. Hospital managements claim that the usage to which their hospitals are put must be controlled, - and that their costs are not rising uncontrollably. Personnel per patient has been rising and more sophisticated equipment is being used in diagnosis and treatment. There is growing evidence that there is merit in the claim that cost increases in the hospitals partly reflect what the economists call an increse in the inputs to the cost flow. A study of the Council on Wage and Price Stability supports the view that the larger part of the rise in cost per patient day is from the changing character of hospital care.[8/]

[8/] Page 20, The Rapid Rise in Hospital Costs, Council on Wage and Price Stability, Staff Report, January 1977.

The weight of the evidence is that costs are not closely controlled in institutions where there is no real compulsion to conserve funds.

We look upon S. 1391 as a bill to give us temporary relief from rising hospital costs. We hope that with the time gained thereby that reimbursement methods for providers will become meaningful prices rather than loosely controlled costs. Certainly, large elements of hospital costs may be determined in advance.

Our Associations find it curious that Congress is almost exclusively concerned with controlling the health care system via cost regulations. It is almost as if we did not strengthen the Anti-Trust laws last year with the intent of making prices do a better job in providing commodities and services of better quality at lower prices in non-health care sectors of the economy. But in health care, we tend only to look to budget controls, even though it is recognized that budgets are most imperfect control mechanisms.

Budgets tend to rise unless those who control know as much about the expenditures as those who spend. The Federal Budget gives us the illusion of control, so we seek to spread its operating precepts to the private sector. Our Associations believe that budgeting techniques have serious limitations for controlling the health care industry

both with respect to operating expenditures and capital expenditures.

Prices and profits in the private sector direct capital expenditure in many ways which cannot be foreseen by a central planning method. If there are too many motels in a city, prices for motel rooms fall with the consequence that motel building is discouraged and capital is directed into other types of housing. However, if there are too many hospital rooms and beds in a city, prices do not do their job of automatically redirecting investment. The reason why the prices for hospital rooms do not signal a change in investment is that third party payers pick up virtually all costs. The feedback to Congress is slow. Years after over-building takes place it is found that in many urban areas there is an excess of beds and a surplus of special facilities. The Hill-Burton Act, Federal tax exemptions on interest of construction financing, Federal tax expenditures for health care insurance, and government use of health care insurance at all levels have all been powerful stimulants to the construction and utilization of hospitals. Congress is now seeking to reverse a large mis-allocation of our national health resources, either by caps on hospital expenditures or by various forms of regulating and budgeting.

In the President's Message to Congress of April 25, 1977 on the Hospital Cost Containment Act of 1977, it was suggested that competition be strengthened in the health industry. Indeed, why is not more pricing tried as an alternative to mountains of regulations? In the vernacular of the bill, funds flow to hospitals either via those who reimburse costs or those who reimburse charges (charges representing prices). If Medicare dropped its allowable cost formula and became a charge payer for the bulk of the ordinary care in hospitals, a basis for competition would be introduced. Obviously, physicians would no longer be completely free to place their patients in the most expensive hospital in town. This would represent a sharp departure from traditions in the medical profession. However, less pleasant restraints on their freedom of action may be in the wings, if exploding costs in health care are not brought under control.

Additional competition could be introduced into the hospital sector by converting the insurance payers from cost reimbursers to charge reimbursers for common treatments. (Cases out of the ordinary could be continued on a cost reimbursement basis.) Incentives could then be used so that between the patient and the doctor the more expensive charges in a city would not be acceptable.

In the health care industry it is not in the public interest that the insurance industry reimburse hospitals, particularly where there is a surplus of beds available, without regard to economics. The better run hospital should get the business. Certainly the insurance industry does not reimburse the insured car owner for damage repairs without regard to competitive prices. As long as health insurance is assisted by Federal Government tax expenditures, the health care insurance industry should not be held free to follow practices, which run up pirces in the health care industry.

Our Associations are suggesting that the hospital industry should not be held outside of the ordinary laws of market economics. Given a choice between the cold winds of the competition or the volumes of regulations needed to keep some restraint on cost reimbursement, hospital managements are likely to go along with proposals to cut down on their cost plus reimbursed business. A study of the various proposed Federal Government reforms for restraining cost rises in Medicare reimbursement, such as S. 1470, the Medicare and Medicaid Reimbursement Reform Act of 1977, should convince Congress that the law of diminishing returns has begun to apply to the annual output of Federal law and regulations on allowable costs and reasonable charges. Our

Associations support these reforms but we recognize that the savings brought about under new regulations are likely to be much less than the year-to-year increases in the cost of health care.

We have suggested that competition be used to help cut down on the costs of hospitalization. Our Associations also favor a shift in emphasis from acute care hospitalization to ambulatory facilities of many kinds such as community and neighborhood health care centers, smaller clinics conveniently located for the elderly and the poor, clinics partly manned by para-medics, and home care. Our Associations also favor the development of Health Maintenance Organizations and many forms of preventive care.

The present approach to diversifying the health care delivery system is that it will be brought about through laws and regulations and planning agencies and review boards of various kinds. Our Associations believe that this central planning approach to the health care industry will bring very slow results and that its costs will be high. Our Associations would hope that competitive and substitute prices can be promoted so that health care facilities will be developed by private initiative which will represent less expensive (and more convenient) facilities than the large institutions favored today. Regretably, the prospects are

not very bright for the things we want because the health care industry has become one of the most regulated fields of activity in the country. Nevertheless, we hope that choices via prices can be emphasized as opposed to reimbursing costs under protective regulations.

Our Associations believe that the Hospital Cost Containment Act of 1977 provides an opportunity for Congress to impose appropriate disclosure requirements on hospitals whose revenues now flow to the extent of 90 percent from third party payers (Federal, State, and County government sources and private insurance firms). Private insurance receives substantial support from the Federal Government in the form of tax expenditures on behalf of business and individuals.

The disclosure requirements of Sec. 125, Part B of the bill appear to us to be inadequate to expose the abuses of public funding which come to light year after year in testimony before Congress. If a hospital receives more than fifty percent of its revenue from third party payers, our Associations believe that not only rigorous disclosure requirements are needed, but that conflict of interest statements are needed from owners or the management, or both.

The public should be able to obtain from hospitals

copies of all reports made to government on appropriate notice. The public should be able to obtain information concerning the total amount of reimbursement of all kinds made to the top ten percentile of its employees ranked in dollar terms and also of the total reimbursement to outside providers of medical services, who are paid more than $30,000 per year. Some sunshine should be thrown on the outside billings of anesthesiologists, pathologists, and radiologists who practice in hospitals. Conflicts of interest should be on file for the owners, trustees or directors, the top management, and anyone in the hospital responsible for purchasings, contracting or leasing services and goods and making capital acquisitions. An extended statement of disclosure requirements for hospitals was made by the AFL/CIO on May 11, 1977 in the testimony of Andrew J. Biemiller on S. 1391 before the Health Subcommittess of the Ways and Means and Interstate and Foreign Commerce Committees. We endorse these proposed disclosure requirements in full.

APPENDED STATISTICAL INFORMATION

TABLE NO. 1 - HEALTH EXPENDITURE COSTS OF THE ELDERLY ON A PER CAPITA BASIS DISTRIBUTED BETWEEN OUT-OF-POCKET AND OTHER SOURCES OF PAYMENT.

TABLE NO. 2 - ESTIMATED AMOUNT, PER CENT DISTRIBUTION, AND PER CAPITA HEALTH CARE EXPENDITURES FOR PERSONS 65 YEARS AND OVER, FISCAL YEAR 1975.

TABLE NO. 3 - NATIONAL HEALTH EXPENDITURE BY SOURCE OF FUNDS ON A PER CAPITA BASIS

TABLE NO. 4 - POPULATION BASIS FOR COMPUTING PER CAPITA BASIS OF HEALTH EXPENDITURES

TABLE NO. 5 - TOTAL POPULATION IN THE OLDER AGES

TABLE NO. 6 - NATIONAL PERSONAL HEALTH CARE EXPENDITURES - HOSPITAL CARE AS A PER CENT OF TOTAL

TABLE NO. 7 - PRICE INCREASES CPI ALL ITEMS COMPARED WITH MEDICAL CARE ITEMS.

TABLE I

HEALTH EXPENDITURE COSTS OF THE ELDERLY ON A PER CAPITA BASIS DISTRIBUTED BETWEEN OUT-OF-POCKET AND OTHER SOURCES OF PAYMENT

Selectee Year 1966 and 1975

	TOTAL	DIRECT OUT OF POCKET	Third Party Payments			
			TOTAL	GOVERN-MENT	INS.	OTHER
1966	$445	$237	$209	$133	$71	$5
1975	$1360	$390	$970	$892	$73	$5

Abstractef from a table prepared by Herman Brotman, consultant, appearing on Page 25, Part I, Development in Aging: 1976, A Report of the Special Committee on Aging United STates Senate.

TABLE NO. II

ESTIMATED AMOUNT, PER CENT DISTRIBUTION, AND PER CAPITA HEALTH CARE EXPENDITURES FOR PERSONS 65 YEARS AND OVER, FISCAL YEAR 1975.

Type of expenditure	Total	Source of funds			
		Private	Public		
			Total	Medicare	Other
		Amount (in millions)			
Total	$30,383	$10,466	$19,917	$12,749	$7,169
Hospital care	13,467	1,379	12,088	9,719	2,369
Physicians' services	4,662	1,987	2,675	2,628	247
Dentists' services	540	502	38	0	38
Other professional services	441	220	221	167	54
Drugs and drug sundries	2,629	2,285	344	0	344
Eyeglasses and appliances	506	498	8	0	8
Nursing-home care	7,650	3,571	4,079	234	3,845
Other health services	268	24	264	0	264
		Percent distribution			
Total	100.0	34.4	65.6	42.0	23.5
Hospital care	100.0	10.2	89.8	72.2	17.6
Physicians' services	100.0	40.9	59.1	54.1	5.1
Dentists' services	100.0	92.9	7.1	0	7.1
Other professional services	100.0	49.8	50.2	38.0	12.2
Drugs and drug sundries	100.0	86.9	13.1	.0	13.1
Eyeglasses and appliances	100.0	98.4	1.6	.0	1.6
Nursing-home care	100.0	46.7	53.3	3.1	50.3
Other health services	100.0	8.2	91.8	.0	91.8
		Per capita			
Total	$1,360.16	$468.53	$891.63	.....	.....
Hospital care	602.89	61.75	541.14	.....	.....
Physicians' services	217.66	88.96	128.69	.....	.....
Dentists' services	24.17	22.45	1.72	.....	.....
Other professional services	19.74	9.83	9.91	.....	.....
Drug and drug sundries	117.66	102.30	15.36	.....	.....
Eyeglasses and appliances	22.65	22.29	.36	.....	.....
Nursing-home care	342.47	159.88	182.58	.....	.....
Other health services	12.89	1.05	11.84	.....	.....

NOTE: Preliminary estimates.

SOURCE: Social Security Administration, Office of Research and Statistics: Age Differences in Health Care Spending, Fiscal Year 1975. Research and Statistics Note No. 11. DHEW Publication No. (SSA) 76-11701. U.S. Government Printing Office, Washington, D.C., 1976.

TABLE III

NATIONAL HEALTH EXPENDITURE BY SOURCE OF FUNDS ON PER CAPITA BASIS SELECTED FISCAL YEARS 1950-1976

FISCAL YEAR	PER CAPITAL TOTAL	HEALTH EXPENDITURES PRIVATE	PUBLIC
1950	$ 78.35	$ 58.38	$ 19.97
1965	197.75	149.27	48.48
1966	211.56	157.15	54.41
1967	237.93	159.15	78.78
1968	264.37	165.83	98.54
1969	295.20	183.50	111.70
1970	333.57	211.18	122.39
1971	368.25	230.92	137.32
1972	409.71	251.50	158.20
1973	447.31	275.35	171.96
1974	495.01	301.74	193.27
1975	564.35	329.48	234.87
1976	637.97	368.61	269.36

ABSTRACTED FROM CHART NO.1, NATIONAL HEALTH EXPENDITURES, FISCAL YEAR 1976, SOCIAL SECURITY BULLETIN, APRIL, 1977

TABLE IV

POPULATION ESTIMATES FOR COMPUTING
PER CAPITA BASIS HEALTH EXPENDITURES

YEAR	TOTAL U.S. POPULATION (THOUSANDS)
1950	153,513
1965	196,671
1966	199,038
1967	201,234
1968	203,369
1969	205,345
1970	207,457
1971	209,539
1972	211,583
1973	213,238
1974	214,783
1975	216,587
1976	218,368

PAGE 22, "NATIONAL HEALTH EXPENDITURES," FISCAL YEAR 1976."
SOCIAL SECURITY BULLETIN

TABLE V

TOTAL POPULATION IN THE OLDER AGES
ESTIMATES AND PROJECTIONS

YEAR	55 YEARS AND OVER (000)	65 YEARS AND OVER (000)
Estimates		
1950	25,793	12,397
1960	32,299	16,675
1970	38,749	20,085
1975	42,180	22,400
PROJECTIONS		
1980	45,570	24,523
1990	49,412	28,933
2000	53,537	30,600

ABSTRACTED FROM TABLE 2-1, "TOTAL POPULATION IN THE OLDER AGES AND DECENNIAL INCREASES: 1900 to 2040," CHAPTER II, CURRENT POPULATION REPORTS, SPECIAL STUDIES, SERIES P-23, NO. 59, MAY, 1976.

TABLE VI

NATIONAL PERSONAL HEALTH CARE EXPENDITURES
HOSPITAL CARE AS PERCENT OF TOTAL

RECENT TRENDS 1974-1976

YEAR	TOTAL (Millions)	HOSPITAL CARE (Millions)	PERCENT OF TOTAL
1976	$120,431	$ 55,400	46.0
1975	$105,745	$ 48,224	45.6
1974	$ 91,315	$ 41,020	44.9

DATA FROM TABLE 3, "NATIONAL HEALTH EXPENDITURES,"
FISCAL YEAR 1976, SOCIAL SECURITY BULLETIN, APRIL 1977

TABLE VII

PRICE INCREASES CPI ALL ITEMS
COMPARED WITH MEDICAL CARE ITEMS
SELECTED FISCAL YEARS, 1965-1976

Fiscal Year	CPI ALL ITEMS	MEDICAL CARE TOTAL	HOSPITAL SERVICE CHARGES	HOSPITAL SEMI-PRIVATE ROOM CH.	PHY-SICIANS FEES	DEN-TIST FEES
1965	1.3	2.1	-	5.3	3.1	2.9
1966	2.2	2.9	-	6.1	3.9	2.9
1967	3.0	6.5	-	17.3	7.1	4.5
1968	3.3	6.4	-	15.9	6.1	5.2
1969	4.8	6.5	-	13.5	6.1	5.8
1970	5.9	6.4	-	12.8	7.2	6.8
1971	5.2	6.9	-	13.3	7.5	6.0
1972	3.6	4.7	-	9.4	5.2	5.7
1973	4.0	3.1	-	5.0	2.6	3.1
1974	9.0	5.7	4.8	6.0	5.0	4.4
1975	11.0	12.5	11.1	16.4	12.8	10.8
1976	7.1	10.2	13.4	15.2	11.4	7.7

SOURCE: BUREAU OF LABOR STATISTICS, CONSUMER PRICE INDEX

Senator KENNEDY. We will stand in recess.

[Whereupon, at 11:27 a.m., the subcommittee adjourned, subject to the call of the Chair.]

HOSPITAL COST CONTAINMENT ACT, 1977

WEDNESDAY, JULY 6, 1977

U.S. SENATE,
SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
OF THE COMMITTEE ON HUMAN RESOURCES,
Bangor, Maine.

The subcommittee met, pursuant to notice, at 12 o'clock noon, in the city council chambers, city hall, Bangor, Maine, Senator William D. Hathaway presiding pro tempore.

Present: Senator Hathaway.

Senator HATHAWAY. The Subcommittee on Health and Scientific Research will come to order.

OPENING STATEMENT OF SENATOR HATHAWAY

Senator HATHAWAY. I would like to welcome you to this hearing on health cost containment held by the Senate Subcommittee on Health and Scientific Research of which I am a member. The committee, as you probably know, is chaired by Senator Kennedy of Massachusetts. We hope to gather testimony on President Carter's Health Cost Containment Act, which I introduced along with Senator Kennedy.

It has become clear that Congress must make an attempt to control health care inflation, which has driven hospital costs and other medical costs sharply upward in the past few years.

By way of illustrating how much those costs have gone up, let me say that 20 years ago health care cost about 5 percent of our gross national product. Today, that same health care eats up more than 8½ percent of our GNP. While not as visible as our energy crisis, this health cost crisis is in many ways just as serious and just as dangerous to our society's financial well-being.

Just as the energy cost increases can cause our standard of living to decline, so can ever increasing health care costs cause us to neglect other areas of human need.

Nearly 12 cents of every Federal dollar now goes to pay for health care, and 9 of that 12 cents goes to pay for the cost of hospital care. Hospital costs eat up 40 percent of the Nation's health care budget. And those costs have been going up at a rate faster than the cost of living for the past 20 years.

Now, in 1965 an average hospital stay cost less than $300. Now that same average stay costs more than $1,300, and Americans now find themselves working more than 1 month out of every year just to pay for their health care needs. Private health insurance premiums

have risen 15 to 29 percent, and the end of the spiral is no where in sight. In fact, the spiral doesn't even appear to be slowing down. The cost of a hospital stay in 1976 increased an amazing 15 percent—a figure 2½ times as great as the increase in the Consumer Price Index and higher even than the increases in the cost of food and energy. I agreed to cosponsor President Carter's Health Cost Containment Act because I strongly agree with its overall goals. The administration claims that it will save about $2 billion in 1978 and as much as $5.5 billion by 1980.

The savings will come about through limiting inpatient reimbursements of acute care hospitals, discouraging unnecessary hospitalization, and through other areas of cost containment. While I believe in the goals of the legislation, I also agree with those of my colleagues who feel that we should move only with great caution in this area.

But whatever we decide to do, we must find ways to encourage hospitals to operate more efficiently. We must look at rising costs not only in hospitals, but eventually also in nursing homes and intermediate care facilities. We must make sure that cost controls do not lead to a decline in patient care. We must make sure that costs beyond the control of hospitals, such as energy costs, are taken into account.

We need also to be concerned about problems of access and quality in rural areas. In a fundamental sense, the health manpower shortages, lack of transportation and rural poverty impact on the goal of this legislation. The way health care is financed and delivered depends on many factors, and Federal policy must address hospital cost containment with the broader questions of access, cost, equity, and quality in view.

These questions, and a good number of others, will have to be answered as we study the President's proposal. And these are some of the questions we hope will be addressed at the hearings here today.

I might add that at the time the President asked me, or the secretary really of HEW, asked me to cosponsor the bill, I declined to do so because I knew that it would have a severe impact on the rural hospitals. I didn't think that some of the provisions were very realistic, and it was only after considerable pressure that was borne upon me that I agreed to cosponsor it; and as many of you probably know, my statement in the Congressional Record at the time of the cosponsorship was akin to that of Paul Rogers, the chairman of a similar committee in the House, expressing a great deal—a great many caveats about the bill and introducing it for the sole purpose of getting hearings on it and finding out just exactly where we could contain costs.

The hearings are today, I think, extremely important because up to this time we have had very little testimony with respect to the impact on rural hospitals. The subcommittee will be going into a markup of the bill, which means amending the original legislation, the original bill as submitted, sometime next week; and then it will go from there to the full committee and be on the floor, I presume, before the first of August. I think the President would like to see some bill enacted as a matter of fact before the first of August. I want to reiterate that these hearings are extremely important because it will give me the necessary background to make the case for rural hospitals when we go into markup of this bill sometime next week.

Our first witness, we have eight witnesses today. I understand we have to be out of this room by 3 o'clock. We should have plenty of

time. Our first witness for the panel, Mike Samuels, Ph. D., Bureau of Community Health Services, HEW, and Isadore "Sam" Seeman, Planning and Evaluation, from HEW.

Gentlemen, it is nice to have you here.

STATEMENT OF ISADORE "SAM" SEEMAN, PLANNING AND EVALUATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. SEEMAN. Senator Hathaway, we appreciate the chance to be here and have an interchange with you on this program. I would like to take a few minutes, if I might, and summarize the administration's position in presenting the bill. Some of what I will say will underscore what you have indicated, because those of us in the administration who are looking at hospital cost increases and health care increases identify the same problems as you have. We think there clearly is a problem that is a concern to all who have responsibility to help pay for health care. Consumers are concerned about it. Policy makers at the State level are concerned because of the medicaid program. Policymakers at the Federal level are concerned because of the impact on the Federal budget for purchasing hospital and health care. When looked at from the point of view of the consumer as you, yourself, cited, private health insurance premiums have been going up 15 to 20 percent a year. That obviously has a very major impact on all who purchase health insurance and that is most of the American people.

One clear illustration of the impact of increasing costs is the impact on the purchase of health care by Federal employees. The Blue Cross premiums for Federal employees last year rose 33 peecent. The payments by the Federal Government itself when we buy care for the aged through medicare and for the poor through medicaid have been increasing at very rapid rates. Medicare and medicaid expenditures in 1975 totaled $32 million. That represented—that plus what the States put in for medicaid represented 25 percent of all national health expenditures. And as you cited, it constituted 11 percent of the total Federal budget for all purposes. Medicare and medicaid expenditures and State and local payments for hospital care are increasing about $4 billion a year. That money, as you pointed out, is also needed for other important health purposes and social welfare purposes. It drains those needs to continue to pay these increases for hospital care.

From whatever short or long view one takes, one recognizes that the increases for hospital care have been very unusual, not comparable to any other sector of the economy. If you look at the period from 1965 through 1971, the general Consumer Price Index went up 4.1 percent while hospital expenditures went up 13 percent. If you take a more recent period, 1974 to 1975, general Consumer Price Index went up 10.6 percent while hospital expenditures went up 17.6 percent. So clearly there is a problem that is of concern to all who pay for hospital and health care.

The administration felt that it was a special concern that needed special attention; and, therefore, proposed the remedies that are set forth in the Hospital Cost Containment Act. And if I might, I would like to just summarize those provisions very briefly. As we all know, what is proposed is the ceiling on the increase in the rate of payment and not on the levels themselves. This ceiling would apply to acute care hospitals. The limit would be set by a formula that takes into

account the general consumer price index so that it does, in fact, recognize that hospitals have to pay more for the things they buy; and the base factor in the formula is the GNP deflator, which represents the average consumer price index change. In addition, we recognize that there are special factors that are driving hospital costs up. Factors generally referred to as "intensity factors," and that also is built into the formula. So there are two components that for the year 1978 would work out arithmetically to constitute a 9-percent increase—6 of it being represented by the general GNP and 3 by the intensity factors, and that formula would apply in future years, so that again both general increases and intensity increases are taken into account in the formula.

The limit would apply to each class of payors—Blue Cross, Blue Shield, medicare, medicaid, private purchasers, commercial insurance. Each class of payor would be guided by the limits that are applicable. Recognizing that these limits can't be applied uniformly and arbitrarily, there are some adjustments that are permitted, adjustments for patient load. And those adjustments are general adjustments but are recognition that there is a particular problem with small hospitals so that there is a different factor in the bill. Hospitals whose annual admissions are less than 4,000 a year, are given a little more generous treatment recognizing that since they are small hospitals they would have to expect wider ranges of admission changes.

There is a strong emphasis in the bill on attempting to make it administratively simple—requiring no new forms, no new audits, no new procedures, utilizing the medicare intermediaries. There is also an exceptions procedure. If there are major changes in the patient load or major increases in the capacity or type of service, the hospital could apply for an exception. The health systems agency would review and comment on them. The State health planning and development agency would make a recommendation, and HEW would then act on them. If no action is taken within 90 days, it is assumed that the exception is approved.

There is an important provision that recognizes the fact that in the past there have been low-wage workers in hospitals so that there is an adjustment for nonsupervisory employee wage increases. In fact, whatever increments are required on the basis of the hospital negotiations with its employees would be recognized and passed through.

There is a provision that would require hospitals to maintain their charity loads so there is not any suffering on the part of the low-income population. Where a State program exists and has existed for a sufficient period of time and is a program of the kind that meets the Federal standards, that State program could prevail instead of the Federal program where the Secretary approves and recognizes that.

Finally, there is in the bill an important provision dealing with capital expenditures since we recognize that in many places there are more hospital beds than are needed, and we recognize that overbedding is a very expensive operation, so that there is a capital expenditure limit; $2.5 million will be distributed among the States according to population initially and the applications for approval of expenditures within that limit to be reviewed by the health systems and State health planning and development agencies.

The bill clearly identifies this proposal as the shortrun, transitional plan. We recognize that the problem is a longstanding one and will

require longrun consideration with some new factors to be introduced. The bill requires the Secretary of HEW to present to the Congress a proposal for a longrun system. We have not worked it out, but we have identified some of the features. There are those who would like to see a system that recognizes the differences in hospitals through some kind of classification. We think that may be a part of the longrun system, but the data are not available to permit such a plan to go into operation now. Other elements of the longrun system would probably include modification in methods of reimbursement; for example, more emphasis on prospective reimbursements, perhaps more emphasis on application arrangements for health maintenance organization's permit. There probably would be some characteristics in the longrun system that affect the delivery system. Dr. Samuels will talk about the importance of primary care and ambulatory care. We see those as important elements of a longrun plan.

We also feel strongly that in the long run more emphasis will need to be given on prevention, on informing the consumer so that he can take be care on his own health and avoid some of the situations that lead to hospital care.

This is a summary of the proposals. I would be happy, after Dr. Samuels has made his presentation, to respond to your questions.

Senator HATHAWAY. Fine, thank you.

STATEMENT OF MIKE SAMUELS, PH. D., BUREAU OF COMMUNITY HEALTH SERVICES, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. SAMUELS. The focus of our hearings today is primarily the Hospital Containment Act, but I would like to thank Senator Hathaway for giving us the opportunity to discuss some of the complementary activities sponsored by the Administration of Rural Health. I think probably the most important consideration, as Sam has identified as the more longrun one, is to talk about this particular act in the context of containing costs across the health care sector.

I think a good way to visualize that is if we are talking about a health care system which in its simplest form consists of three levels—primary care, which is the care that is normally received in a practitioner's office; secondary care, services in the community hospital; and tertiary care, the teaching hospitals and medical schools. What happens is if any one of those particular sectors breaks down, then it has an impact on cost in the other sector. Let's take a very simple example. Let's say that working around the yard or something you do a simple laceration of your hand, nothing very major, something that just requires two or three stitches. If you have access to a primary care physician, we will talk about a cost of somewhere around $10 or $15; or if that particular practice employe nurse practitioners or physician's assistants, it may be even less. However, if you don't have access to that kind of primary care and you have to go either to the secondary facility or the tertiary facility, in the emergency room, then we are talking about a cost of $45 to $60. That is a cost that either the individual bears directly or through public programs that we all bear.

If we take some specific examples in public programs. I know of a situation, not in this State, where the reimbursement under medicaid

for prenatal care and delivery is so low that medicaid mothers can't actually receive that care in their home community. So as a result of that they commute 88 miles to deliver in a tertiary hospital; and the net result of that is if one considers the cost of prenatal care and delivery in their own community hospital as compared to just the delivery alone in a tertiary hospital, that is a cost of about three times as great. And that is a cost that is borne directly by the taxpayers. What we need to do in this longer run is to try to build some sort of a rational health care system, and it is our prospective that probably the weakest link in that system at this point in time are the so-called medically underserved areas, the majority of which are in rural areas but there are a large number in urban centers as well. What we have tried to do in the programs that I represent is to try to "build access"; that is, to put in, initially, cites that provide the primary care service as generally provided by any general practitioner's office with the expectation that these projects then develop what we call "systems building." In other words, making sure that the patient gets directed to the right place for the service that he needs at that point in time. So if it is something very simple, it gets taken care of in the office. If it is something extremely complicated, there is a way the doctor in primary care can get him to a teaching hospital and get information back on his patient and manage that case.

One of the examples I would cite—in fact the project director is here today—is the Kennebec Valley Regional Health Agency in Waterville, Maine, which provides services for Bingham and Somerset Counties. One of the things that they have noted over the last year is that the outpatient, the numbers of outpatient visits in the community hospitals have been rising at a rate of about 20 percent a year, and the cost of providing the service has been a problem. But as a result of having put in three necessary primary care clinics, we find now that this has leveled off in these outpatient services; and in general, the relationship between the clinics and the community hospitals has been a very pleasant one in the sense that the primary care clinics are doing what they are best equipped to do and do most economically. The same thing is true of the community hospitals.

However, the problem we get into in these small rural areas is: Even though that is the appropriate place to deliver the care, they have a lot of problems. There is high unemployment in these areas; but at the same time, the medicaid system doesn't always cover all those who are eligible. It is estimated nationwide that only about 40 percent of the rural poor actually are eligible for medicaid. In the case of the Bingham project, it is only about 12 percent. A lot of this probably relates to the fact that the rural people still have that curious custom of having intact families whereas the welfare system for the most part is directed at single-parent families. Also most rural people have very poor insurance coverage for the most part. In terms of the project itself, the title 18 and 19 reimbursement levels are sometimes too low. The scope of services they cover is not wide enough. There are situations where services of nurse practitioners and physician assistants are not facilitated either because of the reimbursement levels or because of the licensing laws or particular regulations.

The other thing I think that needs to be considered in cost containment hearings is that even if we can solve all those kinds of problems, in our rural areas we are still going to have population base problems.

In other words, we are not going to have a large enough population to support the kind of system that you could have in the urban center. So to some extent there probably is going to be some kind of subsidy there, but I would suggest that kind of subsidization would be fairly low compared to subsidizing the same kinds of primary care services as delivered through the emergency rooms in hospitals.

One of the considerations in handling this because of the large rise in the cost of manpower is that we develop reimbursement systems that pay for the service, and then let the particular practice or institution decide in what way they will deliver that service the most cost-effective way.

The other thing we can do, and we are trying to do this in some of our experimental projects, is to demonstrate clearly to State medicaid agencies that by paying for preventive services and primary care services that they can actually reduce their inhospital costs and their long-term hospitalization costs.

Another area that I might mention briefly where I think there is a chance for a lot of savings is in the area of home health. There are, again, some regulatory problems there in the sense of how home health is now defined. To actually meet those definitions, people really at that point in time should be in a hospital. But from an economic point of view, it is very difficult sometimes to draw the dividing line between those home health services that are truly medically necessary services as opposed to more social services kinds of assistants for people in their homes.

In conclusion, Mr. Chairman, I would suggest again in looking at the Cost Containment Act that it be considered only one part of the whole business of trying to contain costs and that from my particular perspective one of the best ways you can contain costs is by making primary care accessible to people in medically underserved rural and urban areas. It seems to me that you do two things. You not only contain costs, but you also provide health care to people who very desperately need it and also turn people into a system of health care that would see that they get the appropriate service they need at the appropriate time.

Senator HATHAWAY. Thank you very much.

Mr. Seeman, I have heard of some talk of taking the rural hospitals out of the bill; is that correct?

Mr. SEEMAN. Some consideration is being given to the question of hospital size, and certainly the rural hospitals would fall into that category. As we are proceeding with discussions with the committees in both houses, the interest in some modifications of the administration of the original bill certainly is clear; and there is some thought being given to the question of exempting.

Senator HATHAWAY. If these were dropped, how would that affect the total savings?

Mr. SEEMAN. Obviously it would depend on at what level one cuts it off.

Senator HATHAWAY. What level?

Mr. SEEMAN. I have heard discussions of bed size. As you know, in the bill itself the recognition of 4,000 admissions per year is a trigger that affects the way the hospital is treated with regard to the revenue allowed rather than 6 percent.

Senator HATHAWAY. But it is still covered.

Mr. SEEMAN. But it is still covered. It probably would not make a tremendous difference in total savings.

Senator HATHAWAY. So it might be a good idea——especially due to the fact that the National Health Service Corps and other health bills which were passed in the recent past have not really had a chance to take hold particularly in the rural areas and the cost savings might be affected—if we let them have a little more time to develop and see just what savings can be accomplished that way rather than coming at this stage and putting a cap on and telling them, you know, come hell or high water they have got to save that much.

Mr. SEEMAN. And looking at the Maine situation and preparing to come and meet with you today, Senator, out of the 54 hospitals in Maine, 42 of them would be affected by the 4,000 admissions or less cutoff so that a large number of hospitals in Maine are small, rural hospitals; and they would, therefore, profit by that modification.

Senator HATHAWAY. But the exceptions process is still pretty——

Mr. SEEMAN. Yes; and obviously we hope to——

Senator HATHAWAY. Modify it.

Mr. SEEMAN. Modify it and keep it to a minimum so that we don't get tied up too much in it.

Mr. SAMUELS. I think your point is well taken though about the impact of rural programs particularly the National Service Corps and that they are probably at least 2 or 3 years off of really having their full impact in rural areas. The major effort really just got underway last year. Also the impact for the new scholarship program for the National Service Corps probably will take some time.

Senator HATHAWAY. Right. Thank you.

In that interim period, say that we did—say that rural hospitals would be covered for at least a period of 3 years. We could help them in ways that would save them money. Showing them these very deficiencies you have talked about, and there must be some rural hospitals throughout the country that you would consider models with respect to cost savings. I doubt that there are many hospitals, or any hospitals in Maine, that aren't trying to save as much money as they possibly can. I think unlike the big city hospitals—we had hearings on those in Washington when they showed that the disparity of the costs are almost 50 to 75 percent between one big city hospital and another one, you know, providing basically the same service. Obviously, you know, cost savings could be affected in those large, metropolitan areas.

Mr. SEEMAN. I think you would find some receptivity on the part of the administration on this point and a readiness to keep an open mind on it.

Senator HATHAWAY. If the bill did pass in this session, how long would it take HEW to gear up regulations?

Mr. SEEMAN. Since we believe the bill is administratively relatively simple and we sought to make it that way——

Senator HATHAWAY. It won't be by the time we get through with it. [Laughter.]

Mr. SEEMAN. Our goal is to have it effective in the new fiscal year.

Senator HATHAWAY. In 1978?

Mr. SEEMAN. In 1978.

Senator HATHAWAY. So you would have the regulations out by the first of October.

Mr. SEEMAN. We certainly would try, Senator.

Senator HATHAWAY. Well, I am glad. Could you tell me why nursing homes weren't covered?

Mr. SEEMAN. I think primarily because—well, the great impact is in the hospitals. Also there is a system in place which tells us about hospital costs. The costs reports that go through the intermediaries. We don't have that some kind of base information about nursing homes, so that you really would have to build a whole system to know where you are and know where you are moving to. It would be very complex and take a good deal of time even if you wanted to do it at the same time.

Senator HATHAWAY. I think you would be astounded if you saw some of the cost figures in some of the larger nursing homes. I know my wife worked in one for a short period of time in the McLean, Va. area. The cost of patient charges are just out of this world for what the patients are actually getting.

Mr. SEEMAN. It was not because we aren't concerned about it, but it was the mechanics of being able to institute a system simply and quickly.

Senator HATHAWAY. Then you think, at least, a study of that should be incorporated into this bill for the long-range plan.

Mr. SEEMAN. Yes. We clearly want to include this in a long-range program.

Senator HATHAWAY. Thank you very much for your testimony. I will have some other questions in writing. This probably will apply to everybody in view of the time restraint we have on us. I would hope that you would stay around because there may be some questions that arise from other witnesses that you may be able to answer. Thank you.

The next witness is Mr. Thomas W. Cathcart of the Maine Blue Cross. Mr. Cathcart, it is a pleasure to have you with us. You have a written statement. This applies to all the witnesses. You could just put it in the record and summarize it if you wish. Everybody's statement in full will be entered into the record.

STATEMENT OF THOMAS W. CATHCART, VICE PRESIDENT OF RESEARCH AND PROVIDER AFFAIRS, BLUE CROSS AND BLUE SHIELD, STATE OF MAINE

Mr. CATHCART. I do have a written statement, but it is a very brief one, so with your indulgence I will read it.

Senator Hathaway, gentlemen, I am Thomas W. Cathcart, vice president of research and provider affairs for Blue Cross and Blue Shield of Maine. Blue Cross and Blue Shield of Maine provides prepaid health care coverage for over 541,000 Maine people or about one out of every two people in the State. We're also the fiscal intermediary for part A of medicare for most of the institutional providers in Maine.

We at Blue Cross and Blue Shield of Maine have directly felt the impact of the rising cost of inpatient care. In the first quarter of 1977, per diem benefits were up 24.9 percent over the first quarter of 1976. The second quarter figures do not look any more promising. Increases of this magnitude are putting a severe strain on our subscribers' ability to pay. We have been accused recently of exorbitant rate in-

creases for Blue Cross coverage; but, of course, these rate increases merely reflect the rising cost of hospitalization.

The hospitals say that a day of hospitalization this year is a different product from a day of hospitalization last year, and that is unquestionably true. According to the American Hospital Association, the rise in the cost of a day in the hospital is nearly equally divided between (1) a rise in the prices hospitals must pay for goods and services and (2) an increase in the intensity of care. In other words, nearly half of the rise in costs last year was because more care is given in a typical hospital day.

But even if more intense care could be shown to necessarily be better care, the question would still remain as to how long we can continue to pay for hospital care at a rate rising well in excess of the rate of rise in the cost of living. Not too many years ago Americans paid about 5 percent of personal income for health care. Now we pay nearly 10 percent. Can we afford 15 percent? 20 percent? At what point do national expenditures for health care begin to drain resources from other national priorities—some of which have an impact on health—priorities such as housing, nutrition, education?

It has been our hope that a proposed voluntary prospective reimbursement pilot program involving Blue Cross of Maine and a number of Maine hospitals will have a favorable impact on the cost spiral in Maine. We continue to have that hope. Within the past few days we have received a letter of commitment from a committee of the Hospital Association to work with us toward that end. We must admit, however, that a voluntary pilot program in Maine does not do much to solve a national problem. And we must further admit that it will be some years before our pilot program can be developed, implemented, and evaluated. Therefore, while we will continue to pursue the course of developing a voluntary prospective reimbursement pilot program in Maine, we reluctantly find ourselves in support of a transitional limit on the rate of increase in hospital inpatient revenues. We do not feel that such a limit is a sound long-term solution, but we can endorse it as an interim step until permanent reforms can be effected.

Likewise, the provisions regarding capital expenditures in title 2 of the bill seem to us worthy of endorsement as transitional measures. A long-term solution should include decertification of excess capacity with a provision to protect the creditors of the institution.

The bed ceiling in the bill of four beds per 1,000 population is of interest in Maine where we have more than 4½ beds per 1,000 people. Recently the Health Systems Agency—justifiably, and with Blue Cross' support—approved 20 additional beds in Rockland. This might have been problematic had S. 1391 been in effect. Now there is an exception procedure to the four beds per 1,000 provision of the bill. We would hope that when regulations are written that this exception procedure would not be too cumbersome.

In summary, then, Blue Cross and Blue Shield of Maine feels forced to endorse S. 1391 as a transitional cost containment measure for hospitals. We hope that Congress and the administration will follow quickly with long-term reforms.

Senator HATHAWAY. What changes in the present bill would you advocate? You mentioned the exceptions provision which you hope

will be taken care of by regulation, but what changes would you make in the bill as it is now?

Mr. CATHCART. As a short-term matter, I don't think we would advocate any changes in the present bill. When we begin to talk about long-term reforms, then I think we have to begin to talk about some positive incentives for cost saving behavior on the part of hospitals; and I think we have to talk in the health planning part of the bill, title 2 of the bill, about some of the provisions that have been metioned elsewhere in other bills such as disallowing operating expense for unapproved capital expenditures. I think we also have to talk about decertification of excess capacity that is presently there with, as I said in my presentation, of some kind of way of protecting the creditors of the institution. Otherwise hospitals are going to have a very difficult time getting financing up front and if the financing institutions know that 5 years down the road the facility may be decertified as no longer being necessary. So I think some kind of way of protecting the creditor must be necessary.

Senator HATHAWAY. That probably would be very difficult to do though.

Mr. CATHCART. Yes, it would.

Senator HATHAWAY. Would you comment on the variability in costs between small rural hospitasl and the larger, urban ones.

Mr. CATHCART. Yes. I think that if some kind of exception were granted for rural hospitals that the overall cost impact, the overall impact on potential cost savings would not be tremendous. As the previous speaker said, 42 out of the 50 hospitals in the State of Maine are less than 100 beds or less than 4,000 admissions per year I guess is what he said. I can't give you an exact percentage; but a very large percentage of the admissions in the State of Maine and avery large percentage of inpatient revenues are form those other eight hospitals. So even if you exempted all 42 hospitals, you would not have as big an impact on the total overall potential savings of the bill as you might think at first look. On the other hand, some of the rural hospitals in the State of Maine are precisely the hospitals where we do seem to have some excess capacity, where we have occupancy levels that are quite low. Now occupancy levels in rural hospitals must necessarily be lower than they are in urban hospitals. One automobile accident can have a great impact on a 12-bed hospital which it cannot have on a 300-bed hospital; but even given that fact, we do seem to have some excess capacity in the State of Maine. Some of that seems to be in the rural hospitals. So while I would say that there is some possibility of cost savings in the rural hospitals, an exemption of them would not prove disastrous in terms of eating into the potential cost savings of the bill.

Senator HATHAWAY. You would advocate that or at least temporarily.

Mr. CATHCART. I am not prepared to say that today. I think it is worthy of consideration.

Senator HATHAWAY. How about the problem of debundling? If the bill went through, then the X-ray technicians bill separately from the hospital, the doctors that are now billing through the hospital would bill outside. You lose some of the savings that we would get if they were included. Would you advocate that they can't bill outside?

Mr. CATHCART. I think that would be a very radical step.

Senator HATHAWAY. How are you going to avoid that problem?

Mr. CATHCART. That is a very good question, and I am afraid I don't have the answer to that.

Senator HATHAWAY. What cost savings do you think a carrier such as yourself could make?

Mr. CATHCART. Some of the things we have been trying to do are negotiating a prospective reimbursement pilot program. We are also, with the remainder of the hospitals who will not be in the pilot program, right now in the process of negotiating a new reimbursement agreement. We hope to build into that some incentives for cost containment behavior, some economic incentives. We, in Maine, at Blue Cross and Blue Shield, have been very supportive of the health planning system in the State of Maine. In fact, I mentioned a moment ago that any change in the health planning system ought to include penalties under medicare and medicaid for disallowing operating expense and not just depreciation and interest on capital expenditures. The reason why we advocate that is we found ourselves a number of times in a situation where a hospital might undertake a project that would have a tremendous impact on operating cost but with very little capital expenditure, so that the hospital might not suffer terribly but just eating the loss of the depreciation in interest under medicare and medicaid on the capital expenditure. This has put Blue Cross several times in a position where we, because our penalty is stronger than medicare-medicaid, have had to go out on a limb alone and apply our sanction or threat of loss of participation, period. That the Federal participation in the health planning program could be strengthened considerably by going beyond penalties in depreciation and interest.

Senator HATHAWAY. Do you as a carrier cover preventive programs?

Mr. CATHCART. No, we do not.

Senator HATHAWAY. Don't you think it would be a good idea if the carriers could cover preventive programs?

Mr. CATHCART. There are arguments both ways on that. What we are trying to do is to cover care incentives other than in the acute care setting where it is clear that a net cost savings would result. A medical profession, as you probably know, is very divided upon the cost effectiveness and even the medical benefit effectiveness of widespread screening. From an insurance point of view, too, covering purely preventive, diagnostic screening programs for everybody—let's take a pure example of a routine physical examination for everybody.

Senator HATHAWAY. Right.

Mr. CATHCART. There, if it is covered by a third party, then you can assume that everybody is going to be getting one. If everybody gets one, then what you have built into the premium is the cost for everybody to get one plus the administrative costs of paying the claims for them. In other words, it is cheaper for people to pay for that kind of thing out of their own pocket than it is to turn around and pay us to pay it for them. In other words, you are kind of out of the realm of insurance and into just paying us to pay for something that everyone is going to get. It would be like having your automobile insurance cover oil changes. It would be more expensive to do that than it would be to pay for your own oil changes. We have gotten

into a number of programs where we feel that there is a cost tradeoff with standards, let's say, that in cases where hospitalization would probably otherwise be required in the absence of health care we will pay for health care.

Senator HATHAWAY. Then the real problem is to get the people to do this on a voluntary basis?

Mr. CATHCART. That is the real problem, yes.

Senator HATHAWAY. How about the field of alcoholism, for example? You have no third party coverage for that, at least not in the State of Maine. There is in Minnesota. It seems to me that that would bring about a savings in the long run, because there you have an identifiable group of people who—because you know statistically that you are going to have a lot of health problems later on unless you treat them early. Yet third party payments aren't available.

Mr. CATHCART. Right. Yes, that is also true in Maine. We are presently looking at the feasibility of covering alcoholism on a basis other than inpatient care. The Blue Cross Association is also involved with the National Institute of Alcohol and Drug Abuse in a pilot program to study the feasibility of doing that, and we are monitoring that very closely. You may very well be right that there are cost savings involved there.

Senator HATHAWAY. Thank you very much. I appreciate your testimony.

Mr. CATHCART. Thank you.

Senator HATHAWAY. The next witness is the spokesperson for St. Andrews Hospital in Boothbay Harbor. There is no name here. Is there anybody from Boothbay Harbor?

[No response.]

Senator HATHAWAY. Maybe they will appear later. Mr. Stanley Hanson from the Maine Health Systems Agency. Stan, it is a pleasure to see you again. Stan used to work for the person I thought was going to be the spokesperson for St. Andrews Hospital. Go right ahead.

STATEMENT OF STANLEY HANSON, MEMBER, BOARD OF TRUSTEES, MAINE HEALTH SYSTEMS AGENCY

Mr. HANSON. Senator Hathaway, ladies and gentlemen, I would like to clarify that the Board of Trustees of the Maine Health Systems Agency does not have a position on the national cost containment program at this time. The agency staff, however, has examined President Carter's Cost Containment Act.

The Board of Trustees of the Maine Health Systems Agency, as I said, has not taken a position or had an opportunity to do so on this particular legislation. However, the agency's staff has examined President Carter's Cost Containment Act of 1977 and the proposal presented by Senator Herman Talmadge of Georgia and developed a discussion paper on the key issues in cost containment to be used by our board of trustees.

We are sharing that discussion paper with you, Senator Hathaway, because you will be deeply involved as the health subcommittees of the Congress develop a single cost containment program. We hope this document will be of some help to you in this task.

We believe an effective cost containment program must address four key issues. Those issues are the scope of the program, simplicity of administration, equity and flexibility. Each issue poses difficult problems:

SCOPE OF THE PROGRAM

The existing cost containment efforts of the Federal Government tend to be limited in scope, apply only to Federal funds and single out hospitals. Those efforts have not been very effective in limiting cost increases. The following questions, we feel, must be addressed: Should all classes of payors be affected by the program? Medicare already has a ceiling on routine cost reimbursement. That ceiling simply shifts costs to private insurance companies, Blue Cross plans and private-paying patients. Can such a limited ceiling do the job?

Should all aspects of a hospital's operations be covered? Federal controls have historically focused on inpatient beds, ignoring ancillary operations and special care units. Up to this point in time has the public good been served by shifting costs rather than controlling costs?

Should the program include all providers? Federal controls have historically singled out hospitals for cost containment efforts. Hospitals and their medical staffs are a major section and a major cost factor in the health system, but they are only one element. If other providers are exempted from controls, can costs be shifted from hospitals to the exempted providers? If so, is that potential shift large enough to justify comprehensive coverage?

SIMPLICITY OF ADMINISTRATION

More than one-half of Maine's hospitals have fewer than 50 beds and, therefore, have small administrative staffs. Any program will produce administrative costs. There should be an attempt to minimize those costs.

Can any reporting requirements be tied to current reporting forms? Can the administration of the program be handled by existing agencies? Can its purposes and requirements be easily explained to the public?

EQUITY

National ceilings on capital expenditures and annual increases in operating costs can meet the test of simplicity. They must be carefully applied to meet the test of equity.

How shall they be applied to Maine? Applying national ceilings on the basis of population could pose serious problems in a State such as Maine. Many areas of Maine are medically underserved. Would these areas be penalized by arbitrary population-based ceilings? Can a ceiling be designed that takes into account an area's level of investment in health resources?

Can enforcement be guaranteed? How can Congress guarantee that States which act prudently and responsibly will not be penalized? If Maine makes a decision to deny itself an exotic new piece of equipment, do we have any assurance that Boston will not be allowed to purchase 10 pieces of that same equipment?

FLEXIBILITY

Congress has already established a mechanism for creating 211 health service areas in the Nation. Each health service area has a health systems agency which is charged with producing a plan and ranking priorities within the plan. Congress has not required that each plan be identical.

How shall the national ceilings be translated into local ceilings? Should the ceilings be translated into State guidelines via the medical facilities plan? Should the ceilings also be tied into the new network of health service areas thereby providing a working framework in the Health System Agencies?

Is it wise or necessary that the same ceilings be applied to each hospital? The last attempt at cost control limited each hospital's right to increase costs. Is there an advantage in establishing ceilings for each health service area and allowing variations between hospitals?

What are the incentives for responsible action? Shouldn't Congress provide incentives for health service areas which limit costs below the national ceilings? One method might be to allow such sums to accumulate and be spent in another fiscal year. Another method might be to provide a percentage bonus payment to hospitals in a health service area which fell below the ceilings.

It will be difficult for Congress to put together an effective program which addresses these four key issues and is able to attract public support. In preparing this legislation, Congress will face the key philosophical question of quality of care versus cost containment.

As Maine's local voluntary Health Planning and Development Agency, the Maine Health Systems Agency, Inc., must face tough choices involving quality and costs regularly. It does so now within the context of an open ended reimbursement mechanism which will pay for every project which is approved. The reimbursement mechanism makes the decisions more difficult by penalizing responsible States and rewarding irresponsible States.

We hope those inequities will be resolved by whatever new national program emerges from these discussions. If we may provide further assistance in addressing some of the questions we have raised here today, we hope you won't hesitate to call upon us. We will, of course, be providing you with copies of all our agency's deliberations and recommendations as they are developed.

We would like to thank you, Senator Hathaway, for providing us here in Maine with this opportunity to discuss this issue and raising these questions. Thank you very much.

Senator HATHAWAY. Thank you, Stan. I am glad I don't have to answer those questions. When will your recommendations be ready?

Mr. HANSON. At this time, the board has not received the discussion papers and have not had a chance to react to them. I would say it would take us 6 to 8 weeks to prepare the type of recommendations that would address these types of questions. It is a slow process. Very effective but sometimes very slow.

Senator HATHAWAY. The bill may be signed by then.

Mr. HANSON. We will try to rush it.

Senator HATHAWAY. But you are making a pretty good case, or a very good case, for holding off and examining some of these other

problems that we are not going to have time to examine in the next 2 or 3 weeks.

Mr. HANSON. I understand that President Carter—or I believe this legislation requires that President Carter come forward with long-range plans by March 1978. Am I correct?

Senator HATHAWAY. That is correct.

Mr. HANSON. I would hope that many of these questions certainly would be given a great deal of thought and consideration prior to that time. However, if that is not possible, certainly by March 1978 that his remarks or recommendations will include this kind of responsiveness.

Senator HATHAWAY. Do you think the Health Systems Agency in this State can take care of the exceptions process?

Mr. HANSON. I don't believe the Health Systems Agencies anywhere in the country can take care of this process under the present funding restraints. I think this is going to have to be studied, and I would have to question Mr. Seeman's remarks earlier that this program could be administrated as early as October. In view of that statement, I do not feel that we are presently prepared under the present funding mechanism to handle the additional load that this would create for us.

Senator HATHAWAY. How much additional would be needed?

Mr. HANSON. Senator Kennedy concurs and has related the fact that he well understands this.

Senator HATHAWAY. Do you think you can make a good case for exempting the so-called rural hospitals?

Mr. HANSON. I think it is a key issue that has got to be given great study in Maine, particularly, there is a great many, as you pointed out, small hospitals. I think whatever it involves here has got to be fair and equitable for everyone concerned. I do not think this program should be out to destroy all the hospitals. If it isn't handled very carefully, this is what can happen. I do have some concerns on costs. I think the hospitals are starting to respond to that. I think they have to have the leeway to do it in a responsive manner. I think whatever legislation comes forward has got to take that into consideration.

Senator HATHAWAY. In other words, pinpointing certain areas rather than having ceilings. Say, with respect to third party payments, let's go after that and maybe just a couple of other capital expenditures. Maybe one or two others where we do have some experience and we know we can affect savings. Would that be a better approach?

Mr. HANSON. I would have to study the alternatives. I really couldn't answer the question. I am most interested in the hospitals' presentations today as you are in some of the facts and figures. It would help us also judge that aspect of it.

Senator HATHAWAY. Do you think the PSRO should be extended to all services? Do you think it should be extended to all payments?

Mr. HANSON. Probably so. Again, I think that is something that would have to be studied in the context of that program in tying into the overall long-range solutions that, again, will be forthcoming in the next year. That is a hard question to answer, and it, again, relates to available resources and cost effectiveness in itself of these programs.

Senator HATHAWAY. Do your recommendations include comments on the Talmadge bill as well as the administration's bill?

Mr. HANSON. Yes.

Senator HATHAWAY. But you have no recommendation with respect to either one at this time?

Mr. HANSON. No, not at this time.

Senator HATHAWAY. Thanks for raising so many questions. I look forward to receiving your recommendation.

Mr. HANSON. Thank you Senator.

Senator HATHAWAY. Do we have a representative yet from St. Andrews Hospital in Boothbay Harbor?

[No response.]

Senator HATHAWAY. Our next witness is the Maine Hospital Association, Fletcher Bingham. Accompanying him is Maine Hospital Financial Management Association, Kenneth Hughes. Gentlemen, glad to have you here.

STATEMENT OF FLETCHER BINGHAM, PRESIDENT, MAINE HOSPITAL ASSOCIATION

Mr. BINGHAM. Senator Hathaway, ladies, and gentlemen, I am Fletcher Bingham, president of the Maine Hospital Association. The association represents 51 hospitals, and we appreciate the opportunity to appear before you today and share with you our view on two issues: the basic nature of Maine hospitals and the implications which S. 1391 "Hospital Cost Containment Act of 1977" would have on Maine's hospitals. The MHA has prepared lengthy testimony which I would like to submit for the record and I will only highlight this testimony in my comments.

As you know, Maine is a large and relatively sparsely populated State. There are several representatives of small, rural hospitals here today who have prepared brief comments and hopefully you will have time to take their testimony. I only want to emphasize the fact that the overwhelming majority of the hospitals in Maine fall into the small, rural category and share the problems that these individuals have. Of the 51 hospitals that are members of the Maine Hospital Association, 42 or 80 percent are under 100 beds. Generally, I think it is also fair to state that these hospitals are located in the more remote parts of the State. We have prepared a "Profile of Maine Hospitals" and have enclosed it as an appendix to our submitted written statement. I would want to indicate at this point that in discussing the legislative proposal before us today, that we keep in mind the fact that we should consider its application to the 8-bed hospital in Jackman; the 30-bed hospital in Van Buren as well as the 550-bed Maine Medical Center in Portland.

A portion of this hearing is focused on S. 1391, a proposal which in our view deals with only one aspect of a system of providing health care services to the citizens of this State. The bill does not consider the total health delivery system but only its hospital component; and in that case, it does not address the factors which determine hospital costs but merely limits payment to institutions.

There have been three major factors that have had a significant impact on hospital costs: first, the impact of general inflation. Hospitals must pay higher prices and wages for goods and services they use in the delivery of patient care. Thus, the cost of hospital service is adversely impacted by our inability to control inflation in the general economy. The Consumer Price Index has generally been used to

measure increases in hospital care costs. Unfortunately, hospitals buy a mix of goods and services the costs of which move at a rate greater than the CPI. The hospital market basket is especially hard hit by inflation. For example, malpractice insurance costs have increased greatly over the past several years, and energy costs, particularly here in Maine, since 1973 have increased at over 20 percent per year.

DEMAND FOR SERVICES

The growing public demand for health care services is one of the major factors influencing the growth in hospital expenditures. Increased demand is in part a reflection of our growing and aging population. We are living longer and illnesses that besent us as the population ages are the kind that require more care and treatment. As we extend life expectancy, and here I would like to point out that Maine ranks very high in the percentage of its population 65 or older, we are more likely to fall victim to such illnesses as heart disease, cancer, stroke, diabetes, and kidney failure—all of which require long-term medical management and are costly to treat.

Demand also has stimulated by deliberate decisions to remove financial barriers to access to health care. Both the private and public sectors have worked to implement this decision by expanding benefits, broadening coverage, and increasingly eliminating economic barriers to utilization of the health care system.

And finally, intensification of services. A third factor pushing up hospital costs is that of intensification of services. The kinds and volume of services being used by patients are increasing in intensity both in terms of use and sophistication of technology. This intensification is a result of a number of developments in the health system—the change in the mix of patients treated, the availability of new technology in treatment patterns, and the change in character of physician practice. The intensification of services has resulted from the ability to treat patients today which previously were unable to treat because the technology did not exist. Even with all of these factors at work the attached profile clearly indicates that Maine hospitals have been successful in keeping costs significantly lower than the two comparative indexes shown, the New England index and all hospitals in the United States.

Directing the discussion now specifically to S. 1391, there are several major features of the bill that we find objectionable, all of which are contained in Appendix B. Among the most prominent are: (1) a flat 9-percent cap for fiscal year 1978 would not be feasible for most Maine hospitals. The bill suggests that a 9-percent cap on hospital revenues would be feasible in fiscal year 1978 because one-fifth of all hospitals have increased revenues at this level in a prior year and because some States hope to achieve approximately that increase rate this year. The Maine Hospital Association believes that low rates of increase in revenues for some hospitals do not demonstrate that many hospitals can increase revenues at such rates year after year. Rates of increase are higher when service increases or improvements are extensive and lower when no services are added.

Further, no State hospital rate control program has attempted to institute controls in a matter of months or attempted to reduce the rate of increase in total hospital revenues to 9 percent in the first year

of its operations. For example, our neighbor, Massachusetts, with a reputation for strict control, planned for a lengthy preparation period, allowed a 14-percent rate of increase in the first year, and is hoping for a 10-percent rate of increase in the second year. Time must be allowed for the development of a feasible control program.

(2) The program would not set a 9-percent revenue limit for each year, but limits that would become more stringent over time. Some have referred to the plan as imposing a 9-percent limit. Our reading of the bill is that 9 percent would apply to fiscal year 1978, but the formula for the limit actually would tighten down to about 7 percent for fiscal year 1981 which would not even meet the current percentage increases in the prices of goods and services hospitals have to buy. Laying increases below the current rate of general inflation would require a continuing reduction in hospital capacity.

(3) The flat percentage cap would not be equitable among hospitals. The cost of hospital care varies considerably among hospitals and areas. Massachusetts hospitals have costs that are considerably higher than hospitals in Maine. A flat cap would prevent any State with costs from a greater improvement in its services than a State with the higher costs. It would prevent a hospital with inadequate nursing service to exceed the limit in order to meet its deficiencies. The bill would not allow reduction in the differences and the development and application of health services among regions or among hospitals.

Despite our opposition to S. 1391, we are not unmindful of problems faced by those who are sponsoring or underwriting health care for others. Maine hospitals do have concern for the impact of rising hospital costs on governmental health programs, insurance companies and the general public. Maine hospitals are engaged in programs to promote efficiency and contain costs, including management engineering, management training, group purchasing and sharing of services. A complete listing of these programs are in appendix A. We have also cooperated in health planning activities to approve and allocate hospital capital expenditures, and PSRO to appropriately review utilization of facilities as to admission and length of stay, and JCAH activities to monitor quality of care.

We recognize that conditions differ throughout the country and that all areas may not have been effective in addressing all of the problems of operating costs and capital expenditures, although in many areas and in many individual hospitals everywhere these efforts have been outstanding. Accordingly, and as alternatives to S. 1391, we would suggest continuation of several programs which have been created by Congress. The existing programs which we feel have merit and should be continued are:

One, professional standards review organizations. From our experiences in Maine we feel that the PSRO has had a beneficial effect in assuring quality of care while at the same time reducing inappropriate admissions and unnecessarily long patient stay in hospitals.

Two, Public Law 93–641. The HSA and SHCC programs are barely underway, but give some promise in providing rational allocation and expansion of hospital capital assets.

Three. Cost and rate disclosure. This is now being done through medicare and medicaid cost reports and filings. It is also being done in some States through State rate review bodies.We feel that such data disclosure should help everyone to better understand the nature of the

problems faced by hospitals in attempting to maintain quality care in the face of inflationary pressures and governmental regulations.

In summary, we feel that the Cost Containment Act as embodied in S. 1391 does not consider and address many of the real reasons for increasing hospital costs such as the ever-present general inflationary trends in the economy as a whole, the increasing and expanding scope of medical services available to patients and demanded by them and their physicians, and the tendency of the public to overutilize health services in the absence of disincentives such as deductibles and co-payment for health insurance or Federal programs.

It also embodies the wrong solution for cost controls by providing incentives to the less efficient hospital and punishing the more efficient.

Our hospitals are concerned with the impact of increasing health care costs and are willing to consider alternatives to the Cost Containment Act proposals. We have been engaged in cost containment activities for some time and are willing to continue to pursue these. Further, we are willing to consider and support further congressional cost control proposals that have a studied phased-in approach to cost containment with incentives toward efficiency and considerations for passthrough costs largely created by factors outside of hospital management control.

In summation, we believe that it is necessary that other approaches to the administration's proposal be addressed and considered.

Thank you.

We do have some individuals who would like to testify here, if you have time, who are administrators.

Senator HATHAWAY. All right, if we have time we would be glad to have them.

STATEMENT OF KENNETH A. HEWS, PAST PRESIDENT, MEMBER, BOARD OF DIRECTORS, MAINE CHAPTER OF THE HOSPITAL FINANCIAL MANAGEMENT ASSOCIATION

Mr. HEWS. My name is Kenneth A. Hews. I am controller at Eastern Maine Medical Center here in Bangor, Maine. I am also the past president and a member of the board of directors of the Maine chapter of the Hospital Financial Management Association. Our association is taking a very strong stand on the Cost Containment Act of 1977; and if I may, I would like to review with you a few of the comments that I have summarized in reference to that bill.

We share your concern, Senator, in the rapid rising cost of health care in this country.

However, the Cost Containment Act of 1977, if passed, will mean the dismantling of the health care system of this country. The bill is a very complex one which appears to the public to be reasonable, but, when analyzed carefully, proves to have many inequities, complexities, deficiencies, and inherent dangers. I will attempt to outline a few of the problems that this bill will create if enacted.

Some of the inequities are: The proposed program tends to penalize the best managed hospitals and reward those who have been least effective in controlling costs in the past. The individuality of institutions is ignored such as scope of services, length of stay, intensity of services, regional differences; for example, the high energy costs in New Eng-

land. All goods and services purchased by health care organizations will be purchased from an uncontrolled economy and any increases in prices will have to be passed on to the consumer. The bill has a degree of retroactivity to it including the calculation of the base year costs (1976) and the implementation. The program fails to recognize increased costs mandated by the Federal Government such as OSHA requirements, licensure requirements, changes in minimum wages, ERISA, et cetera. The limit on capital expenditures based on population with severely penalized States like Maine. If passed, the limit in Maine would be approximately $12.5 million, and one project in southern Maine would take all of this.

The following are some of the complexities that we see of the bill: The wording of certain——

Senator HATHAWAY. What project is that?

Mr. HEWS. I believe that is Biddeford, the Webber Hospital in Biddeford. It already has been approved I believe, and they are nearly to $12 million. That is an example.

The following are some of the complexities that we see of the bill: The wording of certain parts of the bill is extremely complex and if passed will prove to be a boon to consulting firms. Administration of the bill will be very complex and to some extent, in my opinion, counterproductive to its intent. Many terms have not been defined adequately. Separate accounting for each cost based payor will create additional burden to an already extremely complex accounting system.

If I may digress from my written comments just for a moment, what concerns me about the way the bill is written is that it is vague enough that the Department of Health, Education, and Welfare in writing the regulations they may or they may not follow the intent of Congress. I think that is very important, and I think the bill has to be rewritten and looked at again so that it is not vague so that everyone understands what was voted and what was signed into law.

The following are some of the deficiencies of the bill: The bill will not achieve cost containment but rather a transfer of costs from inpatient through treating patients on the outpatient basis which will put more financial burden on the individual consumer. The most significant aspect of this entire legislation, in my mind, is that it is punitive there are no incentives to this program, only penalties. The consolidation of services will be discouraged by this bill as the hospital receiving the additional patients from the consolidation could be penalized if they are over that 15 percent magic number.

The following are some of the dangers that I see in the bill; Exemption is so limited that fiscal viability will be inhibited. Borrowing for short and long term will not be available. Services will have to be curtailed regardless of community need. Technology will be inhibited regardless of its benefit to the Nation's health.

I have briefly pointed out some of the problems with this proposal. At this time I would like to offer some additional considerations. First, the Federal Government must take a more active and consistent role in dealing with health destroyers such as alcohol, tobacco and other drugs. Federal funds should be allocated to a national education program in this regard as opposed to a multimillion dollar tobacco subsidy. It must be remembered that the hospitals principle mission is to restore health.

Second, we believe the role of the health care industry must be examined carefully. This examination should include an analysis of not only cost but also quality of care, accessibility of care and their funding mechanisms. If hospitals were adequately financed and all payors a true cost, the average room charge could be reduced 7 to 15 percent. The Robin Hood principle has got to be abandoned for something more qeuitable.

In conclusion, Senator, I would like to thank you for allowing me to express my views and those of my association. I would like to state on behalf of Eastern Maine Medical Center and our State association that we stand ready to work with you in partnership toward developing workable alternatives.

I also have three sheets here that I would like to share with you. These sheets represent a portion of a presentation we made to our board of trustees concerning the costs that have been incurred at Eastern Maine Medical Center. I think, while this doesn't explain all the increases in costs at Eastern Maine Medical Center, it does point out some rather significant things. For example, raw food costs since 1972 has doubled. Skipping down the line—the next one is an important one—as I mentioned before, employee retirement has more than doubled. Electricity has gone up considerably, obviously because of the energy problem. Fuel, in 1972 Eastern Maine Medical Center paid $37,000 for fuel. In 1976 we paid $226,000; and in 1977, we will be paying nearly $290,000. Another interesting factor here is that capital interest in 1972 Eastern Maine Medical Center had no long-term debt; but we went through a major renovation process, had two bond issues; and in 1976, we had over a million dollars worth of interest expense. Of course, following along with that capital project is the major increase in depreciation expense, more than triple.

Senator HATHAWAY. That is replacement costs?

Mr. HEWS. That is depreciation expense. Yes; it can be related to replacement costs. Cost there, you see, is straight depreciation. It is not replacement costs. It is not price-level depreciation.

Senator HATHAWAY. It is just cost.

Mr. HEWS. That is cost. The replacement cost is much more than that today. The second schedule is just a brief schedule showing the impact on our routine daily costs of the bond issue. In 1972, we had an $18 million bond issue, and just recently a $2.7 million bond issue. The total of which adds $15 per patient day to our costs.

That concludes my testimony. I will be more than happy to answer any questions you have.

Senator HATHWAY. What is that last item you mentioned in your testimony about saving 7 to 15 percent?

Mr. HEWS. I was referring to the fact that—if I had a chalkboard I could explain it—health care financing is very complex. There are different classes of payors. The Federal Government and medicaid and Blue Cross, to some extent, pay costs as defined by them. That isn't true cost and lt surely isn't charges. If everyone paid something in between costs as defined, true costs and charges, the average cost to all payors could be reduced. In other words, the fair share isn't being paid.

Senator HATHAWAY. What would you like to see done? Pay charges? Pay costs or what?

Mr. HEWS. I would like to see—I think the answer to the system in the long run is to pay some form of charges under a controlled basis.

Senator HATHAWAY. Fletcher, did you say that you were going to submit a plan to us that you think would be more workable, or is it in your testimony?

Mr. BINGHAM. It is in the testimony.

Senator HATHAWAY. You are thinking something more of the plan like they adopted in Massachusetts?

Mr. BINGHAM. No. We have—during this last legislative session there was an attempt to enact a rate reviewing bill. I have attached to the testimony some seven areas of concern that we have with this particular bill, three of which I happen to mention in my testimony. The others deal with the whole issue of classification, the lack of incentives. I agree with Mr. Hanson that regardless of Mr. Seeman's comments this morning we are not sure of she certainty of the duration of the program. The retroactivity is an area that we think should be looked at.

Senator HATHAWAY. Base year?

Mr. BINGHAM. Yes, sir.

Senator HATHAWAY. Should be, what, 1977 instead of 1976?

Mr. BINGHAM. 1977, yes sir.

Senator HATHAWAY. And I presume that you have outlined in there the special problems of rural hospitals?

Mr. BINGHAM. Yes, sir.

Senator HATHAWAY. But you will state that there are ways that you could cut costs?

Mr. BINGHAM. Absolutely.

Senator HATHAWAY. Even if you are to pass through for this fixed cost, it probably would only amount to the 6 percent of the Consumer Price Index. There are still a lot of services that are provided today that may not be necessary. They are given to them because the machinery is there. Statistics show that more X-rays are given today than 10 years ago.

Mr. BINGHAM. There is no question about it. This is the issue that we are trying to address about the intensity of services, the increasing opportunities of the physician to order tests for their patient while their patient is an inpatient. There is no question about it whatsoever.

Senator HATHAWAY. Do you think this is affected by the fact that the machinery is available or are they worried about malpractice suits?

Mr. BINGHAM. There is a representative from the Maine Medical Association here if you would address the question to him.

Senator HATHAWAY. Well, I want to thank you very much for your testimony, and I would assure you that the suggestions you have made will be considered. If we have time for those additional witnesses at the end, I'd be glad to accommodate them.

Mr. BINGHAM. One other item that I am unclear about, and you mentioned in your opening comments, in your discussions with the administration's representatives, I hope that when you are talking about handling the smaller hospitals a little differently that you are talking about exceptions rather than exemptions because the exemption process that is outlined in this bill is rather cumbersome.

Senator HATHAWAY. I was talking about not including them in the bill at all for a period of 2 to 3 years. Thank you very much.

Let's take a 5-minute recess while I have a sandwich.
[At 1:30 p.m. a short recess was taken.]

AFTER RECESS

[At 1:45 p.m. the hearing resumed.]
Senator HATHAWAY. We are ready to resume. Thank you for your indulgence, but I hadn't had anything to eat since 6 o'clock this morning.
Next is the Maine Health Care Association with Kenneth Robinson and Andrew Fennelly.

STATEMENT OF ANDREW FENNELLY, PRESIDENT, MAINE HEALTH CARE ASSOCIATION

Mr. FENNELLY. Senator Hathaway, my name is Andrew Fennelly, president of the Maine Health Care Association. The Maine Health Care Association represents the majority of Maine's nursing homes. At this time I would like to present the position of our association which is the same position we expressed to you in a letter dated May 16, 1977.
I noted with interest your remarks of April 28, 1977, upon introducing the administration's Health Care Containment Act of 1977, S. 1391.
In those introductory comments, you expressed the view that the cost containment controls set forth in S. 1391 should be expanded to include nursing homes. I would like to take this opportunity to call your attention to several important factors relating to nursing homes which should be considered in determining whether or not to amend the act to include nursing homes.
In regard to the specific percentage ceilings outlined in S. 1391, we would simply state that this approach to containing the increased cost of health care may create more problems than it solves. Senator Herman Talmadge, in introducing S. 1470 on May 5, 1977, outlined four possible problems with the flat percentage ceiling approach, which we are also concerned may plague this type of a solution.
He stated that:

> My uncertainty over the wisdom of a cap on hospital revenues stems from a series of concerns: First, that a cap may become a floor; second, that with all the exceptions, the cap may be ineffective as a ceiling; third, that a cap by its very nature is arbitrary and tends to penalize those who have been efficient in the past and reward those who have been inefficient; and fourth, that switching from our current control mechanisms on reimbursement to the new concept of a cap for 1 or 2 years and then to yet another control concept as embodied in my bill may cause such chaos within the hospital field as to minimize the dubious savings involved.

These points are, in our opinion, very valid and need to be very carefully analyzed before the adoption of the type of percentage ceilings delineated in S. 1391.
In addition to the problems of applying such ceilings to hospitals, we would view an extension of them to nursing homes as being extremely inappropriate at the present time. This opinion is based on two factors.
First, based on statistics which are currently available from the National Center for Health Statistics of the Department of Health, Education, and Welfare, the average number of patients being served

daily in nursing homes increased from 1967 to 1976 by approximately 756,000 to 1.3 million or a 72-percent increase. During the same period, the average daily patient census in hospitals increased by just over 100,000 or approximately 14 percent; while hospital expenditures increased by approximately $38.3 billion, compared with $8.9 billion in nursing homes. From this, it is clear that the major cause for the increase in nursing home expenditures has been the 72-percent increase in the number of patients.

There have been, in addition to the enormous increase in patients, several other factors which have contributed significantly to the increased expenditures in nursing homes. For example, we would call your attention to the legislation and regulatory changes in facility and eligibility standards under the medicare and medicaid programs as well as minimum wage increases.

In regard to the changes in the medicare and medicaid programs, major legislative revisions in 1969 and 1972 resulted in new regulatory requirements which caused significant increases in capital and operating expenditures by nursing homes to meet the new standards. These increases have been documented in studies conducted for HEW, with the most recent one conducted by the JWK International Corp. entitled "Assessment of Cost and Operational Impacts of Skilled Nursing Facility/Intermediate Care Facility Standards." Without question, these changes in standards have improved the quality of care. However, we would merely point out that they have also resulted in increased expenditures for nursing home care.

As for minimum wages, in 1967 the minimum wage for nursing home employees was $1.40 per hour; and in 1976, it was $2.20 per hour or an increase of 57 percent. The importance of this increase becomes self-evident when you consider that approximately 40 percent of the approximately 700,000 employees fall into a wage classification at or just above the minimum wage. Thus a 57-percent increase has had a sizable impact on the industry. The impact of increases in employee wages would continue under the provisions of S. 1391 in that expenditures for the wages of these employees would fall into the classification of "nonsupervisory personnel" which would be exempted from the restrictions in the bill. Therefore, this particular pressure on increases in expenditures would continue to exist under the proposed legislation, if applied to nursing homes. Again, we by no means object to this increase, but rather point out that it has contributed to the increases in general of nursing home expenditures.

When considering these three preceding factors, as well as the general rate of inflation in the country from 1967 through 1976 of 6.1 percent annualized, we would suggest that it is not unreasonable that we have experienced an increase in nursing home expenditures of $8.9 billion. It should be noted that we are speaking about expenditures, not costs. Data on the latter is not presently available, to the best of our knowledge.

The concept proposed in S. 1391 would not address any of the three preceding factors; and in our opinion, would not, therefore, be appropriate for application to nursing homes.

The second area of difference lies in the impact which the medicaid program has on nursing homes as opposed to hospitals. At the present time, medicaid pays for approximately 54 percent of the patients in nursing homes while only 15 percent in hospitals. Because of the

enormity of the portion of medicaid patients in nursing homes, the payment systems utilized by the medicaid program are extremely influential in terms of the total expenditures for nursing homes. The importance of this issue in regard to the noncomparability between the existing nursing home situation with that of the hospitals cannot be overemphasized.

Under the existing medicaid payment system, nursing homes are not at this time being paid on the same basis as hospitals. The medicaid program has been required to pay hospitals on the basis of the "reasonable cost" of in-patient hospital services provided under the plan (State medicaid plan). While at the same time, until the passage by Congress in 1972 of Public Law 92–603, there was no similar specific Federal mandate as to the basis of payment to nursing homes. As a result, many States utilized payment methods which did not recognize and were unrelated to the "reasonable cost" of providing skilled or intermediate nursing services under the medicaid program. While this situation would change once the States and the Federal Government belatedly implement section 249 of Public Law 92–603 and require that payments to nursing homes be made on a "reasonable cost related basis," the relationship between costs and the payment systems as they exist today are not comparable with that of hospitals.

The key, however, is that until section 249 is implemented, there is really not a valid statistical base on which to implement the concept for nursing homes as proposed under S. 1391 for hospitals.

In summary, we would urge that you analyze the four concerns which were noted earlier regarding the proposed ceilings on hospital revenues; and would, for the reasons outlined, fundamentally oppose their application to nursing homes.

Thank you very much for allowing us to present our position regarding this issue.

On the State level, Senator, I might add that the average medicaid costs of ICF patients in the State of Maine is less than $24 a day. On a 24-hour basis, that is less than $1 per hour. I might point out that I am presently paying my babysitter more than $1 an hour, and she is not giving nursing care, three meals a day and various other things that we are giving for less than $1 an hour.

Senator HATHAWAY. Thank you.

STATEMENT OF KENNETH ROBINSON, CHAIRMAN, SERVICES COMMITTEE, MAINE HEALTH CARE ASSOCIATION

Mr. ROBINSON. Senator Hathaway, I will be very brief. I have here three papers. They are position papers which were taken by the American Health Care Association in region 1, which is New England. I am chairman of the [inaudible] services committee. I will put these in your folder just for you to go over and study. I think you need some time. That is all I have to say.

Senator HATHAWAY. Thank you very much. You are not saying that costs can't be contained in nursing homes?

Mr. FENNELLY. Presently I do not believe that the nursing home industry is the reason for S. 1391. I do not believe that we have had costs that are unreasonably high. As I indicated to you, in the State of Maine, it is less than $1 an hour and less than $24 a day on the average ICF costs.

Senator HATHAWAY. That is fairly low though. In metropolitan areas it is higher than that.

Mr. FENNELLY. I don't really know. I don't believe on an average they are much higher for ICF care.

Senator HATHAWAY. What do you mean, ICF?

Mr. FENNELLY. Intermediate care, which makes up, I would say, 90 percent of nursing home beds. That would have to do with medicare. Medicare facilities——

Senator HATHAWAY. Medicaid?

Mr. FENNELLY. Medicaid facilities I mean. Medicare facilities would have some kind of ceilings.

Senator HATHAWAY. I think statistics show that in the metropolitan areas they are running anywhere from $100 to $1,000 a month for a person to stay. That is quite a whack out of somebody's paycheck, who is not able to get Government contributions; and it comes out of the paycheck of the person's children who may be in a position where they are trying to educate their own children and take care of their parents at the same time. It is quite a burden.

Mr. FENNELLY. I am not aware that there is any responsibility of children of any patient to subsidize any bills.

Senator HATHAWAY. I don't think it is necessarily any responsibility, but a lot of them feel it is a moral obligation. Senator Moss, as you know, has held extensive hearings on costs in nursing homes. Unfortunately, he wasn't able to generate any legislation to contain those costs; but there is considerable documentation of very high charges. I am not saying that you people do here in the State or other States; but in specific metropolitan areas, they were quite high. I think at least it should be looked into in this bill. Maybe not subjected to the same provisions as hospitals may be subjected to.

Mr. FENNELLY. Here, in Maine——

Senator HATHAWAY. If you are going to evaluate the whole health care system, which has been suggested by previous witnesses, and with which I agree, certainly nursing homes should not be left out.

Mr. FENNELLY. Here, in Maine, I find that we have, I believe, just the opposite. Many patients who should be paying their own bills are transferring funds to relatives and going on medicaid before they should be eligible for it. I believe the Talmadge bill is supposed to rectify this particular problem. Again, it is somewhat news to me that if a person expends their funds, why they're not eligible for medicaid and why any family member should have to suffer other than the fact that they might be a little concerned about having their parents utilize their funds and have nothing left over for them. That seems to be the area that I can recognize.

Senator HATHAWAY. Well, there is a limitation on the amount of medicaid funds that any State has.

Mr. FENNELLY. We agreed with this, and that is one of the reasons why we hope that the legislature enacts the Talmadge bill, which would eliminate patients from transferring funds and going on to medicaid at an untimely time such as they are doing right now. We are hoping we can conserve on medicaid funds by correcting this deficiency that they may transfer a million dollars to a daughter and go on medicaid tomorrow, which is happening in the State of Maine probably on a daily basis. They may not be transferring a million

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dollars, but they are transferring sizable amounts of funds and applying for medicaid. I would assume that that would be the way to cut back on medicaid expenditures is to correct this deficiency of making it easy to get on the program when you are really not eligible.

Senator HATHAWAY. Thank you very much, both of you.

Mr. ROBINSON. We had a bill in Maine on that, but we had to withdraw it. Senator Hathaway, I would like to say that in the testimony that Mr. Fennelly gave, we are in no way in opposition with the Maine Hospital Association. We realize they have a problem also.

Senator HATHAWAY. I understand. Thank you.

The next witness is Mr. Ken Morgan representing the AFL–CIO.

STATEMENT OF KENNETH MORGAN, DIRECTOR, EDUCATION AND RESEARCH, MAINE AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS (AFL–CIO)

Mr. MORGAN. Senator Hathaway, my name is Kenneth Morgan. I am director of education and research for the Maine AFL–CIO. I am here in place of President Dorsky today who had to be out of town in Augusta. I found out recently that I had to testify, and I have to confess that I am not really familiar with the details. But I do want to make some general comments on the AFL–CIO's position on cost containment.

The ascending costs of health care in the United States is a problem and a disgrace of staggering national proportion. Fiscal 1976, $139 billion was spent on health care, a 14-percent increase over the previous year. This expenditure amounted to 8.6 percent of the gross national product, more than any other country in the world. Not only do we spend more but the statistics show that the quality of our health care is not so high as that of many other countries. The congressional budget office furthermore estimates that health care expenditures will be increased to more than 10 percent of the gross national product by 1981 if the present system continues, but perhaps we should say the lack of the health care system in this country. Clearly, something has to be done, not only in respect to improving the quality of care for all Americans but to control the astronomical increases in costs as well.

President Carter recently told the United Auto Workers convention that health care costs must be brought under control or that the cost of national health care will double every 5 years. He furthermore promised to propose "a workable national health insurance program by early next year." The AFL–CIO has been and continues to be committed to a national health insurance program that already has been before Congress for several years. The plan is usually referred to as either "health security" or the Kennedy–Corman bill. It provides for universal coverage of all American citizens and for comprehensive care. It contains cost and quality controls, reforms for health care delivery system and provides for consumer participation. It would be financed by a social insurance system of payroll taxes and general revenues.

This hearing is not the proper place, however, to go into the details of the Kennedy-Corman Bill. At the AFL–CIO Executive Council meeting in February, a statement was adopted welcoming the Carter administration's intention of establishing Government machinery to

curb runaway hospital costs. It also noted, however, the doctor's costs as well as other medical care costs should be contained as well. It further stated that enactment of national health insurance should not be postponed until health care costs are brought under control.

The AFL–CIO will look favorably on proposals to contain escalating hospital costs as is envisioned in this particular bill. It should be pointed out, however, that any such proposal that is used as an excuse to hold down wages of hospital employees should not be accepted. These workers have long been among the lowest paid and exploited of American workers. However, from the testimony that has been presented this afternoon, apparently there are provisions in this particular bill to take care of this particular situation. The real answer to America's health care crisis, an important part of which is health care inflation, is the fundamental translation of the fragmented health care system that exists today. The time has long since been overdue for more long-term planning. We believe that health security planning is the real answer and that health care problems should all be brought together in one package. Health security would limit health care programs resulting in significant future segments by establishing overall budgets of physician's services, hospital payments and other health care costs. Quality controls and the fact that a single agency would make all payments would provide financial leverage necessary to control costs.

Thank you.

Senator HATHAWAY. Thank you very much for your testimony. You mentioned the wage passthrough. As you know, this is discretionary with the hospital. I understand that the National AFL-CIO position is that it should be mandatory, should pass through all wage increases. You think that is a good provision. The problem with that is you don't get the kind of bargaining between the hospital and employees that is necessary to establish an equitable rate of pay, because the hospital has to pass them all through. They shrug their shoulders and say, "It is not going to be countered," and pass them all through.

Mr. MORGAN. As I said before, I am not familiar with the actual technical provisions of the bill. I can only report on the general principle that we have taken.

Senator HATHAWAY. Okay. Thank you very much.

Maine Medical Association, represented by Jeffrey Hollingsworth. Maine Osteopathic Association represented by Dr. Harrison Aldrich.

STATEMENT OF D. JEFFREY HOLLINGSWORTH, ASSISTANT EXECUTIVE DIRECTOR, MAINE MEDICAL ASSOCIATION

Mr. HOLLINGSWORTH. Mr Chairman, I am D. Jeffrey Hollingsworth, assistant executive director of the Maine Medical Association, a voluntary not-for-profit organization of physicians and surgeons in the State of Maine founded in 1853. The association has over 1,200 members, which represents nearly 80 percent of the total number of physicians and surgeons in the State. Our executive office is located in Brunswick, Maine.

Although we were notified only two business days in advance that this hearing was to take place, I am nevertheless pleased to submit on its behalf the views of the association on the proposed legislation for the record.

Mr. Chairman, this bill, serving as the initial battering ram in the administration's attempt to force through a so-called "National Health Insurance" program will allegedly, in the words of HEW Secretary Califano, "Curb the voracious appetite of the hospital industry" with respect to budgets, charges, income and related financial aspects of hospital costs.

In reallty, however, it is just another form of wage and price controls whlch will, in the words of Senator Herman Talmadge of Georgia, "Tend to penalize those hospitals which have been efficient in the past and reward those which have been inefficient." Or, to quote testimony before a committee of the Congress by Michael Blomberg, executive director of the Federation of American Hospitals, the proposed arbitrary 9-percent ceiling on hospital costs per year would, "By utilizing a basic formula which permits the same percentage increase to all providers allow high-cost facilities. . . an incentive to continue to operate inefficiently in order to garner a larger share of the available funds. In contrast, more efficient, lower-cost hospitals would be penalized for their lower base periods." After all, Mr. Chairman, most hospitals ln this country are—and perhaps unfortunately so—not in business to make a profit; and while nearly every hospital administrator will agree that something must be done to manage rising costs, they do not agree that the answer lies with a percentage limit for all intents and purposes pulled out of a hat and figured upon the actual costs of each hospital, a method which cannot help but adversely affect conscientious hospitals most seriously working to keep costs down.

Further, the bill is worded such that this ceiling is to remain at 9 percent and get regressively tighter in perpetuity unless otherwise modified by legislative action. It exempts segments which are responsible for significant cost increases, such as union employees and the Government itself, and displays a serious lack of comprehension on the part of the administration for the economic facts of life under our free-market system.

In the State of Maine, where many of the small community hospitals represent the only health care facility for miles around, the prospect of a bill purported to save consumer dollars but which actually drive up costs or force the hospital to close altogether, thereby restricting the availability of medical care, is pathetically ironic. Secretary Califano's perception of a hospital industry rife with flab, waste, and greed is not accurately applicable to most of the institutions in the State of Maine and is indicative of faulty reasoning based on a false dialectic, in our judgment. In fact, he is in contradiction with officials of his own department. I quote from the "Foreword" of "Controlling the Cost of Health Care," a May 1977 position paper of HEW's National Center for Health Services Research, to whit:

> Cost containment is not the central goal of Federal health care policy. It is the central constraint on the achievement of the basic, positive goals of public health care policy.
>
> Many of the incentives for rising medical care expenditures are the result of public policy. Cost containment strategies which are designed to modify these incentives will limit the achievement of other health objectives. Therefore, no cost containment strategy should be initiated without assessing how incentives and disincentives currently influencing behavior in the health care system will respond to its imposition.

It is a fact that the increasing role of Government in the control of health care delivery is responsible for a healthy portion of increasing costs. Regulations by OSHA, Government-restructured pension plans of hospital employees, unemployment compensation payments, PSRO, medicare-medicaid strictures, and all the rest cost, hospitals significant amounts of time and money and require additional satellite staffing, as with PSRO, HSA, and so forth. If one is to speak of over-utilization or under-utilization, it is well to remember the encouragement given to hospital expansion by the Federal Hill-Burton funding program with its poor planning and short sightedness.

During the Nixon administration's wage-price control era, one hospital in Indiana; for example, was forced to employ the help of an expensive outside CPA firm, despite a highly professional business staff of its own, just to fill out wage control forms. Imagine, Mr. Chairman, what it will cost if the Carter administration has its way. To cite Mr. Blomberg again, if the proposal were enacted into law, it "would stimulate employment in the accounting industry."

Here in Maine, under the onus of this ill-conceived scheme, we can picture the small community hospital attempting to comply by freezing its services and referring cases it might otherwise be able to take to larger regional hospitals. For the small hospitals and for the community physicians who serve there, difficult times would result indeed. What would encourage an otherwise dedicated medical team to remain in a community whose hospital is struggling and dying under the weight of some arbitrary edict from Washington? Where will the money come from to finance the new equipment and services the larger hospitals will be forced to acquire in order to meet the greater demand? How will any savings be realized by the patient if, instead of traveling 10 or 15 miles to see a doctor or get to a hospital, he must sacrifice 1 day's work and journey 30, 40, or 50 miles to the nearest regional institution? With this 9 percent solution, how will Maine doctors and hospitals be encouraged to conduct new research and handle high-risk cases or develop new technological advancements? Where will the money come from for replacement of worn-out or obsolete equipment and for maintenance of a modern physical plant, to say nothing of new services? In passing this legislation, will the Congress establish itself as the moral judge of the dollar value of increased life spans and lower infant death rates, fewer fatal heart attacks and reduced cancer mortality, and every other life-saving and healing device or technique for the people of Maine and the Nation? Who will pay the wage demands of striking union employees at certain hospitals, who are exempt from this cost cap? The taxpayers? If there are dollars to be saved from this bill, the administration has either hidden them well or has not printed them up yet.

Mr. Chairman, with respect to medical care legislation, bad proposals tend to have a habit of becoming bad laws. The litany is a long and sorry one. In the case of the 9-percent solution, while we favor the principle of cost containment, this association believes that this bill is not the means to accomplish it. We would suggest that there are other alternatives, a number of which have been suggested by such groups as the American Hospital Association which we can agree with to meet this problem. We would again suggest that the Government put its own house in order and examine the impact of

its own activities in skyrocketing the price of health care and the cost of living.

Among the several alternatives which could work, and of which some are already being used, are: 1. Improving health care planning by the hospital industry itself, and not by the Government, to improve bed-effectiveness, convert or close excess beds, carefully limiting hospital capital investment establishing better education and management techniques and upgrading in-house utilization review without Government compulsion or imposition.

2. Public disclosure of hospital costs data.

3. Careful consideration of Senator Talmadge's Medicare-Medicaid Administrative and Reimursement Act or similar proposals in order to reexamine Federal payment systems.

4. Support for an improvement of programs designed to encourage people with poor health habits to amend or change those habits.

5. Reviewing Government regulations and programs to improve the impact of their benefit-to-cost ratio.

6. Using available and future hospital utilization and cost data in a feedback mechanism to the staff and hospital administration in education programs for doctors and administrators as an alternative to PSRO.

7. Increase public awareness of the cost of utilizing health services without imposing barriers to access to medical care and treatment.

The opportunity to participate in this hearing is appreciated. Thank you.

STATEMENT OF DR. HARRISON ALDRICH, REPRESENTING THE MAINE OSTEOPATHIC ASSOCIATION

Dr. ALDRICH. Good afternoon, Senator Hathaway. It is a pleasure to be here. I represent the Maine Osteopathic Association, which represents approximately 180 physicians in rural Maine and Maine centers. The rural physician served by the osteopathic profession and the rural people are about 60 percent of the health care in this area.

This type of bill, although it may not directly impose upon doctors' fees, do in fact have control on the hospital level and with many people already discussing what has gone on and ways to correct it. Instead of repeating most of the feelings that have already been very well outlined, I pose a few questions at this time that have concern for our profession.

In this era of expanding and concern of rural health care, we are looking for new doctors in the area. How are we going to allow these doctors to practice, take care of these people who are no longer or at this time being cared for if there is going to be a cap when these physicians will, in fact, need hospital beds and hospital care for their patients? This, along with the many small hospitals that exist in the State of Maine, there has been some proposal as to the number of 4,000 and 5,000 admissions with no cap. I certainly think that a close look at this is extremely necessary. The percentages with small numbers would fluctuate considerably in small institutions around the State. And as already stated, this would have a dramatic affect upon the health care, as we see it, in the State of Maine where many rural people go to small hospitals and in true get excellent care and are actually

cared for without the necessity of being moved to big, medical centers. This could at this point, conceivably put such institutions as this out of business.

I also have concern about the educational costs, the impact of educational costs in hospitals. Many of our hospitals are involved in educating residents, interns. This, too, has an affect upon the hospital costs. If we are to improve and increase the doctors in the area, residents and interns certainly are an important part. This is part of the hospital costs. Also increasing disease and fluctuations in disease causes many variations with the hospital at any time during the year. Here, again, small hospitals fluctuate in great numbers from month to month and year to year which, in fact, make a great factor and limit, maybe, how many patients could in fact get better medical care or be deprived of it.

These are but a few of the questions that we have at this time facing us if, in fact, such a bill were to be placed upon us.

Senator HATHAWAY. I want to thank both of you for your input and would be glad to take your considerations into account. I assume, Mr. Hollingsworth, while you do not want Government programs, you said you wanted the Talmadge bill and a few other governmental prongs in there such as requiring public disclosure of hospital costs and receipts. I presume you would advocate the same things for doctor costs and receipts?

Mr. HOLLINGSWORTH. Insofar as the Government is concerned with its own programs such as medicare and medicaid, then it obviously has the responsibility to see that those programs operate as efficiently as can be done. With respect to disclosing hospital cost data, that is something that I would advocate ought to be done by the industry itself, if possible. The distinction must be made——

Senator HATHAWAY. The industry has had plenty of time to do this and hasn't done it yet. That is one of the reasons for the bill.

Mr. HOLLINGSWORTH. Well, I don't think——

Senator HATHAWAY. If everyone did things on their own, we wouldn't have to have Government projects.

Mr. HOLLINGSWORTH. Well——

Senator HATHAWAY. Whether it be State or local or Federal.

Mr. HOLLINGSWORTH. I fail to see, to the contrary, however, where the Government action is necessary. Is it to protect us from ourselves, or is it to protect the consumer from the institutions that serve them? I don't believe that Government as a compelling force is necessarily a positive effect.

Senator HATHAWAY. It is basically for the protection of the consumer whom we consider is paying too high a cost in certain areas. One of those areas is the whole health care system including physicians' fees as well as hospital costs and other services. This bill doesn't touch physicians' fees. Do you think it should?

Mr. HOLLINGWORTH. No; I do not. I do not think that hospital costs and physicians' fees and what have you are necessarily an accurate reflection of a true price in a given free market because you have so many outset——

Senator HATHAWAY. You don't have a free market medical care. People don't get sick by choice.

Mr. HOLLINGSWORTH. That's true.

Senator HATHAWAY. They have to go see a doctor because circumstances require it. The Canadians have had very good experience in controlling physicians' fees. Why shouldn't we adopt the same thing?

Mr. HOLLINGSWORTH. Take, for instance, the problem of malpractice insurance. There are some reliable statistics to indicate that 25 percent of the average cost of a day's stay in the hospital must go exclusively to pay for malpractice insurance. We know for a fact that the cost of an average office visit to see a physician has increased substantially due to the sudden high rise in the cost of malpractice insurance coverage. These are outside, artificial stimuli that cannot be foreseen, and I don't think the Government can do anything about it through any type of a price control mechanism.

Senator HATHAWAY. Well, the Government can do something about it. I am not so sure that we advocate that approach. Malpractice insurance in Canada is about 1 percent of what it is here, but there are other factors that make physicians' fees high. They have control over them. Perhaps we can look into them. We have had testimony already indicating that the busier the doctor is the more drugs he prescribes. Obviously, this is an initial cost that the patient has to pay. We know that groups of doctors bought cat scanners; where if they had some review of this or had to be certified before they could buy them, why, they might not buy quite as many.

Mr. HOLLINGSWORTH. Points have also been made about the increasing demand for health services. I think that must be taken into account as well. However, let me point this out: That in the State of Maine we are very fortunate, indeed, to have 100 percent complete hospital statistics with respect to admissions and procedures. I believe we are one of the few places in the world that has this type of statistics available. This can enable Maine doctors and hospitals, working jointly, to discover, for instance, what particular doctor might be performing an excessive amount of hysterectomies or someone else may be prescribing an excessive amount of drugs which is out of whack with the statewide average.

Through this type of data analysis and joint cooperation, as I pointed out as an alternative to PSRO which is supposed to be a cost-saving entity, here in the State of Maine at least once this type of data is analyzed and programs are set up hospital by hospital, I think that the medical profession and the hospital industry can work very effectively to reduce hospital costs, to examine admissions more closely, to determine what kinds of procedures are being done in excess or not being done enough. I think these types of activities, which is a voluntary effort, if given time can work better than the oldness of Government compulsion with arbitrary dates established and arbitrary limits set up.

Senator HATHAWAY. Well, how is this going to work and how much time is going to be needed?

Mr. HOLLINGSWORTH. Well——

Senator HATHAWAY. You are going to say to a physician, "You performed too many hysterectomies last year and cut down the number"?

Mr. HOLLINGSWORTH. They do it now. It is done in some instances already.

Senator HATHAWAY. Who tells them?

Mr. HOLLINGSWORTH. Well, PSRO does it.

Senator HATHAWAY. PSRO just applies to the Federal programs.

Mr. HOLLINGSWORTH. True, but within the medical association itself, there are committees which analyze and review doctor performance.

Senator HATHAWAY. Do they provide sanctions?

Mr. HOLLINGSWORTH. In some cases, yes. And also through peer review by the doctors themselves. Such things as expulsion from the society or what have you. The sanctions can be imposed upon doctors. But when we speak of the overall rise in health care or energy or whatever you are speaking of, we must also take into account the impact of inflation. When we discuss inflation, we must get back to: Where does inflation come from? I think that most rational, intelligent individuals will recognize that inflation is a direct result of Government action since Government controls the money supply and has other controls on the flow of goods and services and supply and demand. So arbitrary caps of this nature do not take this factor into account. I cannot see but where it will only postpone a situation that would develop into a worse one than before. We know that from wage and price controls. I think enough has been said on that. Just the mere fact of our experience under the Nixon wage and price control should be compelling reason enough to defeat a bill of this nature

Senator HATHAWAY. The wage and price controls employed before before were operated across the board into very industry. I think in certain areas where we don't have competitive forces at work naturally to bring down or stabilize prices, then you have to have some kind of regulation. This is an area where, obviously, we haven't been able to keep down costs; and something has to be done.

Mr. HOLLINGSWORTH. I would respectfully disagree because I believe regulation creates an artificial situation. In any situation in which Government intervenes to control, the rule of thumb is that it either creates a shortage or a surplus, becuase Government is not designed for these types of activities. The private market sector is. Therefore, regulations of the type that are mentioned in general are unspecific, cannot help but to create an artificial situation that will only postpone the problem for a later date that will only be worse then what we have to begin with.

Senator HATHAWAY. You mean you would eliminate all kinds of regulations—telephone, electricity, and all the other utilities and let the free market take care of whether you have telephone service today or not?

Mr. HOLLINGSWORTH. The market system is——

Senator HATHAWAY. Whether you have mail service?

Mr. HOLLINGSWORTH. With respect to mail service, I think enough has been said about that.

Senator HATHAWAY. You gave it to a private corporation and look what has happened.

Mr. HOLLINGSWORTH. That was not exactly a private corporation, Mr. Senator.

Senator HATHAWAY. Thank goodness it wasn't. It was only quasi-private. And so we have got quasi-service. If it was totally private, then you get no service at all, particularly in the rural areas. Of course they go where the money is, which is in the big cities.

Mr. HOLLINGSWORTH. I disagree with that.

Senator HATHAWAY. The same thing with the medical profession. That is why we have to come up with bills like the Health Professions Educational Assistance Act to distribute doctors and medical personnel throughout the country. The law of supply and demand doesn't take care of it.

Mr. HOLLINGSWORTH. Well, I think——

Senator HATHAWAY. I am not blaming the individual doctors for this. I don't think there is but only a very small percentage of them who are performing more operations than are necessary or charging higher prices than are necessary; but I think that if you looked into almost anybody's business, you could find where they could effect cost savings. Here is a very serious situation, the health of the Nation. I think we should look into it and see where we can effect cost savings all the way across the board from physicians' fees to hospital costs of other services.

Mr. HOLLINGSWORTH. When a government institutes compelled cost savings, whatever savings you have are made up in the cost of complying with the Government compulsion.

Senator HATHAWAY. I don't think you could make a case of that at all.

Mr. HOLLINGSWORTH. Let me make this point: when Dr. Samuels spoke this morning, he made a remark to the effect that we must build a rational health care system. Mr. Morgan of the AFL–CIO made the point that we lack a health care system. I think it might have been better put if they had said, "We must build a brave, new world," because it seems to me that the thrust of this legislation and the subsequent legislation to come on health in this country is leading toward national health insurance. In other words, the Government as a guarantor and messiah of health. I think we merely need look to Europe and the other nations of the world that have systems of this type to see what a disaster that could lead to.

Senator HATHAWAY. I don't think you could document the case that it is a disaster. I think they have a better health service for people in general in those countries that have some kind of a national health service program than we have.

Mr. HOLLINGSWORTH. Well——

Senator HATHAWAY. I think that our individual doctors and our institutions of research are probably better than theirs.

Mr. HOLLINGSWORTH. You can tell that, I should think, to individuals in Britain who sometimes wait as much as 5 years on a waiting list for a simple operation.

Senator HATHAWAY. Well, you know, you can always point to bazaar examples. Health service in Canada, 85 percent of the people agreed it was excellent service.

Mr. HOLLINGSWORTH. Of course, it is "free," isn't it?

Senator HATHAWAY. No, they pay higher taxes than we pay.

Mr. HOLLINGSWORTH. Of course. So it is not a free system. I don't agree and I don't think that the doctors of the State of Maine will agree that the Government is the best provider of health care for the consumer.

Senator HATHAWAY. The Government wouldn't be providing the services. It would just be paying for them. The doctors and the institutions will still be providing services.

Mr. HOLLINGSWORTH. Payment of services does not necessarily mean services are provided free and clear of restrictions. That is obvious.

Senator HATHAWAY. That is true. Perhaps that is what it needs, some restrictions.

Mr. HOLLINGSWORTH. Again, I would have to disagree respectfully.

Senator HATHAWAY. Anything else you would like to say, Doctor?

Dr. ALDRICH. I am not sure I want to get into a dissertation about it. I would have to say though in respect, I don't feel that we as Americans have to turn our head or hang our head in shame in any way, shape or form about the medical care delivered in the United States as compared to any other nation. I don't think, in spite of the fact that Britain and Canada supposedly have an excellent system, I don't think ours is really all that bad. I have to agree in some aspects with Jeff. That many people as soon as they feel that they have health care for nothing or provided by health and welfare or medicare, frequently physicians are bombarded with many excess calls that for sure are not necessary. When the patients themselves have to pay out of their pocket, it makes a little different presentation; and they are not so apt to go to the physician's office quite as frequently.

I do feel that in general that the health care system as presented in the United States really is not all that bad; and when they say the cost care to the physician is not contained, I cannot agree with that. Medicare has put an amount that the physician can increase yearly. There has already been this for the last 4 or 5 years.

Senator HATHAWAY. Why shouldn't we do that across the board, not just for medicare recipients but for everybody, if you agree that that is a good system?

Dr. ALDRICH. I feel that is interfering with free enterprise.

Senator HATHAWAY. There is no free enterprise. This isn't like the corner grocery store or diaper service. People get sick. They don't have any control over it. They have to see a doctor.

Dr. ALDRICH. I——

Senator HATHAWAY. They are at the mercy of the system. I am not saying that is bad, but that is the way the system is.

Dr. ALDRICH. I am not sure——

Senator HATHAWAY. People don't decide whether they are going to get sick or not. It is not like deciding whether you will buy a new automobile.

Dr. ALDRICH. I agree with you 100 percent that no one has the opportunity to pick when they will be sick; but I think you can pick any one area of any type of profession and you will find the bad part of it. I would have to think that most physicians taking the Hippocratic oath have not failed to see any patient in need, irregardless of the cost or what they might themselves have. I think many physicians have given many, many hours of free time. So I am not really sure that——

Senator HATHAWAY. I think you are right on an individual basis. Physicians don't voluntarily go to Alaska or northern Maine or they don't go to these other areas, the hard core ghetto areas, to practice because the money isn't there. I don't blame them for it. Most of us follow the dollar. So we have had to come up with some Federal legislation to provide incentives for distribution. You say you want

to keep the Federal Government out of it. What would we do without medicare or what would we be doing without medicaid? Both of these programs have made the medical profession fairly affluent and at the same time provided the needed service for older and indigent throughout the country. So that when you say you don't favor national health care programs, we are about halfway there right now. It is just a question of taking care of those who still remain uncared for at a reasonable cost.

Dr. ALDRICH. I am sure this gives many of us great concern that national health continues to move on as the price continues to rise, and this is one of the things we are talking about now. I still believe that for the most part within the United States there are very few people who, in fact, are not getting adequate medical care.

Senator HATHAWAY. I think you are right. So we don't have very far to go.

Dr. ALDRICH. I think the big gap that you are talking about, between 65 and under, there is far more people than there are for 65 and over; and the few health and welfare that we have or the number of health and welfare and what is not on, I think is a vast percentage.

I would like to speak just briefly to the fact that you say the Government has intervened and brought to areas such as the boondocks of Maine, let's say, or Alaska where many physicians won't go. I have great concern about some of the programs they have instituted to, in fact, reimburse a physician to go to, let's say, the tip of Maine or Alaska. It is great to give a fellow or give anyone an incentive and say—Hey, finish your college education and we'll pay for it, but you have to serve us for x number of years after. How are you going to guarantee what kind of output they are going to give you at the other end of the horn when they, in fact, now have to serve the 2 years that they really hate up there. I don't feel that this is true medical care, and I don't think this is the true way to do it. I think the way that it should be done, and I think the way that it can be accomplished in rural areas such as Maine, is to continue to educate the people, to bring back physicians or bring back fellows who have gone from the State of Maine back to the State of Maine to train like has been proposed by the New England College of Osteopathic Medicine or has been proposed by residents and interns. I think you will find a great majority of these areas can, in fact, be covered.

Senator HATHAWAY. We tried that for years, and we had the National Service Corps and now we have the health manpower legislation. We don't legislate just for the fun of it. It is because of a need and because people haven't voluntarily done these things. I don't blame them. A person who is born, brought up in the Boston area probably doesn't want to go to Alaska to serve. That is where he is used to living. But I don't see anything wrong in exacting the 2-year requirement out of him if the Federal Government, which is all of us here, the taxpayers, is going to pay for his medical education in return for that person serving in an underserved area.

Dr. ALDRICH. I think that is a super idea if they are very selective. The only problem is: 85 to 90 percent of the fellows that are now serving in these areas finish off their 2 years and then leave.

Senator HATHAWAY. I don't think those statistics are correct. The figures that I have are that the majority stayed there. We can check it out.

Dr. ALDRICH. OK.

Senator HATHAWAY. At least if they are going there, that area is getting more than what it had before they went there. I doubt that any person is going to graduate from medical school, go to these areas and not do a good job. As you say, the physician does take an oath to do a good job. I don't think the fact that he is made to serve in some remote area would force him to shortchange his patients.

Dr. SAMUELS. Senator, it is 40 percent retention right now for National Service Corps.

Dr. ALDRICH. Does this include both rural and other areas or just rural areas?

Dr. SAMUELS. It includes both, although they are predominantly rural.

Dr. ALDRICH. Well, I was 20 percent off. The other thing that I would be concerned about is there is a movement generally nationally to move out to these rural areas, and many physicians are moving out. I would hate to see that just——

Senator HATHAWAY. Well, these people are distributed on the basis of what the need is. So if they are going voluntarily to Alaska, the need isn't going to be very great.

Dr. ALDRICH. That is right.

Senator HATHAWAY. So there will be less need for the national health service corps program.

Dr. ALDRICH. I agree with this. I think that—going back to the other thing, I think that maybe the professions are taking care of themselves to some degree. I think they are trying to upgrade and to keep a closer watch on their own profession and to reseed the areas that appear to be now diluting.

Senator HATHAWAY. Well, I hope you don't misunderstand what I say. I am a lawyer, but I am sure you can go into the legal profession and do the same thing as to cost savings with respect to what lawyers are charging. That doesn't happen to be a crying need at the present time. Whereas medical services are and will continue to be. Probably almost any profession that you go into, you could affect considerable cost savings; but just as in the area of food, if the price of food went up too high, you would have Government controls on food because that is necessary to life.

Dr. ALDRICH. I agree that there has been a greater demand for medical care. I also agree that medical care in general and the thrust of health care in particular to the public has been far greater in the last 4 or 5 years as to how to take care of yourself, what do do, et cetera; and in turn, this has put a bigger burden on the medical profession per se. So I am sure that you would naturally see an increase here of more patients going to physicians. I think this has upgraded it. I am not saying that some Government involvement shouldn't, in fact, occur. The only thing that bothers me is total Government intervention or total Government, say, health insurance where the patients themselves have lost some control along with the physician.

Senator HATHAWAY. Thank you both very much.

We have about 20 minutes left. Are there any others in the room who would like to testify. Derek?

STATEMENT OF DEREK V. BUSH, PRESIDENT OF MAINE COAST REGIONAL HEALTH FACILITIES, ELLSWORTH, MAINE

Mr. BUSH. I am glad that there was 20 minutes left over so that some of us small hospital administrators and chief executives could tell you how we feel about this.

I have a statement, which I will give to you, but I would just like to emphasize a couple of points to supplement what Fletcher Bingham said in testimony before the group this morning.

In addition to being president of the Maine Coast Memorial Hospital in Ellsworth, I am also chairman of the association of its small hospital forum, which tries to help the 42, 43 actually, small hospitals in the State of Maine. I also represent New England on the American Hospital Association Regional Advisory Council.

There are two issues that I would like to really emphasize, if I might. The first one is this question of reasonable costs. As you know, when medicare came into effect, they put a reasonable cost on payment to hospitals for health care in hospitals; and then in 1972, I understood they were going to put a reasonable limit on the reasonable cost. I never understood the first reasonable, let alone the second. But is health care cost in Maine really that high? Compared to what? You heard from Tom Cathcart of Blue Cross this morning, who spoke of the number of people that Blue Cross provides coverage for as third party payors.

Unfortunately, in the rural areas, there is very little third-party payor coverage other than what is provided by the Federal and State Government. This tends to put an enormous cash pressure upon rural hospitals. We may break even on paper. We do, by the way, by Federal law publish our annual report. There is a very simple way we do it in Ellsworth. We just publish it as a part of the Ellsworth American, and that it is the cheapest way I know to get 12,000 copies to the people in our area. I have been chief executive officer of the hospital for over 20 years, and I have never had the luxury yet of having too much money to run my hospital.

In the old days, in the bad old days, before medicare—and I was in Canada, by the way. As you know, I came to this country. So I had some experience in Canadian health insurance program. We used to use our trustees to go out and collect bills. It might be a sack of potatoes from one and a couple of dozen eggs from somebody else. There is no question in my mind that the Medicare Act has been a boon to hospitals and, indeed, to the physicians whose patients are in those hospitals. You have created many problems for us under those acts, but the financial aspects have been a great help to us. The problem is these 20 to 30 percent near-poor people—they are not poor. They are thrifty. They are hard workers. They are typical down-Easters. They don't want charity. They want to work—they don't give a high-priority to health care. In the Ellsworth area, we have a group contract for my own hospital employees. We are the biggest employer in Ellsworth. In fact, in most small towns where the hospital is situated in Maine, the hospital is the biggest employer. So there is a great economic impact here, too.

For a family, regardless of how many children there are of an employee of mine, you can buy 121 days of health care coverage for each of those members for $620 a year. If you run one automobile in

the State of Maine—finance it, insure it, buy gasoline and drive it 10,000 miles—you pay three times as much just to run a car. The problem is people will say that a car is essential in Maine because we are a rural area. So is health care protection. The problem is that we have a cash flow problem that this 9-percent limit would compound even more.

Now, I would like to just say a few words about incentives. We had a program in Washington last year, which Mr. Hunter attended on your behalf where I presented a paper on cost containment. I had a cost containment program in my hospital for several years. That is the only way that I can keep costs down. I consider my hospital to be a fairly low-cost hospital, even by Maine standards, and some of my peers tend to agree with me. I had all kinds of memorandums issued in my hospital saying, "We have got to keep the costs down. Don't waste costs." Employees didn't cooperate. Why should they? There was no vested interest for them to cooperate. I then said,

> We have a good budgetary management system in our hospital. If we can keep our costs below what we estimate them to be and provide the same or more care, for every dollar you save, I will give you 60 cents of it.

Now they are saving all kinds of money because it is their money. Before, when they went to the bathroom and they washed their hands, they grabbed 10 paper towels. Now they take one. And if one of them catches one of the others wasting, they are wasting their money.

Incentives, Senator. It is the name of the game, and there will be no effective cost-control program in this hospital industry of ours without incentives. Penalize the bad guys. You can save costs. You can still save costs in my hospital. You can save costs in every hospital, but it will only work with incentives. But really penalize those who should be penalized. Don't do it across the board, because the fat has been cut off at my hospital and you are getting into the meat and into the goods.

Senator HATHAWAY. But, Derek, would you exempt the rurals for a while until we can review them more closely? Would you include them but have special conditions for them or just what are you recommending?

Mr. BUSH. That is like asking a kid if he wants to go in a candy store and help himself. [Laughter.]

Senator HATHAWAY. I am asking you to be reasonable. [Laughter.]

Mr. BUSH. Yeah. We are not as sophisticated as our city neighbors, perhaps; and for the industry as a whole I would say, yes. I am not afraid of health care planning or PSRO. If my hospital can't justify what we are doing, then we shouldn't be doing it. The thing that I dislike is the arbitrariness of an across-the-board cap on everything. That I cannot live with because it is unfair. I could live with it if someone made me, but I would have to cut some service. I don't have any fat left.

Senator HATHAWAY. But if what you say is true, then we have to go through it on a hospital-by-hospital basis throughout the country in order to come up with a really good plan, which may be extremely difficult to do.

Mr. BUSH. Oh, no. I don't believe so. I think the fiscal intermediary can quickly determine—one of the figures that pops out of the fiscal intermediary report is the medicare per diem costs, the nonmedicare

per diem costs, the cost of intensive care unit, the cost on the nursery. All you have got to do is look at the annual cost report, and there may be some hospitals in this country that are not onto medicare but have some—I discussed national health with you in Washington. There were a few hospitals down South that haven't yet come under this bill. I am sure that most fiscal intermediaries in the State of Maine, which is Maine Blue Cross, could give you, before you left here tomorrow, a breakdown of the per diem costs for the last fiscal year in the State of Maine on the cost per day for over 65, under 65, intensive care, nursery. They could even tell you what it cost to feed them. There is a mass of information in those.

Senator HATHAWAY. So in that way we are just finding out where the fat is?

Mr. BUSH. Sure.

Senator HATHAWAY. Thank you very much sir.

Mr. BUSH. Thank you.

Senator HATHAWAY. Anybody else who would like to testify?

STATEMENT OF MARTIN S. ULAN, ADMINISTRATOR, YORK HOSPITAL, YORK, MAINE

Mr. ULAN. My name is Martin Ulan. I am administrator of the York Hospital in the southern end of the State. I want to make a few comments which pertain to the individual hospitals of which I am responsible.

Like many small hospitals in Maine, York Hospital has recruited 12 physicians in the last 5 years, and there are three more arriving this year. Their most frequent observation shortly after arriving is that the patients they have seen have neglected long-term conditions that lead to disabilities and ailments that are debilitating and interfere with their enjoyment of optimal health.

The bill does not make adequate provision for hospitals facing the problem of meeting health care needs in what were previously medically deprived areas. There should always be separate regulations for the small rural and semirural hospitals, and they should not be grouped with the large urban hospitals and teaching institutions. Incidentally, I did administer a 500-bed medical school teaching hospital before retiring to the State of Maine.

The 9½-percent limitation on increases in cost based on prior charges is unfair to the small institutions because the formulas used to determine reimbursement to small hospitals under the medicare reimbursement formula prior to 1977 have been acknowledged as being unfair. The formula actually reimbursed the small hospital to a lesser degree than the larger institutions. Any regulations controlling cost increases and reimbursable income to the smaller hospitals should take into account this long-standing disparity and unfairness in the reimbursement formula used to date.

Another provision which I would consider unfair to the smaller hospitals is the passthrough provision for salaries of nonsupervisory personnel. In smaller institutions with service areas and cost interest consisting of one to three people, very often the so-called lead employee or supervisor is a working individual and production worker as well as a supervisor.

The limitation on capital expenditures can impose a hardship on those regions of the State that were previously medically undermanned.

Some consideration should be made to insure that areas of medical poverty be given special consideration. Considering the size of the Federal budget and the relative importance to this Nation of the military budget and the health budget, I would recommend a more realistic annual budget for capital expenditures than the proposed $2 billion. As a matter of fact, one way to reduce costs might be to take the entire amount that is allocated for capital expenditures and actually make those grants to hospitals so that no one would have to be responsible for meeting the interest charges that would result from borrowing the amount of money designated for capital expenditures.

It must always be remembered that small hospitals are an important element of the health care system. There are admitting diagnoses that can be adequately treated in a small hospital at a lower cost per admission than at larger institutions. In addition, it would save your constituents the out-of-pocket cost to the individual family in dollars and traveling time.

One of the major considerations associated with the care of the geriatric patient involves nursing homes and terminal care in hospitals. The book, "The Last Segregation," describes what other countries have done in reimbursing the family who cares for terminal or geriatric patients. It would seem to me that the $250 annual tax credit which was proposed and finally dropped in the last credit bill is inadequate and does not really solve any problems. Some consideration should be given to adopting programs or procedures used in other countries.

Senator HATHAWAY. Like what?

Mr. ULAN. If we paid one-quarter to one half of the money to a family willing to take care of their relative rather than to a nursing home, we could substantially reduce some of those costs.

York Hospital has one other factor that seriously affects its costs. This factor does not affect all other small institutions. There are two Federal facilities—Portsmouth Naval Base and the Peakes Air Force Base. The presence of these two Federal facilities sets a community standard for wages, work standards, and fringe benefits that has an insidious effect on hospital costs. We have never had an employee from either of these agencies leave the Federal facility to work for York Hospital because the work standards were lower, wages higher, and fringe benefits better. We do lose a trained employee almost every month. There reason for leaving to go to the Federal facility is based on higher wages, lower work standards, and better fringe benefits.

Because of the brevity of time, I will close but submit the document which I prepared for this hearing with you.

Senator HATHAWAY. Fine. Thank you very much. You might be interested to know that I do have a bill, along with others, for providing tax credits for people who take care of their parents at home rather than sending them to a nursing home. I can't tell you how the prognosis for the bill is, but at least it is pending.

Mr. ULAN. With having had three of the older members of my family die in my home, I know what the costs are; and I do know that those costs were borne by me personally. Whereas if I had done what other people did and sent them to nursing homes, then the cost would be shared among all taxpayers. There are many people who would be willing to do the same thing if there was sufficient tax relief or other form of payment that could help.

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Senator HATHAWAY. Right.

Mr. ULAN. Thank you.

Senator HATHAWAY. I agree with you. Thank you very much.

We have 5 more minutes. Anybody else?

Dr. PATTERSON. Yes; I would.

Senator HATHAWAY. OK. We will give you 2 minutes because we have somebody else. I will split the time with you.

STATEMENT OF DR. WAYNE PATTERSON, MAINE MEDICAL CENTER

Dr. PATTERSON. I didn't intend to testify; but after listening to some of the gentlemen preceding me, it prompted me to come up here. I have been listeing to all the money that runs into thousands. Figures that we, the average person, do not handle in the course of our daily lives. But I would like someone to mention is things like $25. For instance, a month and a half ago I had occasion to go to the hospital, the emergency room. I was there a little over an hour. I received my bill, $105. This was outpatient care. I was diagnosed tonsillitis. Now I think it is an extreme amount of money to pay for that diagnosis. For the short time I was there I received an X-ray for $22, special reading for $5, a blood test for $10, urinalysis for $5, $15 for the emergency room and $25 for the staff doctor. I could have gone to the best doctor in town and they wouldn't have charged me that much. That equals $105.

Then I received a bill that the gentleman—I wish he would give me the answer—represented Blue Cross, they paid $59 of this bill. Now they paid this bill not knowing whether I received these services or not. I don't think that they handle their own financial affairs this way. He made a statement that these rates are going high. Why wouldn't they? If you are going to give out money this way without checking whether or not I received 10 X-rays or 1 X-ray, naturally, my rate is going to go up. I think that is extreme. I am sure that if Freese's sent him a bill for three suits and he bought one, he would make a complaint. That is my complaint. It is very short and sweet.

Senator HATHAWAY. Thank you very much. Do you have a written statement?

Dr. PATTERSON. No.

Senator HATHAWAY. You are just holding those papers in your hand.

Dr. PATTERSON. And as far as the demand for services. I didn't ask for any of these services. I requested to sign a statement, be willing to sign a statement, that I refused these services. My son who is going to medical school and never had anything, he could have told me I had tonsillitis and go get some penicillin.

Senator HATHAWAY. John? Oh, I thought it was John Martin.

Dr. PATTERSON. I wish I looked like John Martin.

I am from the Maine Medical Center. What we would like to do is just put a written document on record and follow up with a letter so we don't run you overtime today.

Senator HATHAWAY. Fine. You have 3 minutes, if you would like to testify. Anyone else?

Your name, please.

STATEMENT OF JANET BEACH, HOSPITAL ADMINISTRATOR OF TRAINING, YALE UNIVERSITY

Ms. BEACH. My name is Janet Beach, and I am hospital administrator of training at Yale, former director of John Hopkins. I was a nurse before that and for the last 20 years I have been a mother. So I have a pretty rounded background.

I would like to leave two thoughts with you. First, in looking back in these 10 years at the increased costs in hospitals, no one has mentioned that more than 50 percent of the schools of nursing have been closed in this country without the people—I mean the people, the public—even being aware that they were being closed. This is a tremendous factor. In their place—I believe it is safe to say that 98 percent of all the students that were in schools paid tuition. But now interns are making as much as $10,000 to $20,000 a year; residents, $15,000 to $35,000 a year. With those increased costs to pay, it is impossible to continue schools of nursing. So our future in having registered nurses is zero minus.

The second thing, in all that has been said today, I haven't heard—I haven't been here every second. But let's ask the people what they want. It has always been a campaign of mine everywhere to try to make the public realize that they own the hospitals. If we went out in the streets of the city right now and said, "Who owns the hospital," I am sure that not one person in 100 knows they own the hospital. Let's ask them what they want and start from there rather than imposing on them what we think they need. That is all.

Senator HATHAWAY. Thank you very much. I guess that about does it.

[The following material was supplied for the record:]

AMERICAN ASSOCIATION [illegible] COMPREHENSIVE [illegible] PLANNING

CAPITAL CONTROL OPTIONS FOR RESTRAINING MEDICAL CARE COST INCREASES

An AACHP Working Paper

April 1977

BACKGROUND

The Carter Administration's recently announced proposal to limit annual increases of hospital charges to nine percent has once again focused public attention, as well as political pressure, on the health care system's perennial problem--uncontrollable cost inflation.

National health expenditures tripled between 1965 and 1975. In FY 1976, the annual expenditure for health totalled $139.3 billion, up 14 percent over the $122.2 billion spent in FY 1975. This rate of increase was approximately twice the CPI for the same period.

The largest expenditure category was hospital care, representing nearly 40 percent of the total at $55.4 billion. This was a $7 billion--14.5 percent--increase over FY 1975. Physicians' services, nearly half as large as hospital expenditures, were estimated at $26.4 billion, an increase of 15 percent over 1975 expenditures.

Continued increases of this magnitude jeapordize the availability of reasonably-priced quality medical care for all Americans and delay any serious consideration of a national health insurance program, a publicly stated political priority of the Carter Administration. Thus, the Administration must first take action to curb annual medical care cost increases.

Inflation in the current health services market is a result of the following factors:

- The increased demand for services, largely a result of the government financing programs, Medicare and Medicaid, as well as increased private health insurance coverage.
- A method of payment for medical services utilizing a third-party insurance mechanism which shields both the consumer and provider from the impact of the full cost of treatment at the time of utilization.

- The nature of the reimbursement system, which is primarily based on retrospective costs incurred, offers little incentive to restrain costs at the time services are provided.

- The uneven distribution and mix of health resources (facilities, services, and manpower).

- The introduction of high-level medical technology which is heavily capital and labor intensive.

- The excess capacity in the medical care system, especially hospital beds, which means that the consumer must bear the burden of paying for the fixed costs of underutilized facilities and equipment.

- The nature of the product, which makes any kind of consumer cost consciousness and comparative shopping difficult. Since consumers do not have the knowledge to diagnose or prescribe for themselves, they must rely upon the medical profession. Also, consumers have high expectations for medicine and urge physicians to provide the maximum possible amount of services.

- The impact of medical malpractice, which results in the increased practice of defensive medicine and increased malpractice insurance premiums reflected in higher professional charges.

By focusing their cost containment efforts on constraining increases in hospital costs, the Administration has chosen the largest, and thus most visible, portion of the medical marketplace. However, the dynamics of hospital costs involve sophisticated factors and complicated relationships which may not be affected by a simple lid on the increase of hospital charges. For example, a cap on total revenues does nothing about the distribution of costs within the cap, which has a significant impact on the quality of medical care.

ISSUE

The present rate of inflation in the hospital sector, due in large part to the rapid increase in high technology services, unnecessary duplication of facilities and services, and the excess capacity of acute care beds, can be effectively addressed only by a combination of capital and fiscal controls. The American Association for Comprehensive Health Planning (AACHP) believes that any hospital cost control legislation enacted must be supportive of the principles of the certificate of need and rate setting processes for facilities and services embodied in PL 93-641, "The National Health Planning and Resources Development Act." Further, any such hospital cost containment legislation must build on the integrity of the functions and relationships established under PL 93-641 between the federal, state, and regional levels.

THE RELATIONSHIP BETWEEN
COST CONTAINMENT AND PL 93-641

One of the major contributing factors to the rate of increase in hospital costs is capital investment. Moreover, exacerbating the effect of direct capital expenditures on health care costs, there are additional long-term indirect costs associated with more personnel, supplies, and utilization required to support new facilities and equipment.

While rate regulation is undertaken to control the level of health care cost inflation, other compatible objectives must be recognized:

- Prevention of unnecessary expansion of facilities and services.
- Reduction of excess capacity in the health care system.
- Reduction of unnecessary utilization.

- Encouragement of the development of effective and efficient health care delivery alternatives to inpatient facilities and services.

- Conditioning public expectations concerning the relationship between the availability of medical care services and cost.

Thus, a strong system-wide planning program is necessary to address these concerns so that medical care resources are developed according to regional and community needs while at the same time addressing imbalances in the distribution and mix of services and facilities. Without an aggressive planning program, operating cost limitations can inadvertently entrench the existing system, foreclosing efforts to improve it. Also, system-wide evaluations are necessary to determine whether or not institutionally-based rate regulation decisions are decreasing total health care costs and are increasing the cost-effectiveness of the system.

Finally, a major advantage of linking the two programs is that it would effectively involve wide public participation in the national effort to contain the rise in health care costs. This is important because cost containment efforts will ultimately force the making of highly unpopular decisions and this can best be accomplished by maximizing citizen involvement, understanding, and support. This is precisely the current role of planning agencies.

Several requirements must be considered if the two functions are to be integrated successfully:

- Complementary guidelines, standards, and criteria at the federal, state, and local levels.

- Clear delineation of functional relationships.

- Adequate fiscal and manpower support for both functions.

- Compatible systems of data acquisition and utilization.

SOME OPTIONS FOR
CONTROLLING CAPITAL EXPENDITURES

1. *Preventing expenditures for new unnecessary capacity.*

A. A national ceiling on annual capital expenditures.

A national limit could be established on certificate of need approvals for capital expenditures and then allocated to the states based on need, adjusted to consider cost differentials in various areas. The state health planning mechanisms would then determine the allocation of their share in accordance with federal standards and guidelines, and based on Health Systems Agency (HSA) recommendations. This approach maximizes community involvement in the decision, yet forces the issue within national economic limits. To be fully effective, however, the program should be extended to cover expensive equipment, regardless of its location, normally used in hospital settings.

B. Pooling of depreciation payments.

Capital formation, which includes all fiscal mechanisms allowing facility construction and expansion, needs to be controlled. This includes all forms of financing, such as loans, tax-free bonds, investments, philanthropy, and tax credits.

One approach would prohibit third-party payors from reimbursing depreciation funds directly to hospitals and would instead require a fixed proportion of reimbursement to be paid to a capital pool. The pooled money would be allocated through the health planning

mechanism established under PL 93-641, consistent with nationally established need criteria and to be used based on local priorities and in accordance with certificate of need determination.

Thus, the creative role of planning agencies would allow for redistribution of resources to shortage areas and provide a means for funding alternatives that may serve as a substitution, in whole or in part, for more costly inpatient services.

II. *Reducing excess capacity.*

The national average of 4.4 beds per 1,000 population exceeds various estimates of bed/population ratio accepted as sufficient to meet medical need. The Institute of Medicine recommends reducing the national bed/population ratio to 4.0 beds per 1,000 population within five years and well below that in the years to follow. There is a significant danger, however, that any cap established on the bed/population ratio could become a floor or minimum objective. HMOs, for example, operate efficiently with 2.5-3.0 beds per 1,000 population without any apparent detriment to the quality of services or to the health status of the population served. Furthermore, the determination of the appropriate bed/population ratio for a specific region depends heavily upon the level of health status in the community.

The national surplus of about 100,000 short-term hospital beds contributes millions of dollars annually to the spiralling inflation rate of hospital costs. The advantages of reducing this excess bed capacity are the elimination of both maintenance costs for surplus beds and unnecessary related utilization. A regional average of 4 or less beds per 1,000 per HSA area could be achieved by a moratorium on new construction and modernization, by direct purchase and closure of excess beds, conversion to other uses, or by decertification of identified unneeded facilities or services.

The main drawbacks of this approach are excessive time lag of impact of closing beds by attrition, the high cost of buying out excess capacity if that option alone should be adopted, legal constraints, and political resistance.

CONCLUSION AND RECOMMENDATIONS

Regardless of the approach selected by the Administration to constrain the rate of health care cost increases, it is obvious that the health planning and resources development mechanisms established under PL 93-641 provide a ready vehicle to implement certain aspects of revenue and capital controls. Some modifications to the law, however, will be necessary to strengthen the roles of HSAs, Statewide Health Coordinating Councils, and State Health Planning and Development Agencies (SHPDAs) in cost containment activities. Primarily, the certificate of need process must be strengthened by abandoning demand-based certificate of need activity and undertaking the initiative for creating regional health care systems projected on population-based needs, or other nationally established goals, limits and guidelines. A comprehensive certificate of need program must be able to:

- control the introduction of new capacity into the system;
- withdraw certificate of need for previously approved projects not yet under construction that are found to be unnecessary based on updated criteria; and
- decertify or convert the mix of existing facilities and services in the system.

The American Association for Comprehensive Health Planning endorses the following principles to be incorporated in any national hospital cost containment program:

1. Any national hospital cost containment program must address both operating revenues and capital controls.

2. Such a national program must be complementary to the roles, relationships and established functions at the federal, state and regional levels as articulated by PL 93-641.

3. In order to meet these objectives and carry out such a national program, PL 93-641 should be amended to:

   a. Include the review of federal facilities (VA, PHS Hospitals, and Department of Defense facilities) under the certificate of need authority granted to the states.

   b. Require that the state health plan be consistent with the national guidelines required by the law.

   c. Require that SHPDA and HSA decisions be consistent with the state health plan.

   d. Authorize SHPDAs, based on HSA recommendations, to decertify completely or convert unnecessary facilities or services, including projects previously approved, but not yet under construction, that are judged to be unneeded.

   e. Certificate of need authority should include review of expensive equipment, regardless of its setting, normally used in hospital locations. A dollar threshold ($100,000-$150,000) should be the determining factor. These expenditures would be included under the national certificate of need cap.

4. Under Section 1122, deny all federal reimbursement for unapproved facilities and services, rather than the withholding of depreciation reimbursement.

5. National caps should be established for hospital operating revenues and capital expenditures, as well as expensive equipment, regardless of location. The capital expenditures limit should be established by a national certificate of need cap distributed to the states according to a formula established by the Secretary of HEW. The formula should include regional need and cost variations.

6. To avoid wasteful duplication, the capital expenditures should be authorized only by the certificate of need and/or Section 1122 mechanisms. These activities should be consistent with the state health plan and/or medical facilities plan.

7. Any process established for exceptions to the revenue and capital limits must be consistent with the federal, state, and regional functions and relationships in PL 93-641. The state and areawide health planning mechanisms must be utilized in the exceptions process for both revenue and capital limits.

8. Incentives should be created to encourage the development of alternative, less costly, delivery mechanisms.

9. Explicit national guidelines should be published under the authority of PL 93-641 placing a moratorium on the construction or conversion of facilities which would result in additional bed capacity in areas with a bed/population ratio of more than 4 per 1,000, and an occupancy level less than 80 percent. However, extreme caution must be utilized to ensure that unnecessary capacity is not created in areas under that ceiling. An appropriate exceptions process should be established based on criteria of the Secretary of HEW. This process would include the state and areawide health planning mechanisms.

10. FHA loan guarantees, tax-free bonding authority, and other incentives for capital formation must be discontinued for unapproved facilities and equipment in support of capital limits and moratoriums.

Senator HATHAWAY. Thank you, and you can be sure that this testimony will be invaluable in our deliberations next week. Thank you very much for coming. Additional statements submitted for the record will appear in the appendix to these hearings.

[At 3 p.m. the hearing was closed.]

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