REIMBURSEMENT GUIDELINES FOR MEDICARE

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

EIGHTY-NINTH CONGRESS

SECOND SESSION

EXECUTIVE PROCEEDINGS DISCUSSING PROPOSED HOSPITAL INSURANCE REIMBURSEMENT GUIDELINES WITH OFFICIALS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

MAY 25, 1966

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REIMBURSEMENT GUIDELINES FOR MEDICARE

WEDNESDAY, MAY 25, 1966

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

The committee met, pursuant to notice, at 10 a.m., in room 2221, New Senate Office Building, Senator Russell B. Long (chairman) presiding.

Present: Senators Long, Smathers, Anderson, Douglas, Talmadge, Ribicoff, Williams, Carlson, and Curtis.

Also present: Thomas Vail, chief counsel; Jay Constantine, staff member, and Fred Arner, legislative reference service.

The CHAIRMAN. This meeting is called for the purpose of discussing the proposed hospital insurance reimbursement guidelines with officials of the Department of Health, Education, and Welfare. The staff of our committee has examined the proposed guidelines and raises a number of questions.

The staff indicates that if the proposed guidelines do not conform to the intent of Congress, hundreds of millions, even billions of dollars in payments may be made to hospitals beyond the estimated amount reported to Congress by the Department during the consideration of the medicare bill last year.

At this point I would like to include in the record of the hearings a copy of the staff report. The report that I have just received from the General Accounting Office regarding the proposed medicare reimbursement formulas will also be included. (See app. A, p. 135.)

The staff report, I believe, is familiar to most of the members of the committee.

(The staff report referred to follows:)

PROPOSED MEDICARE REIMBURSEMENT FORMULA

Congressional Intent, Policy and Costs

May 16, 1966

Prepared by the Staff of the Committee on Finance

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INTRODUCTION

The proposed Medicare reimbursement formula for providers of services under the Hospital Insurance Program was announced by the Department of Health, Education, and Welfare on Monday, May 2, 1966. This formula involves costs which are at least $750 million greater than the amount Congress was advised would be paid out of the Trust Fund over the next 10 years for care of aged persons. The $750 million of added costs do not include increased expenditures from general revenues for the Title XIX welfare program of health care. The proposed Medicare formula would establish the pattern for reimbursement of hospitals under Title XIX which, when fully implemented, may involve Government financing of as much or more hospitalization than will be purchased under Medicare. The costs of the Maternal and Child Health, and Crippled Children's programs would also be affected by the Medicare pattern of reimbursement.

The staff has examined the reimbursement guidelines and suggests that the increased costs of all these programs--potentially billions of dollars--raise questions concerning a number of important policy decisions, some of which appear to have been taken contrary to Congressional intent. These are presented and discussed in this document.

Because of the importance of the question, the General Accounting Office has also examined the reimbursement guidelines and is submitting a report of its own to the Committee.

I. Question: SHOULD DEPRECIATION BE ALLOWED ON ASSETS PAID FOR WITH PUBLIC FUNDS?

1. Summary of Reimbursement Guideline: The proposed regulations authorize allowance of depreciation on the assets of an institution without distinction between assets paid for with public funds or with private equity capital. A variety of liberal depreciation methods are provided, including: accelerated depreciation; allowance for depreciation on assets already fully depreciated but still in use; and payment of a percentage of reimbursable costs (aggregating 27-1/2 percent over 10 years) in lieu of depreciation on assets acquired prior to 1966. The individual institution may select the method most favorable to it. It may also change from one method to another with the approval of the fiscal intermediary (Blue Cross). Depreciation is not required to be funded so as to establish a reserve toward replacement, modernization or expansion. Neither are such allowances required to be applied toward repayment of principal on debt which may have been incurred in the acquisition of the assets on which depreciation is allowed.

2. Rationale for Allowance of Depreciation on Publicly-Financed Assets: Proposed reimbursement under Medicare includes allowance of depreciation on assets paid for with Federal funds. The rationale given in the published guideline for this decision is that: "Essentially there is no substantial difference between assets financed with Hill-Burton, other Federal or Public funds, and other donated depreciable assets. These

assets, like other assets, become a part of the provider institution to be used in providing services. Irrespective of the source of financing of assets, if they are used in the providing of services, they are, in fact, a cost of producing those services. Therefore, assets financed by Hill-Burton or other Federal or Public funds are to be treated as any other assets and their cost reflected in depreciation."

3. Staff Evaluation of Effects of the Proposed Guideline: Because depreciation is not required to be funded, most of the depreciation allowances will probably be absorbed into the operating revenues of institutions and applied toward current expenses. A substantial portion of the capital costs of non-profit and public institutions has been and is being paid for by the Federal government. The Federal share of Hill-Burton grants exceeds $2.6 billion. The Hill-Burton program is budgeted at $270 million for the coming fiscal year. Federal programs such as the Community Mental Health Centers Act and the Appalachia legislation also contribute toward construction costs of health facilities. The pending Hospital Modernization Bill would involve Federal expenditures of up to $4 or $5 billion over a 10-year period. All of these programs involve expenditures from general revenues.

The position taken in justification of the proposed guideline seems inconsistent with the reasoning used in the same formula in the guideline limiting allowable research expenses. The reason given for that limitation is: "Funds for this purpose are provided under many Federal

programs and by other tax-supported agencies." Because comparable sources of aid are available for construction of facilities it is difficult for the staff to understand why a similar restriction was not applied with respect to depreciation. As a matter of fact, the staff believes that the legislative history indicates a Congressional intent that some types of limitations were contemplated. The reports on the Social Security Amendments of 1965 of both the Committee on Finance and the Ways and Means contain the following identical language: "Reasonable costs should include appropriate treatment of depreciation on buildings and equipment (taking into account such factors as the effect of Hill-Burton construction grants and practices with respect to funding of depreciation)..." (H. Rept. No. 213, 89th Cong., 1st Sess. 31, 32; S. Rept. 404, 89th Cong., 1st Sess. 35, 36 (1965).) Despite those instructions, which the staff views as quite explicit, depreciation on Hill-Burton assets (and assets acquired with other public monies) is allowed by the proposed guidelines without distinction from other assets and no requirements whatsoever are imposed with regard to funding of depreciation payments.

The net effect of this "lumping" of publicly-financed assets with other assets for purposes of depreciation as well as the absence of a funding requirement is to place the Federal government in a strange and costly position:

(a) The Federal government pays for the assets with its original grant.

(b) The Government pays for them again through depreciation allowances (even permitting accelerated depreciation!)[1/]

(c) The Government may very well pay a third time when the same facility needs to be replaced and modernized and applies for an appropriate grant. (In this case it is assumed that the facility has absorbed its depreciation allowances into operational expenses and has therefore no funds available with which to finance replacement).

Title XIX of the Social Security Act established a comprehensive welfare health care program. That program, like Medicare (Title XVIII) requires the payment to hospitals of their "reasonable costs." It is anticipated that the definition of "reasonable costs" in Medicare will also be applicable under Title XIX. Thus, inclusion of depreciation allowances on publicly-financed assets in Medicare's reimbursement formula would lead to similar allowances under Title XIX as well, with resulting further increased costs to general revenues.

Full implementation of Title XIX in conjunction with Medicare could involve the Federal government in the payment for upwards of 50 percent of all days of hospital care. Applying the proposed Medicare formula, the Federal government could be reimbursing $40 or %50 million or even more each year in depreciation allowances on Federally-financed assets. Increased costs to the Federal government would also result

1/ As will be demonstrated in Parts 2 and 3, the Federal government will also be making a bonus payment with respect to depreciation allowed.

from allowance of depreciation on assets acquired with State and local tax funds.

Questions have been raised as to whether the Federal government should allow any depreciation at all on assets it has paid for -- apart from the issue of a funding requirement on any such depreciation allowances.

4. Staff Conclusions: Because of the strong indication in the Committee reports that some limitations were contemplated by the Congress in allowances for depreciation under Medicare and because of the anticipated increased costs required to be met from general revenues, the staff suggests that the Committee might want to consider whether one of the limitations described below might better reflect the Congressional intent than does the proposed guideline:

A. No Depreciation:

1. No depreciation should be allowed on publicly-financed assets.

2. No depreciation should be allowed on Federally-financed assets.

Comment: Apart from the rationale previously made for this recommendation including the Committee reports there is another supporting reason. In the future, when the institution seeks to replace or modernize Federally-financed assets, it will, if a new Federal grant is sought, have to justify the

continuing need for the facility to the State Hill-Burton agency (or similar agency). Thus, the Federal government would not automatically, through its depreciation payments, be contributing to the continued existence of a facility (or part of such facility) for which no further justification existed.

B. Funded Depreciation:

1. Depreciation should be allowed on publicly-financed assets only if all depreciation allowances (including those for non-publicly-financed assets) are funded in accordance with a plan approved by the State or an agency or agencies designated by the State. Such funds would be used for repayment of principal on debt incurred in acquiring the assets or for replacement or modernization. The plan might be modified in light of changed circumstances, subject to the approval of the appropriate State agency. If a modification resulted in a withdrawal of funds for purposes other than replacement or modernization, an appropriate adjustment might be made relative to future depreciation allowances to that institution.

2. Depreciation should be allowed on publicly-financed assets only if those specific allowances are for publicly-financed assets funded on the basis outlined above.

3. Depreciation should be allowed on Federally-funded assets only if all depreciation allowances (including those for non-Federally financed assets) are funded on the basis outlined above.

4. Depreciation should be allowed on Federally-financed assets if those specific allowances for Federally-financed assets are funded on the basis outlined above.

Comment: The significance of a requirement that depreciation be funded under Medicare was brought out by Robert J. Myers, Chief Actuary of Social Security. He advised the Health Insurance Benefits Advisory Council that: "Considering the interest earned on the funded allowances...hospitals would have enough money at the end of the period of depreciation, not only to replace their facilities, but also to build larger facilities to accommodate an increase in population -- assuming construction costs advance on an average of 1 percent a year and population increases at 1-1/2 percent a year."

II. Question: DOES THE LAW AUTHORIZE THE SECRETARY OF HEW TO PAY MORE THAN THE ACTUAL COSTS OF CARE?

1. Summary of Reimbursement Guideline. - The proposed regulations authorize the payment of a bonus of 2 percent of allowable cost. The bonus is limited, however, so that it may not exceed "a reasonable long term interest rate on the providers equity capital." In calculating the bonus, depreciation on publicly-financed assets is an allowable cost, and in computing the limitation, publicly-financed assets (whether or not depreciated) are treated as equity capital. This bonus concept also is known as a payment for use of capital or "imputed interest."

Under the proposed regulations "reasonable long term interest rate" is approximately 4-3/4 percent, the rate of return on government obligations currently being acquired by the Social Security Trust Fund.

2. Rationale for Allowance for Two Percent Bonus Factor. - The Department rationalizes the 2 percent bonus by the following:

> "In accord with the established practice of a number of large third-party purchasers, this allowance, in lieu of a direct return on the equity capital of providers, recognizes the continuing need for capital funds to secure, preserve and improve service-rendering capabilities. *****
>
> Although the methods to be utilized by hospitals for determining the actual cost of services provided to beneficiaries are the best available, some lack of precision in methods at the present stage of cost finding represents a contingency which is a further consideration for including this allowance."

3. Staff Evaluation of Effects of the Proposed Guideline. - The staff questions whether the Medicare statute authorizes the payment to providers of services of any bonus based on costs of operations. To allow

such a bonus creates an incentive to let costs rise unnecessarily and profits the least efficient operators the most.

A. LEGISLATIVE INTENT: The law (sec. 1861(v) (1)) states that the "reasonable cost of any services shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services...." It further states that "in prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment...to providers of services."

Lack of Congressional Consideration of Bonus Factor. - The reports of the Committees spell out guidelines as to what constitute "reasonable costs" but there is no mention whatever of an "allowance" for the return on capital of the provider of services. Likewise, there was no testimony by an official of the Department before either Committee indicating that such a factor would constitute an element of reasonable cost. The testimony and the Committee reports keep repeating the theme that reimbursement is only authorized for "actual" costs. The reports state, "Although payment may be made on various bases the objective, whatever method of computation is used, will be to approximate as closely as practicable the actual cost (both direct and indirect) of services rendered to the beneficiaries of the program." (Senate Report 404, Part I, p. 36)

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And the following colloquy took place between Chairman Mills and Commissioner Ball at the House hearings:

"The CHAIRMAN. Let us get this one point clear, now. What you are seeking to do is to pay reasonable costs. You are not seeking to pay reasonable charges. You are not seeking to pay anything except what it costs the hospital to take care of this particular patient. There is to be no profit in connection with your computation of what constitutes a reasonable cost.

Mr. BALL. That is right.

The CHAIRMAN. So you do not take into consideration any profit. On the other hand, you make no allowance for losses.

Mr. BALL. That is right.

The CHAIRMAN. Am I right?

Mr. BALL. Yes. That is it.

The CHAIRMAN. What you are endeavoring to do is to reach a figure with the hospitals of what is the cost of taking care of someone, not the charges, not the profit, just the cost.

Mr. BALL. Yes, sir.

The CHAIRMAN. You want this done for cost?

Mr. BALL. Yes, sir.

The CHAIRMAN. Have you had conversations with hospitals about this, to see what their willingness is to participate on what is a reasonable cost basis, not allowing them any profit in connection with these patients?

Mr. BALL. Yes, indeed, Mr. Chairman. We have consulted many, many times over the last several years both with representatives---

The CHAIRMAN. Do you get the same answer from them that I do, that on the basis of their general situation today they would like to break even?

> Mr. BALL. Oh, yes. The idea of getting a reasonable cost reimbursement as distinct from what is frequently now below cost for people over 65. I think they are very much in favor of this approach, and we are really following the principles, that the hospitals advocate. (pages 148-149)

In contrast to the 2 percent allowance, other major, and often controversial, areas as to what constitutes reasonable cost were discussed in the hearings and in the reports. These include the treatment of interest, depreciation, bad debts, charity payments, research costs, and educational costs. For instance, the reports state the following as to deprecation and interest:

> "In the determination of reasonable costs of services consideration should be given to all necessary and proper expenses incurred in rendering the services, including normal standby costs. Reasonable costs should include appropriate treatment of depreciation on buildings and equipment (taking into account such factors as the effect of Hill-Burton construction grants and practices with respect to funding of depreciation) as well as necessary and proper interest on capital indebtedness." (House Report 213, 89th Cong., pages 31-32; Senate Report 404, Part I, pages 35-36)

Principles of Reimbursement. - As to the requirement that the Secretary shall take into consideration the reimbursement principles developed by national organizations and associations of providers of services, the reports state:

> "The appropriate basis of payment for hospital services when payment is made by public or private agencies has been the subject of extended and painstaking consideration for more than a decade. Governing principles have been developed which have attained a large measure of agreement." (S. Rept. 404, Part I, page 35.)

The staff questions whether the principle of a 2 percent bonus has attained "a large measure of agreement." Throughout the testimony of Department spokesmen in the hearings, it was apparent that primary reliance was going to be on the principles of reimbursement of the American Hospital Association. The following colloquy between Chairman Mills and Commissioner Ball is typical:

> "The CHAIRMAN. But the point is this as I understand it, Mr. Cohen. How do we get together with the hospital to determine that the payments which will be made under this title shall be the reasonable costs of such services? I understand now costs are not the charges.
>
> Mr. BALL. Mr. Chairman, the first thing that is required is that we develop a cost formula, and this is a matter that the Secretary is authorized to do after consultation with groups nationally that had had experience with this.
>
> The CHAIRMAN. And using the general principles that are used by national organizations.
>
> Mr. BALL. Yes. If you don't think this document is too long, it is a 17-page description of the principles of payment for hospital care which the American Hospital Association has developed and which, in general, we would expect to follow.
>
> The CHAIRMAN. Leave a copy of that with the committee, will you?
>
> Mr. BALL. All right. Then with that, which is a decision on what is to be included, and what is to be excluded------" (p. 142)

However, the principles of the American Hospital Association did not then, and do not now, recognize such a bonus as an element of "cost." Moreover, the staff is not aware of any other "principles" which do. As

Mr. Alanson Willcox, General Counsel of HEW, stated in his memorandum of January 27, 1966 on this subject:

> "In none of the authorities has there been found any affirmative recognition of a return on capital as an element of cost. On the contrary, in the relatively few instances in which there is a direct consideration of the issue (Saulsbury Oil Co. v. Phillips Petroleum Co., and the cited Internal Revenue Service regulations), it appears that such charges have not been allowed as cost items."

And then Mr. Willcox's concluding paragraph of the memorandum:

> "It must be recognized, however, that there is a long history pointing against the inclusion of return on capital (other than interest) as an element of costs, and that Congress legislated in the light of this history. The principles developed by the American Hospital Association, to which both statute and Committee reports direct the Secretary's consideration, do not recognize such an element. Its inclusion would mark an important innovation in hospital financing, and it is doubtful that Congress, even in authorizing administrative determination of items to be included, intended to permit so great a departure from tradition."

Also pertinent is Mr. Willcox's statement before the Health Insurance Benefits Advisory Council on January 28, as reported in the minutes:

> "At this point the Chairman asked Mr. Willcox, General Counsel, Department of Health, Education, and Welfare, to discuss the legal aspects of this question. Mr. Willcox described his exploration of this problem. He said that thus far he was inclined to the view that Congress did not intend imputed interest to be included as an item of cost. His conclusion in this regard, he said was based on two things. First, imputed interest was not considered by the Congress at the time the contribution rates were being set. Secondly, the law directs the Secretary to consider the cost principles of national organizations; the AHA principles, the only national principles in this area which have gained any general acceptance, do not include an

allowance for imputed interest. Mr. Willcox said that he saw no legal basis for distinguishing between proprietary and non-proprietary institutions. He pointed out that, while Congress was aware that proprietary institutions would be participating in the program, there had been no discussion of allowing a profit element or an imputed-interest element."

Effect Upon Fiscal Soundness of Hospital Insurance Trust Fund. - Also of importance in determining whether the Secretary has the authority to include this bonus factor in "reasonable" costs is the issue of adequate financing for the new hospital insurance program. Naturally, what constitutes "reasonable costs" is a major item in the determination of the cost of the hospital insurance legislation. It is apparent that the Chief Actuary was not aware that this element was included in the concept of reasonable cost when he made his cost estimates to the Congress last year and in the Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund which was sent to Congress on February 28 of this year. The Trustees' report showed the trust fund in exact actuarial balance on a long-term basis -- benefits and contributions both at 1.23 percent of payroll and "reasonable costs" described on page 12 in the way the concept has been traditionally presented to Congress. The Principles of Reimbursement, released this month, will increase costs by .032 percent of payroll (the bulk of which is for the 2 percent factor) and put the fund out of actuarial balance by that amount.

On January 8, 1966, according to the minutes of the Advisory Council, Mr. Myers stated "that the payment of imputed interest was not considered at the time cost estimates for the program were prepared

for the Congress." And, on January 28, the following colloquy was reported in the minutes of the Council:

> "One member said that it appeared to him that the reimbursement formula was being designed to justify previous cost estimates, with no consideration being given to whether this formula meets the needs of the patients and hospitals. Mr. Myers said that the estimates were being emphasized because they reflect the legislative intent. He said that he was certain that if the Congress had been persuaded that hospitals should be reimbursed for imputed interest at the time the legislation was being considered, it would have taken this into account in the financing of the program. He said that it was his view that even the use of an accelerated method of depreciation was going beyond the congressional intent."

B. POLICY QUESTIONS AND RAMIFICATIONS: The following questions and commentary are grouped as follows: those concerned with the fiscal implications to the hospital insurance system of introduction of the bonus factor; those concerned with the appropriate role of the insurance program in the financing of capital development of health institutions; and those concerned with the ramifications for other programs with emphasis on Hill-Burton and good hospital planning, cost accounting, etc.

The staff is concerned that putting the hospital insurance fund out of actuarial balance before the first benefit is paid will cause adverse public reaction to the system. Moreover, we question whether using up a "cushion" in the cost estimate will make it hard to cope with some of the more difficult-to-estimate costs aspects of the program, such as utilization of facilities.

Also we question whether this bonus will use up funds which might better be used for extension of the duration of benefits, for broadening the program to include the disabled, or for other purposes.

The definition of "reasonable" cost established for hospital insurance under medicare is incorporated into the new Title XIX -- Medical Assistance welfare program. The same is true for the Maternal and Child Health and Crippled Children programs. Because of this, the staff believes the 2 percent bonus not only will increase Federal costs but also will increase State and local costs under these grant-in-aid programs. This is so since the cost of the service to which the matching formula is applied will be larger because of the bonus. Also inefficient cost control encouraged by the bonus could push costs still higher. The staff also understands that some States will have difficulty enough in providing matching funds for the "actual" costs of hospital care without the two percent bonus.

Another significant consequence of including a bonus factor in the Medicare reimbursement formula is that it will put pressure on other Federal programs which purchase hospital care to also provide a bonus. These other programs include the Veterans Administration, Indian Health under the Public Health Service and the Vocational Rehabilitation Administration. It could also encourage the American Hospital Association to include a bonus factor in its principles of reimbursement and this would increase costs for private service benefit prepayment plans.

During Congressional hearings, the argument was presented many times by Administration spokesmen that hospitals would greatly benefit from the payment of "actual" costs. Arthur Hess repeated these arguments to the Advisory Council on January 28, 1966, but questioned whether it was wise to go farther. The minutes state:

> "Mr. Hess said that the picture at the end of the first year of operation will reflect some profound changes which it is impossible to foretell at this point. However, it was, he believed, clear that the financial position of hospitals will improve as a result of (1) the placing of all aged patients on a full-cost basis, (2) cost reimbursement arrangements under title XIX, (3) the shift of the aged from ward accommodations (which generally result in a loss to hospitals) to semi-private accommodations, (4) the expected increase in hospital utilization (higher occupancy rates), (5) the increased use of ancillary services, and (6) the reimbursement on a cost basis for outpatient emergency, diagnostic and therapeutic services provided to the aged. He also pointed out that, as a result of the tentative decisions made with respect to depreciation and some of the other elements of hospital cost -- such as the assumption of the payment of some teaching and education costs and the recognition of the need to keep payments current -- hospitals will probably find their net position significantly improved under the program. The Administration's concern now, he said, is whether it is wise to move beyond this point and commit the program, and potentially the public assistance programs, to reimbursement principles, the effects of which cannot be adequately assessed at this time."

The staff also is concerned as to whether a hospital insurance program enacted to pay for service benefits should be utilized as a hospital construction program. On January 19, 1966, before the Advisory Council, Commissioner Ball questioned the role of basic capital needs in an insurance program. The minutes state:

> "Mr. Ball indicated that the Secretary and the Department have given much consideration to the question of the basic capital needs of hospitals, but not in terms of the hospital insurance program being a major source of funds for the immediate modernization of old facilities and the building of new facilities. He indicated that what is being considered is a new program -- not just Hill-Burton, but a new grant program or a guaranteed loan program -- under which the Federal Government could provide part of the funds needed to expand and improve hospital facilities. (Presumably, he referred to the pending "Hospital Modernization" bill.) He said that the question before the Council is, as he sees it, the appropriate contribution of patient income to the expansion and improvement of hospital facilities. He said that while he agreed that the hospital insurance program should share the responsibility for maintaining the present level of quality, it seemed to him from the discussion which had taken place that the hospital insurance program was being viewed as a major source of funds for capital expansion."

The staff also is impressed with Surgeon General Stewart's concern both with the lack of control in hospital planning and the change in the method of tax support which the 2 percent medicare bonus factor would help effectuate. Surgeon General Stewart stated:

> "Under hospital insurance, be it Social Security, Blue Cross, or any other--rich and poor pay equally for presumably equal benefits. But when capital depreciation factors are added to the insurance cost, rich and poor are paying equal shares of very expensive capital expenditures. The regressiveness of this taxing becomes more important as the proportion of the total capital so financed increases.
>
> "Meeting capital needs through a reimbursement formula presents another type of problem. That is--the hospitals with the best plants will have entitlement to the largest factor, which will mean that they will draw a share of the fund reflecting their present advantaged condition, and maintaining the status quo.
>
> "This is both a national and a community problem. Public effort is increasingly directed to area-wide planning for the development of health services and facilities. Needs change,

populations move. But a hospital board with money in its pocket can be expected to be more concerned with its institutional future than with the broad needs of the community. Unless those charged with an overview of community health needs have some financial leverage to help develop facilities geared to needs, the hospital rich will get richer and the poor will get poorer.

"To promote hospital construction meeting community needs, the Hill-Burton formula now gives greater assistance to States with greater need, out of general tax revenue. Although the present formula has a rural emphasis which needs to be modified, the basic concept is sound. In contrast, a Medicare depreciation formula based on present value of hospital plant runs the danger of giving disproportionate amounts to the richer states and the more well-housed hospitals. Care would seem to be needed to assure that the share of the Medicare dollar going to capital plant depreciation should benefit those States poor in facilities at least as much, proportionally, as it benefits those which are most advantaged.

"Over the long run, with such powerful financial mechanisms, decisions in one of these programs cannot be independent of the other. It seems essential that the impact on hospital construction of the Hill-Burton and the Medicare programs reinforce each other rather than working at cross purposes, since the ultimate objective of both is to assure the availability of good health care to the people in all regions and in every community of the country."

The staff is equally concerned as to whether using medicare as a "construction" program will meet the objectives of its advocates. Although it is advertised as a "growth" factor, will the bonus provide any significant or immediate relief to the problem of presently inadequate facilities? The staff thinks not. There is no assurance in the guidelines that it will be used for improvement of facilities at all, since there is no requirement that the proceeds be used for such purposes. Moreover, the staff believes that the greatest bonus may go to new and fully-paid for facilities which have no substantial immediate construction need.

The staff is impressed with the expressions of the Surgeon General that the proper planning of hospital facilities might be thwarted. We fear a bonus might perpetuate the too-small hospital, or the specialized hospital operating inefficiently. Newly built hospitals, which have no large immediate capital needs might add unnecessary beds and duplicate expensive special equipment, thus wasting scarce resources and increasing the costs of all programs. It would appear to the staff that this provision encourages indiscriminate expansion and will impede the efforts of the traditional State and hospital planning agencies.

It has already been pointed out that reimbursing with a 2 percent bonus is a "cost-plus" arrangement which subsidizes the inefficient institution relatively more than the efficient. This is true because any factor based on percentage of costs has a tendency to reduce incentives to keep down costs. At this point, the staff suggests that paying such a bonus to non-profit hospitals built with Hill-Burton funds involves a "profit" on, and a pyramiding of, Federal money. Philosophically, this may be unsound. It is true that the 2 percent factor is not to exceed a reasonable return on equity capital but this limitation will be calculated under the guidelines by treating Federally-financed assets as if they were equity capital. Moreover, the principles of reimbursement also allow depreciation on Federally-financed assets without requirement of funding and there is nothing in the guidelines to prevent a hospital, when it needs replacement, from getting a new Hill-Burton grant and repeating the whole process.

Finally, the staff believes that although the Department rationalizes the bonus factor partly on the basis of "lack of precision" in determining actual costs, the two percent bonus actually leads to further complexity and even less precision. It would require a determination of the value of the assets of the hospital used and useful to the program. Many hospitals have meager capital cost data. Moreover, there is no definition of "equity capital" in the guidelines. The absence of a precise definition hardly leads to precision.

The staff believes that the rate of return would likely become a matter of great controversy and there is no legislative history to provide any protection against arbitrary administrative determination.

Also, as to the rationale of the Department of reimbursing for "lack of precision" in cost finding, this may be a two-way street. Overpayments may be equally as prevalent as under-payments. In any event, the law authorizes retroactive adjustment to insure full reimbursement.

4. Staff Conclusions. For the reasons developed above, the staff is of the opinion that the two percent bonus factor is of such great importance that it should not be included in the reimbursement guidelines without specific Congressional approval. We are convinced that both the statute and the legislative history of the Medicare bill explicitly negate any conclusion that the two-percent bonus factor complies with Congressional intent.

We emphasize the great additional cost it entails, the precedents it establishes, and the impact on hospital planning, and the inefficiency it will encourage. The bonus concept is contrary to prevailing reimbursement principles and if initiated will undoubtedly lead to future increases in the proposed 2 percent, further straining the Trust Fund and general revenues.

III. Question: CAN "REASONABLE COST" INCLUDE A "RETURN ON INVESTMENT" FOR PROPRIETARY INSTITUTIONS WITHOUT SIMILAR PAYMENT TO NON-PROFIT FACILITIES?

1. Summary of Guideline. - Under the guideline both proprietary and non-profit institutions are entitled to a 2 percent bonus above their actual costs of operation. There is no provision in the guideline which recognizes return on capital investment as an essential element (sometimes called profit) in reimbursing proprietary institutions.

2. Rationale for Lack of Distinction. - Commissioner Ball in a statement on May 2, 1966, at a press conference held to announce the proposed reimbursement formula, stated with reference to the 2 percent bonus factor:

> "The allowance will apply to both non-profit and profit-making organizations alike. Thus, we will avoid the anomalous result that would arise from reimbursing a profit-making organization more than a non-profit organization for rendering exactly the same service solely by reason of allowing a return on investment in one case but not the other."

3. Staff Evaluation of Failure to Distinguish. - The proposed 2 percent factor appears to have created more anomalies between the two types of institutions than it purported to resolve. This issue is related to the question concerning the allowance in the proposed formula of a bonus of 2 percent of allowable costs as a "growth and development" factor. The allowance would be payable to all institutions -- proprietary and non-profit alike, subject to the limitation that it not result in a payment

greater than the amount that would be yielded by a "reasonable long-term interest rate" on the institution's equity capital. At present, that "reasonable rate" is about 4-3/4 percent.

The Social Security Administration estimates that the proposed formula, if unchanged, will increase the original cost estimates provided to the Congress by 2-1/2 percent. This would amount to an increase of some $750 million over the original cost projection for the first 10 years of the program's operation. Three-fourths of the $750 million increased cost is directly attributable to the addition of the 2 percent bonus factor into payments for non-profit institutions. 1/ None of the increased costs are attributable to payment of a return on the investment of proprietary facilities. Payment of a return on invested capital of proprietary institutions had been included in the original cost estimates given to the Congress. The minutes of the Health Insurance Benefits Advisory Council's meeting of January 29, 1966, verify this. They contain the following (p. 33):

> "After lunch, the Chairman informed the Council that Mr. Myers (Robert J. Myers, Chief Actuary, Social Security Administration) wished to make a statement that had bearing on the subject under discussion. Mr. Myers stated that, while the report of the Committee on Ways and Means of the House of Representatives contains no specific mention of the payment of imputed interest to proprietary institutions, he had believed payment for the use of capital in the case of proprietary institutions to be an element of reasonable cost, and his

1/ The balance of the increased costs are due to allowing "accelerated depreciation" and payment of one month's estimated costs in advance to institutions.

> estimates of the cost of the program included the cost of such payments. He explained that from the standpoint of cost to the program, it is irrelevant whether the proprietor is paid imputed interest for the use of his own capital or is reimbursed for the interest paid on borrowed capital; for purposes of preparing the cost estimates it was assumed that the proprietor is unlikely to use his own capital if he is not paid for it. Mr. Myers later indicated that the same rationale does not apply to the payment of imputed interest to voluntary institutions and that, in his opinion, either amendment of the law or, at least, a strong indication of congressional intent would be necessary to permit such payments." (emphasis supplied)

Section 1861 (v) (1) of Public Law 89-97, which defines "reasonable cost", provides a basis for differentiation in reimbursement between proprietary and non-profit institutions. That provision includes the following sentence:

> "The reasonable cost of any services shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services..."

The key words here are "various types or classes of institutions." Proprietary and non-profit facilities are different "types of institutions" within the meaning of the statute. The minutes of the Health Insurance Benefits Advisory Council for January 8, 1966 (page 23) recognize this distinction because of the usage of the terms "voluntary" and "proprietary" to describe "the type of institution."

The allowance of a bonus based on costs in the proposed formula is substantially more advantageous to non-profit institutions than it is to proprietary facilities. This results from the fact that proprietary

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facilities have, on the average, substantially less equity capital than comparable non-profit institutions. Conversely, proprietary facilities have relatively greater debt. The imbalance results in the following effects:

(a) The 2 percent on allowable costs is payable on such costs only after deduction of interest expense. The proprietary institutions, because of their greater debt structure, would have to deduct larger payments of interest than would the non-profits, thus reducing the costs base on which the 2 percent would be calculated.

(b) The payment of 2 percent of allowable costs cannot exceed 4-3/4 percent (current rate) of equity capital. The smaller equity of the proprietary institution relative to the non-profit facility means, as a practical matter, that the non-profits will be entitled to the full 2 percent of costs while the proprietaries will be limited to a nominal 4-3/4 percent on their smaller equities.

(c) The non-profits have a further substantial advantage in the computation of the two alternatives. Hill-Burton, and other publicly-financed and donated assets of non-profit institutions, will not be subtracted from their

> equity capital for purposes of calculating the 4-3/4 percent limit. And, without subtraction of Hill-Burton assets from equity, the Federal Government will find itself in the rather peculiar position of paying what amounts to interest on its own money.

The following example illustrates the disparate effects of application of the guideline as between proprietary and non-profit institutions.

ILLUSTRATION OF REIMBURSEMENT DISPARITY AS BETWEEN PROPRIETARY AND NON-PROFIT INSTITUTIONS

Nursing Home A (Non-Profit)

Calculation 1. (Based on 2% of Allowable Cost)

Allowable costs	$ 500,000
less interest	10,000
Net Allowable	490,000
2% x 490,000	$ 9,800

Calculation 2. (Based on 4-3/4% of Equity Capital)

Equity Capital (Hill-Burton)	$ 250,000
Equity Capital (Private)	125,000
Total Equity Capital	$ 375,000
4-3/4% x 375,000	$ 17,812

Nursing Home A receives the full benefit of the 2 percent allowance of $9,800.

Nursing Home B (Proprietary)

Calculation 1. (Based on 2% of Allowable Cost)

Allowable Costs	$ 500,000
less interest*	50,000
Net Allowable	450,000
2% x 450,000	$ 9,000

Calculation 2. (Based on 4-3/4% Equity Capital)

Equity Capital (Private)	$ 125,000
4-3/4% x $125,000	$ 5,937

Nursing Home B is limited to an allowance of only $5,937 because of its financial structure.

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*Greater interest due to absence of public financing and to larger mortgages

Non-profit institutions have financial advantages not available to proprietary facilities:

(a) The billions of dollars in grants under Hill-Burton together with the billions more which the proposed Hospital Modernization bill would authorize, have not been, and would not be, available to proprietary facilities.

(b) Non-profits are granted tax-exemption unlike the proprietaries.

(c) Charitable contributions, private grant-in-aid and endowment funds are available to non-profit institutions, but are seldom, if ever, available to proprietary facilities.

It appears reasonable to assume that non-profit institutions would expect to be reimbursed only for their normal costs of providing care. They are not ordinarily paid a "return on investment." The hearings, executive sessions, and reports on the Social Security Amendments of 1965, do not reveal any demand or expectation of such a return. The cost estimates for the program did not include such a factor.

On the other hand, it is equally reasonable to assume that a proprietary facility would expect recognition of the cost of attracting and retaining capital. Unlike non-profit institutions, the proprietary facility normally does anticipate a return on its capital investment. The expectation and realization of a return on investment is the essential motive

behind establishment and continuation of a proprietary health facility. In contrast, "public service" is the prime motive for the existence of the non-profit institution.

Without expectation of a "return on capital" there would be little incentive for the development and participation of proprietary institutions necessary to the successful provision of services to beneficiaries of this program. This point appears so obvious to the staff -- and to the Chief Actuary of the Social Security Administration -- that had Congress intended to deny a "cost of capital" factor to proprietary institutions it would have specifically excluded such an expense.

4. Staff Conclusions. - In the opinion of the staff, justification exists both in the statute itself and in the accompanying actuarial concept of what constitutes reasonable costs for the payment of an appropriate return on capital to proprietary institutions without similar authorization for non-profit facilities. The differences between proprietary and non-profit facilities can be summarized as follows:

(a) tax treatment;

(b) availability of grants-in-aid and charitable contributions; and

(c) normal and traditional expectations of reimbursement.

All of these factors persuade the staff that a distinction is called for by the statute.

We are not suggesting, however, that proprietary institutions should be reimbursed on any basis related to costs of operation. In our opinion, reimbursement to proprietary institutions should be based solely on a fair return for equity capital invested in the facility.

IV: Question: SHOULD INSTITUTIONS BE GIVEN ONE MONTH'S ESTIMATED COSTS IN ADVANCE?

1. Summary of Guideline. - The proposed regulation authorizes advance "interest-free" payments to a provider of services of up to one-twelfth of the annual estimated costs of care to be furnished beneficiaries. The advance will be available annually and is not restricted to the first year of the program. According to the draft regulation (page 80) "the use made of funds received as advance payments is solely within the discretion of the provider." The estimated advance payments total $200 million during the first year of the program, and will increase each year as the total costs of the program rise.

2. Rationale for Advance Payment. - The rationale for these payments is:

> "Prior to rendering services and submitting bills for such services, providers as a matter of course need to make cash outlays from their own funds for necessary equipment and supplies, and for the services of supporting personnel. In the case of new providers and providers desiring to institute new or improved services, such outlays place a special burden on their finances.
>
> "The intermediary will process interim payments for services rendered to beneficiaries as expeditiously as possible. Nevertheless, whatever the billing schedule of the provider and however promptly the intermediary processes the request for payment, there is a period of time during which the provider has some of its funds tied up in services to beneficiaries for which the program is obligated to pay but has not yet paid.
>
> "In recognition of the fact that providers must make such outlays of funds in order to render services to beneficiaries of the program, it is appropriate that the health insurance program should provide funds to providers at the point in time when such outlays are necessary. This would place providers in a stronger position by reducing

the burden upon the provider of financing the lag between outlays and collection for services.

"Among the possible effects of advance payments which would be of advantage to providers and the program are the following:

A. Improvement in the ability of the institution to earn discounts offered by suppliers.

B. Permitting reduction in accounts payable and more advantageous purchasing.

C. Contributing to ability to refinance indebtedness to obtain more advantageous terms.

"Advance payment will be available to providers upon request. Such payment does not constitute a loan and is interest free." (Principles of Reimbursement for Provider Costs under Public Law 89-97, pages 78-79)

3. Staff Evaluation and Effects of the Proposed Guideline. - With regard to the three "possible effects of advance payments" quoted above, it is suggested that such results would involve all patient care in an institution and not, as the statute requires, be limited to beneficiaries of the program. The staff questions the legality of the advance payments. It can find no authority in the statute for such advance payments. Moreover, title 31 of the United States Code states:

"No advance of public money shall be made in any case unless authorized by the appropriation concerned or other law....." Sec. 529

The staff further notes that Congress did authorize advances to the fiscal intermediaries to facilitate payments (sec. 1816(c)) but, in contrast, gave no authority to make advances to providers. For these reasons, the staff suggests that the advances authorized by the guidelines are contrary to the intent of Congress.

As already pointed out, these advances are interest-free. This means a loss of interest income to the Trust Fund of substantial amounts -- about $10 millions during the first year. During subsequent years as the advances outstanding increase, the interest loss will also increase. This loss of interest was not taken into consideration in the preparation of the original cost estimates, upon which the hospital insurance program was based.

In weighing the advisability of advance payments for care not yet provided, the staff points out that under the medicare statute, hospitals and extended care facilities are required to be paid for care not less than once every 30 days. As a practical matter, we understand that it is the intent of the Social Security Administration to have payments made every 10 or 15 days. This speed is believed to equal or exceed that of any other third-party payment agency (such as Blue Cross) in the country. Neither Blue Cross organizations nor other health insurers typically provide hospitals with advance payments for care not yet provided. Hospitals normally receive payment within a reasonable time after care has been rendered.

Undoubtedly some hospitals incur short-term debt to meet working capital requirements, but many do not. However, all hospitals are entitled to advances under the proposed guideline. The hospital is then free to apply the advance towards payment of principal on long-term debt or to simply merge the advance into its general working capital available for beneficiaries and non-beneficiaries alike.

While there may be some immediate expenses for some hospitals in modifying their operations so as to meet standards and other requirements of Medicare, these are requirements which might necessitate short-term borrowing only. And the guidelines do provide for reimbursement of short-term interest expense.

4. Staff Conclusions. - The staff is of the opinion that the advance payments under the medicare guidelines were not contemplated by Congress and may be contrary to law. Moreover, in view of the fact that payments for services will be prompt and because retroactive adjustment is authorized by the statute for underpayments (or overpayments) to insure full reimbursement, it does not appear that medicare is causing any financial strain so unusual as to justify this precedent.

APPENDIX 1

FOR THE PRESS
FOR IMMEDIATE RELEASE
MAY 4, 1966

COMMITTEE ON FINANCE
UNITED STATES SENATE
2227 New Senate Office Bldg.

CHAIRMAN RUSSELL B. LONG (D., LA.), COMMITTEE ON FINANCE, STATES PROPOSED MEDICARE GUIDELINES ARE FINANCIALLY UNSOUND

Russell B. Long, Chairman of the Committee on Finance, reported today that the proposed medicare guidelines announced by the Social Security Administration place the Hospital Trust Fund in actuarial imbalance and will increase the cost of medicare by some $750 million over the next ten years unless changes are made. He stated:

"Last Monday, the Social Security Administration issued its proposed guidelines for reimbursement of hospitals and other institutions providing services to medicare beneficiaries.

"Here and now I want to express my grave concern over the serious financial consequences which may result if those guidelines are put into effect without change.

"According to the Commissioner of Social Security, this formula for ...vment will increase the costs of medicare by some $750 million over the next ...0 years. This is an increase over and above the cost estimates Social Security reported to the Congress at the time medicare was enacted.

"I might also point out that the so-called reimbursement guidelines for medicare would set a pattern which might very well result in substantially increased costs in other public health programs -- such as welfare.

"The proposed reimbursement guidelines will place the Hospital Insurance Trust Fund in actuarial imbalance, which, unless otherwise corrected, will require additional tax revenues to adjust.

"In view of the seriousness of this situation, I have directed the staff of the Finance Committee to undertake a careful review of the reimbursement guidelines and the background behind those guidelines. Further, I have requested the Comptroller General to provide the Committee on Finance with an analysis and report concerning both the advisability and financial effects of the proposed reimbursement formula.

"I urge the Department to cooperate with me in getting this program back into balance, starting it on a sound basis, and running it in behalf of the older people for whom Congress enacted it.

"This Congress gave birth to medicare, and it has a responsibility to the people to see to it that the child does not wander astray. I intend to carry out my responsibility and I am certain other Senators will join in that task."

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APPENDIX 2

INCREASE IN COST OF HOSPITAL INSURANCE (HI) PROGRAM AS RESULT OF ENUNCIATED PRINCIPLES OF REIMBURSEMENT
May 2, 1966

These Principles involved certain elements that result in somewhat higher costs than had been anticipated when the actuarial cost estimates for the HI program were made at the time of enactment of the legislation.

In summary, the estimated level-cost of the program is increased by .03% of taxable payroll -- namely, from 1.23% to 1.26%, or a relative increase of about 2-1/2%. Since the HI program was initially estimated to be in exact actuarial balance, this means that a current estimate would show a lack of balance of .03% of taxable payroll.

The following table shows the individual components of the increase in the level-cost of the HI program as a result of the enunciated Principles of Reimbursement (as percentages of taxable payroll):

2% Allowance for Growth and Development	.025%
1-month Advance of Funds	.004
Accelerated Depreciation	.003
Total	.032

In terms of dollar amounts at least $750 million will be involved in the first ten years. There are some indications that this amount may be substantially higher. This does not take account of the fiscal effect on the new Title XIX - Medical Assistance welfare program - or the Maternal and Child Health and Crippled Children programs which have had the concept of "reasonable cost" reimbursement for hospitals incorporated into

their provisions by PL 89-97. Moreover, these principles of reimbursement might well be extended to other Federal, State and local programs which purchase institutional services with even greater fiscal ramifications.

The CHAIRMAN. In brief, what the General Accounting Office says, as I understand it, is that the Department is within the law in these guidelines. As I understand it, they do raise questions of congressional policy. But as far as the legality of the guidelines is concerned—that is the impression I gained.

Senator ANDERSON. I don't gain that impression.

The CHAIRMAN. As I understand it, I believe the question is not a matter of law. It is a matter of the desirability of doing it.

Now, Mr. Ball and Mr. Cohen, did you come here with a prepared statement on this issue? If you did, I suggest that you lead off with that statement, then.

Senator CARLSON. May I inquire—the statement you are about to read, does that respond to some of the questions raised in the Comptroller General's report?

Mr. BALL. Senator, we have not seen the Comptroller General's report until right now. But I presume it does, because his report relates, I am sure, to the same issues that the staff report does, and our statement in part addresses itself to those issues.

Senator CARLSON. I notice in the Comptroller General's report that they have some questions as to the legal authority of the Secretary of Health, Education, and Welfare to do certain things, and then they also raise some questions about the making of advance payments. I hope before we get through this morning, we will get into those phases of it.

Mr. COHEN. May I state who is here this morning. I am Wilbur Cohen, the Under Secretary. We also have Mr. Alanson Willcox, our general counsel, and Dr. William Stewart, the Surgeon General of the Public Health Service. Mr. Robert Ball, the Commissioner of Social Security. Robert J. Myers, our Chief Actuary. Arthur Hess, the Director of the Bureau of Health Insurance, and Howard Bost, the Deputy Director of the Bureau of Health Insurance, the two gentlemen administering the program. And Kermit Gordon is here, who is the Chairman of the Health Insurance Benefits Advisory Council, and, as you know, the former Director of the Bureau of the Budget.

The CHAIRMAN. I think I can just briefly summarize what the problems were as we saw them—at least the questions the staff raised. One, the question of whether it is appropriate to allow depreciation for assets paid for with public funds. That is a very big item. There is a question whether it should be allowed at all—for a person to depreciate something he never paid for to begin with. And if it is to be allowed, should it be allowed on public funds. And if so, should there not be a requirement that these funds be set aside to either expand or replace hospital facilities.

In other words, we ask the question whether in these guidelines, we have by executive action—a case of starting another Hill-Burton program, in addition to the one that Congress enacted.

Then we have the second question—whether the law would authorize the Secretary of HEW to pay more than the actual costs of care.

Now, having had some discussion of this matter, I want to say that it could perhaps be done within the law—but the question is the desirability of doing it.

Three. Can the reasonable cost include a return on investment for proprietary institutions without a similar payment to the nonprofit facilities. And that is a fair question to be raised. It seems to me that it was intended that there should be a return on investment to proprietary institutions—and that there is no similar requirement that they be made to public or nonprofit groups.

And the fourth question. Should the institution be given 1 month's estimated payments in advance?

Now, those four items together result in an increased cost of about $75 million a year. If these guidelines are applied consistently in all Government programs as undoubtedly will be the case if this formula goes into effect, it is going to mean—we guess it will mean at least that much more increased costs to the other Federal medical programs. And so that would mean a total increase of about $150 million a year, half of it to the medicare program, and the other half of it to other programs where the Federal Government pays or shares in medical care costs.

As a percentage of payroll it may not look very big, but it is a lot of money.

And further we fear that unless a close rein is kept on the future negotiations which will take place with the providers of health care, health facilities, doctors and others, that the increases could be far more than that.

Suppose you proceed, then, with your statement, Mr. Ball.

Senator ANDERSON. Is this a completely executive session?

The CHAIRMAN. Let me say this. As far as I am concerned, after we hold this session, I would be glad to discuss the matter of making the record generally available. My thought about it is it would be best to go ahead and develop the facts, and see what questions are raised. And I am frank to say to you, Senator, that the reason I called it in this fashion was because I was informed that if we didn't watch out we were going to have to invite all these hospital people to come in here and demand a lot more than this. Perhaps we'd first better take a look at what we have here, and see if you think this is proper, this is appropriate—or whether you think that this goes too far. Because frankly, if we open this to public hearings, we are going to have a lot of people come in and say they ought to be getting a lot more than this.

I think we would best decide then what we want to do about it.

Senator WILLIAMS. Was there any talk that if it was held in executive session, they might come in and ask to be cut back?

The CHAIRMAN. Well, they are not going to ask to be cut back. You can be sure of that. I am on notice of the fact that the hospitals, if this is going to be a public hearing, can be expected to come in here and say that the Department was altogether too severe with them. The Department's position is that while the committee might be inclined to think they went too far—that the hospitals are generally in agreement that they didn't go far enough.

Now, I think we would do best to see whether, in our judgment we think that they went too far in allowing some of these expenses, and see where we want to go from there.

At the moment, we are just talking about oversight of what the executive branch is doing.

There is no interest in making this a classified record.

But it is one thing to exercise oversight interest in what the executive branch is doing—and I think in that we have a right to keep it between the committee and the executive branch. When we go beyond that—if we want to tell them we think they ought to have a different policy than they have, there are a lot of people that could be adversely affected who would want to be heard, and I think perhaps have a right to ask to be heard.

Senator ANDERSON. I just want to be sure how we are going to proceed on this. If somebody calls me, I want to know it is an executive session—and then somebody else releases it.

The CHAIRMAN. I would propose that we proceed here in executive session on the basis that this is an executive record, and if anybody wants to release any part of it, we could discuss it then.

I personally have no reason to think that I would object. But I should think we could discuss it at that time, and see what the record will show.

For example, I don't know what Mr. Ball is going to tell us here. I have discussed this subject with him.

But his statement today might not be the same as it was when I discussed it with him several days ago. And I would say if there is anything about the statement you want to release, I have no interest in keeping it within the committee.

(Discussion off the record.)

The CHAIRMAN. Proceed, Mr. Ball.

STATEMENT OF ROBERT M. BALL, COMMISSIONER OF SOCIAL SECURITY, ACCOMPANIED BY WILBUR J. COHEN, UNDER SECRETARY; ALANSON W. WILLCOX, GENERAL COUNSEL; DR. WILLIAM H. STEWART, SURGEON GENERAL; ROBERT J. MYERS, CHIEF ACTUARY, SOCIAL SECURITY ADMINISTRATION; ARTHUR E. HESS, DIRECTOR, BUREAU OF HEALTH INSURANCE, SOCIAL SECURITY ADMINISTRATION; DR. HOWARD BOST, DEPUTY DIRECTOR, BUREAU OF HEALTH INSURANCE, SSA; KERMIT GORDON, CHAIRMAN, HEALTH INSURANCE BENEFITS ADVISORY COUNCIL; AND CHARLES E. HAWKINS, LEGISLATIVE REFERENCE OFFICER, WELFARE ADMINISTRATION

Mr. BALL. Mr. Chairman and members of the committee, I am pleased to report to the committee on one of the essential steps for getting medicare underway just 36 days from now—the step of establishing the principles of reimbursement for participating hospitals and other institutions.

First, I would like to report that the reimbursement formula which we have announced does not raise any question of increased contribution rates for medicare. The Chief Actuary of the Social Security Administration has estimated that the reimbursement principles involve a slightly higher cost than he had originally anticipated, raising the estimated level cost over the next 25 years from 1.23 to 1.26 percent of taxable payroll, or an increase of 0.03 percent of payroll. This is a relative increase of 2½ percent and is well within the margin comparable to these that we and the Congress have

considered acceptable for the old-age and survivors insurance and disability insurance trust funds.

Moreover, he has informed me that the estimates contain a considerable margin of safety. This safety margin arises from the fact that the estimates assume that earnings levels will increase substantially over the next 25 years but that the maximum earnings taxed under the program is assumed to remain unchanged.

If the maximum earnings taxable under the program is increased somewhat as earnings rise, the long-range cost of the program measured as a percentage of payroll will decline.

The decisions that have been made in the development of the principles have come out of extended study and consultation with many experts on this subject. Very extensive work has been done on the specifics of the principles with representatives of the American Hospital Association, the National Blue Cross Association, the American Nursing Home Association, the American Association of Hospital Accountants, individual Blue Cross plans, private insurance organizations, and State and Federal agencies which purchase providers' services.

There have been meetings also with hospital directors and comptrollers, nationally recognized authorities in the field of health-care costs, and many other interested individuals and organizations. The statutory Health Insurance Benefits Advisory Council has given extensive consideration to the principles of cost reimbursement to be applied in this program, and the principles are based upon their advice and have their unanimous support.

It was to be expected that some differences of opinion would arise over principles of reimbursement—they always have when the purchasers and sellers of services consider such an issue. Representatives of consumer groups, understandably, want to get full value for their money and representatives of providers, understandably, want to be sure they are getting from each financial source the full amount that can be justified. We do not expect that everyone will like all parts of the final product.

The reimbursement task, as stated by the law, is to determine the reasonable cost of the covered services furnished to beneficiaries of the program and to make the payments covering this cost. We are instructed to engage in a cost-finding process related to the beneficiaries of this program and to reimburse on an individual-hospital basis. The determination of the program costs to be paid has two parts—determining what are the costs which should be included for purposes of program payments, and determining the share of those costs that are related to the services furnished the beneficiaries of this program.

The report of the Committee on Finance indicates that—

> Governing principles have been developed which have attained a large measure of agreement * * *. In framing the regulations the Secretary and his staff will consult with the organizations that have developed these principles as well as with leading associations of providers of services.

Using these precedents the inclusion and exclusion of some cost items was relatively easy. Thus, discounts and allowances received on the purchase of goods or services are reductions of the cost to which they relate. The value of voluntary services provided by sisters or other

members of religious orders is includible in the amount that would be paid other employees for similar work. Grants, gifts, and income from endowments will not be deducted from operating costs unless they are designated by the donor for the payment of specific operating costs, i.e., the program will not be the beneficiary of general charitable contributions. Necessary and proper interest on capital indebtedness will be allowed. Also, an appropriate part of the net cost of approved educational activities, to the extent it is not otherwise supported by tuition or grants, is to be included.

Under our principles the program will assume responsibility for bad debts to the extent that they grow out of the failure of beneficiaries of the program to pay their share of the cost of covered services, that is, bed debts (after bona fide efforts at collection) growing out of the deductible or the coinsurance feature applicable to hospital stays of over 60 days.

The program, on the other hand, will not take responsibility for the cost of a hospital in providing charity services or courtesy allowances, although hospital services provided as a "fringe benefit" for employees under a formal plan will be includible as part of labor costs. Nor may costs for research purposes be included as reimbursable costs except for those of usual patient care involved in the research. A reasonable allowance of compensation for the services of owners in profit-making organizations will be allowed providing their services are actually performed in a function necessary to provide patient care.

One of the most difficult problems in defining includible cost is the design of principles governing depreciation. The American Hospital Association argued very vigorously for establishing depreciation on a cost-of-replacement basis. They argued that if hospitals were to be kept up to date in terms of modern technology they needed a depreciation allowance that would be continuously kept up to date in terms of current prices. The new American Hospital Association principles on reimbursement support depreciation on a replacement cost basis and the Southern California Blue Cross now reimburses hospitals on this basis. It is, of course, true that the cost of an asset in the hospital field is far higher when it is replaced than it was at the time it was purchased, not only because of price rises but because the new asset will reflect the cost of new technology.

However, our conclusion was that, although there was some merit in the argument for a replacement cost basis, the use of this basis was too much of a departure from the most common practice and would also be very difficult to administer equitably. We were also concerned that a replacement basis for depreciation would have increased the overall cost of the hospital program by approximately 4 to 5 percent over the estimates that had been made at the time the law was passed.

Although the decision has been made to base depreciation essentially on historical costs, we have at the same time adopted certain other depreciation principles that make this element of the cost reimbursement formula more responsive to current needs and at least partly meet some of the objections that have been raised to a conventional historical cost approach.

Specifically, we are allowing a new estimate of useful life for assets in use at the beginning of the program whether or not the assets have

been partially or fully depreciated on the books of the hospital for other purposes. Depreciation represents a cost of services because capital is used up in the production of services. Thus, an asset actually used for the production of medicare services is a cost to the owner even though his books may show the asset as having been fully depreciated for other purposes.

Second, in recognition of the fact that many hospitals do not have records of the historical cost of their assets, we also will allow hospitals to take at their option either actual depreciation on those assets acquired before 1966 or a flat allowance of 5 percent of operating cost for the first year of operation, with this percentage declining one-half of 1 percent in each succeeding year. Assets acquired after 1965 would be depreciated on a historical cost basis only. This option is open both to those who have historical depreciation records and those who do not, in order to avoid the possibility that an institution might be penalized for having good records.

Under the principles, depreciation will be allowed on assets regardless of the source from which the assets were originally financed. The matter of whether depreciation should be allowed on assets financed by Hill-Burton or other public funds was considered at length by the Health Insuance Benefits Advisory Council and by the Department. It was concluded that the need to replace a used up asset occurs whether the asset was originally purchased with private or with public funds. The grant originally may have helped to create an addition to the resources of an institution but it is a function of payment of depreciation to provide funds which make it possible to keep the asset or its future equivalent permanently.

Consideration was also given to the question of whether funding of depreciation could be required. It was our conclusion that under the law we would not make the payment of "reasonable cost" dependent upon the willingness of the provider to apply the payment to any specified purpose. We concluded that since depreciation, regardless of the source of funds, is a necessary part of the cost, and that since we are required to pay costs, we could not under present law make this payment conditional.

The principles also allow an institution to follow generally approved accounting methods for taking accelerated depreciation as well as straight-line depreciation. It will often be necessary to accelerate the depreciation of assets financed with borrowed capital in order to provide a depreciation allowance of sufficient size to meet the required mortgage payments. In the case of depreciation on assets created by capital that is not borrowed, accelerated depreciation helps, at least in some small part, to meet the greater cost of replacing assets as compared with historical cost. Although we have not, in the treatment of depreciation, been nearly as liberal as if we had allowed a replacement cost basis for depreciation, we have tried to meet some of the problems inherent in a historical cost approach.

Another aspect of cost to which extensive consideration was given was the possibility of a specific allowance for a return on equity capital. It seems quite clear from the wording of the law and the legislative history that "reasonable cost" by definition excludes profit in the economic sense of payment for risk bearing.

However, there is some merit in the concept that the production of services does involve a cost for the use of capital that is equivalent

to what that capital could earn without risk—a pure payment for the use of money, as measured, say, by the interest yield on long-term Government issues.

Hospital and nursing home people argued vigorously for this concept and the majority of the Health Insurance Benefits Advisory Council were rather favorably inclined toward the adoption of such a principle. The Council agreed, however, to reserve judgment on the question and not to recommend this principle during the first year of operation.

The Council was impressed by the fact that the adoption of such a principle would have increased the overall cost of the hospital insurance program by about 6 percent and by the fact that it was difficult to predict the combined effect on hospital financing of other elements in the medicare reimbursement formula and possible new Government programs of grants and loans. For these reasons they preferred to postpone action on this principle. The majority of the Council believed that any inclusion in the cost of an allowance for the use of money should apply equally to nonprofit organizations and profit-making organizations alike.

Although it was decided not to make a specific allowance for a return on equity capital, it was recognized that failure to do so may involve some understatement of actual cost. Another matter of considerable controversy in the development of reimbursement principles has been the method of apportioning of allowable costs between the medicare beneficiaries and the other patients in the hospital. We were urged vigorously by many groups, including the hospital associations and Blue Cross, to go along with the common practice of arriving at the apportionment of costs by the device of multiplying the average per diem cost for all patients by the number of patient-days used by our beneficiaries. Our objection to this approach is that the preponderance of presently available evidence indicates that the over 65 patient is not typical from the standpoint of average per diem cost.

On the average he stays in the general hospital more than twice as long and the ancillary services that he uses are averaged over the longer period of time, resulting in an average per diem cost, if we looked at the aged alone, significantly below the average per diem cost for all patients. On the other hand, in extended care facilities and psychiatric institutions and tuberculosis sanatoriums, which are long-term care institutions, medicare program patients will be covered only at the first and more active phases of their care and it is true their costs may exceed the average per diem level.

In rebuttal of this position, the advocates of the average per diem approach argued, with some merit, that there are offsetting factors which on the average increase the cost of general hospital services for older people and which we were not taking into account. Specifically, they argued that older people on the average require more nursing services than younger people, and that most procedures take longer for older people than for younger people, and thus cost more.

Although we do not believe that there is sufficient evidence to conclude that these additional costs for the aged would fully offset the known factors leading to the conclusion that the aged have a lower per diem cost, we nevertheless recognize that certain services for the aged probably do cost somewhat more and that we are not taking this fact specifically into account in our approach. To have adopted

an average per diem approach on the theory that these two tendencies were offsetting would have added about 8 percent to the overall cost of the hospital insurance program as compared to the approach that we have taken.

We also decided against the use of the average per diem method of allocation because it is unfair as between one hospital and another.

The CHAIRMAN. By what percentage did your approach increase the overall cost?

Mr. BALL. Two and a half percent.

The CHAIRMAN. That would make the overall cost 10½ percent beyond——

Mr. BALL. Except, Mr. Chairman, if we had acceded to these various ideas that were put forward and argued for, then a large part of the rationale for the 2 percent would have disappeared. I think it is an either-or question.

The CHAIRMAN. Well, now, let me just see if I understand this.

Should that 2½ percent be subtracted from the 10½ percent, which would lead you to a conclusion, then, that you are talking about, let's say, an 8 percent increase over the original estimate, or are we talking about an 8 percent increase over the 2½ percent that we have involved here?

Mr. BALL. Eight percent over the original estimate, actually, Mr. Chairman.

Senator ANDERSON. Just a minute. The language doesn't say that, does it? "Would have added 8 percent"—can I read you what you said yourself?

Mr. BALL. "The approach we have taken."

Senator ANDERSON. "* * * would have added about 8 percent to the overall cost of the hospital insurance program as compared to the approach we have taken."

So if you added—

Mr. BALL. The 8 percent is a rounded figure, and that 2½ percent that we have put in I am not sure would really affect this anyway, would it, Mr. Myers?

Mr. MYERS. Mr. Chairman, on this point, I believe that the proper thing to compare the 2½ percent with is the 6 percent that would have been added if imputed interest on capital had been considered. This 2½ percent is really a part of that 6 percent, whereas the 8 percent we are talking about here is the difference in average daily cost for the aged as against average daily cost for everybody.

The CHAIRMAN. But did you have the impression anywhere that the congressional intent was that we should have allowed imputed interest on capital?

Mr. MYERS. No. In making the cost estimates, I had no thought that that would be done.

The CHAIRMAN. What we are talking about is an item neither you nor we had any idea of allowing. I never had an idea we were going to allow imputed interest. Nobody, so far as I know, in your Department—did your Department have any idea that we were going to allow imputed interest?

Mr. BALL. No, Mr. Chairman. And I think one of the main reasons that the staff resisted the tendency of the Health Insurance Benefits Advisory Council to move to this position was not necessarily on the merits of the economic argument, but the fact that it had not

been considered, and that it therefore ought to be postponed. That was the thought there.

Senator WILLIAMS. May I ask you a question. What does the law provide? Could you have allowed that had you so desired under the laws passed by the Congress?

Mr. BALL. We believe there is enough leeway in the definition of cost, Senator, that a case could certainly be made for that. And I would like to have Mr. Willcox answer finally. But I believe that a case could be made for including it in cost.

Senator WILLIAMS. I understand you are saying the law is so fuzzy that you can change the cost variations from 2 to 8 percent at your discretion, without any further change in the law?

Mr. BALL. Senator, I think the elements that go into cost are debatable enough at several points to allow a significant variation—as much as 8 percent easily. And as I am suggesting here, reasonably good cases are made for increases in one area of 5 percent, another of 8, and still another of 6.

Senator WILLIAMS. Do I understand then that with 8 percent, 6 percent, and 5 percent—that you could conceivably interpret the law so as to have allowed you to make all of those increases, which total 19 percent?

Mr. BALL. I think it is conceivable. We certainly would not have intended to do that.

Senator WILLIAMS. I would say the law is fuzzier than some of us really thought.

Senator ANDERSON. That is what I sort of object to. When we passed the bill, there was a great deal said about the fact that the hospital end of it was fairly well understood. We talked about it for years, and knew what it meant. Now, we find out the law is so fuzzy—why didn't you testify to that when the bill was under consideration?

Senator WILLIAMS. Did you know at the time the law was up here that it was that fuzzy, as it was written?

Senator ANDERSON. It wasn't that fuzzy when it was up here.

Senator WILLIAMS. Is that your intention—or is this just a fuzzy interpretation?

Mr. BALL. Senator, I think the language of the law "reasonable cost" is open to a great variety of interpretations. The discussion, the legislative history, the committee report, pinned that down considerably, and we had no intention ever of adding these three things together and allowing a 19 percent additional in the light of the legislative history. I was answering literally the question of whether the term "reasonable cost" could have included such things.

But I don't think it would have been reasonable to so interpret the term in the light of the discussions and the legislative history.

Senator ANDERSON. May I go back to one question. I want to deal with the testimony you have given yourself. You are not talking about a lot of other things. You say "to have adopted an average per diem approach" would have cost 8 percent over what you did do. Now, did the law contemplate an average per diem approach?

Mr. BALL. Well, Senator, I think this is debatable.

Senator ANDERSON. You do?

Mr. BALL. If it had been proven that the aged actually did cost more for nursing services and to put through X-rays and laboratories

and so on, to the extent that this balanced the factor—that we had always taken into account—of their auxiliary services being averaged over a longer period of time—if that case could have been proven, then I think the law would allow an average per diem approach.

Senator ANDERSON. If that case could have been proven, then all the testimony given before the Congress was wrong, wasn't it—because your group and other groups testified round after round that it was less.

Mr. BALL. Right.

Senator ANDERSON. You cannot have it both ways, can you?

Mr. BALL. That is the conclusion we have come to here, Senator. What I am saying is that the hospitals developed evidence that indicated that there were additional costs that we were not taking into account—not that they persuaded us that they were fully offsetting. We turned down average per diem. That was their contention. We turned it down. But in making the argument, I think they were persuasive—not that they were fully offsetting—but that our approach had not fully recognized that older people do cost somewhat more in the admitting process, in the X-ray and laboratory departments and whatever you put them through, and for nursing services. What I am saying here is not that they persuaded us of average per diem, but they persuaded us that our approach, without some additional allowance, might have not been a full reimbursement. And these various factors became the basis for our allowing the 2 percent as a part of basic cost.

Should I continue with the development of that?

The CHAIRMAN. Might I suggest that we get on with the statement, because I believe that members of the committee will have a chance to become familiar with this—there are a lot of questions they are going to want to ask, as this is a big issue.

Senator WILLIAMS. I have no objection to continuing with the statement. But I am just wondering if we don't get a better understanding of this if questions are asked when these points are raised as we have done in this instance and clear them up.

The CHAIRMAN. I have a number of questions to go back over myself.

Senator WILLIAMS. In determining these costs, do you stick to the formula of costs incurred, or do you just estimate costs that may be incurred if they owed money and so forth and so on? Or do you hold to the actual costs that are incurred?

Mr. BALL. Senator, the payments are first made on an estimated basis, but there is a settlement at the end of the accounting period on the costs actually incurred, under the principles described.

Senator WILLIAMS. In computing the costs incurred, how can you get an estimate for interest which is not owed, not paid? How can you get an allowance for an interest charge not owed and not paid, if you are going to stick to the formula of actual costs incurred?

Mr. BALL. We did not accede to this argument for allowing an interest return on equity capital. But, in turning it down, we nevertheless felt there was a case there where we had perhaps undercompensated. And this is under the theory I described—that the use of any capital, the use of money any place, anywhere, has a value—at least the equivalent of what that money could have earned at interest if put into a nonrisk venture. And this in itself is an incurred cost.

Senator WILLIAMS. Proceed with your statement. Maybe I will understand it better later. I don't understand your answer now.

Senator RIBICOFF. Just a point of inquiry, if I may, Mr. Chairman.

I am just curious as I listened to some of the questions and the statement.

I am just curious whether the Department ever discussed this matter with the chairman and the ranking minority member of both the House and the Senate committees before they announced these procedures, or entered into any of these agreements, and of course, with Mr. Anderson, who is the author. Because it is very obvious that these are about as important as the bill itself. And the questions are raised now.

Did you ever discuss these questions with those in charge of the legislative end of it?

The CHAIRMAN. Well, I was told about it. I am frank to say I did not fully understand it. So little did I understand it, that later, when my staff showed me a statement they proposed to issue, I didn't realize they were both talking about the same thing. So there is a lot more involved here than I realized at the time it was explained to me. I was in a hurry myself at the time. And having seen it—this has not gone into effect, Senator Ribicoff. These are regulations that they propose to announce.

So having seen it, and having seen what the staff suggested, then I suggested that we talk about it.

At the previous meeting of the committee, I had available the staff memorandum which raises these issues.

Subsequent to that, I had an opportunity to discuss this matter with Mr. Ball and with Mr. Myers, Mr. Gordon, and some of the other gentlemen who are in this room. We gave them the opportunity to become familiar with the questions we had and we were alerted to their response.

You now have a tentative understanding with the hospitals, as I understand it—isn't that right, Mr. Ball? The hospitals feel this is what the guidelines will be.

Mr. BALL. Yes, Mr. Chairman, the substance of them was released on May 2 to the press, and they have not yet been issued in regulation form.

The CHAIRMAN. That is right. So that if you concluded that you were wrong about some items here, you still have the power to say "We are sorry, we cannot do this, we will have to change it," do you not?

Senator RIBICOFF. Is it just with the hospitals, or also with the nursing homes and doctors? Have you made agreements with everybody?

Mr. BALL. These principles apply to all institutions. They don't apply to doctors. They apply to nursing homes, hospitals, and other institutions since this is reimbursement on a cost basis. You remember, Senator, the doctors were on a charge basis.

Senator RIBICOFF. In other words, you have made tentative agreements with all institutions. Now we come in after you have made tentative agreements. This goes into effect July 1, and here it is almost the end of May.

Senator WILLIAMS. To keep the record straight, no one in the Department has discussed this with me, and all I know about it is

what I read in the newspapers. Nor have they made any attempt to discuss it with me, as far as I know. I don't say they have to.

Senator RIBICOFF. We have two very practical problems I think the leadership of the committee should have known about. Now, you have the embarrassing situation, if you change it, you probably cause almost a revolution and confusion within weeks before the plan goes into effect.

Senator ANDERSON. Isn't that better than bankrupting the fund?

Senator RIBICOFF. Certainly.

The CHAIRMAN. Well, of course, if I do say so, it is better to discuss it now than not to discuss it at all.

Senator RIBICOFF. I think you should, Mr. Chairman. I am just trying to get a little bit of the background of this.

The CHAIRMAN. I am frank to say that one reason we are sitting here in this hearing is because I wanted these important issues discussed with every Senator, and I wanted every Senator to be in a position to evaluate the matter as this goes along. I would expect, with regard to future decisions on medicare, that the same thing would be true. We have a responsibility ourselves, and so does the Department, not just the chairman, but the committee. Every member of the committee should have an opportunity to know what is going on. And I would prefer that they have an opportunity to be advised and have a staff member help them, so we can talk about and understand what is being done. If they think that the costs are going out of bounds, they can complain about it at that time. If they think the Department is being too niggardly in allowing some of these costs, they have that privilege, too.

Senator RIBICOFF. The thought occurs to me, Mr. Chairman, that you might consider some sort of ad hoc committee on oversight. The Finance Committee might be checking with these people constantly. This is going to be very complex and complicated, and it is going to require continuous attention by somebody.

Senator WILLIAMS. Assuming that the committee approves all of these so-called liberalizations that you proposed, how much extra payroll tax would it necessitate to finance this 18 or 19 percent which you are proposing, plus whatever you may have in the rest of it?

Mr. BALL. We are not proposing it, sir, you understand. We are proposing what would increase the cost over what the estimates were of a relative increase of two and a half percent, or 0.03 percent of payroll. And we do not believe any change in the contribution rate is needed for such a small increase.

Senator WILLIAMS. You referred to that, I noticed, in your letter, as being the acceptable rate of increase.

Now, does that mean this is going to be two and a half percent again next year—that you are going to liberalize it? Is that the plan?

Mr. BALL. No. What we meant to indicate there, Senator, is that over the years the committees and the Congress, and we in the executive branch, have recognized that these long-range costs estimates cannot be absolutely precise, and that if the fund is either underbalanced or overbalanced, a relatively small amount, like two or two and a half percent—that has never been considered a reason not to consider the fund in full actuarial balance—that amount of leeway in long-range estimates has always been considered acceptable.

Now, of course, if you added another two and a half percent, making it 5 percent out of balance, another 5, and so on, of course then you would have to have contribution rate increases, and that again was the reason why even though we felt there was some merit to some of these arguments that were made, we resisted the idea of any further increase in cost.

Senator CURTIS. Would you yield at that point? Referring to the first three lines on page 2 of the statement:

> If maximum earnings taxable under the program is increased somewhat as earnings rise, the long-range cost to the program measured as a percentage of payroll would decline.

Now, isn't it true that when you raise the base upon which the percentage of the payroll tax is applied, you raise the dollar amounts that both the employee and the employer must pay?

Mr. BALL Yes.

Senator CURTIS. And have you taken into account, when you say that this cost is going to increase, I think, from 1.23 to 1.26 percent of payroll—the fact that that might include a higher figure upon which the tax will be figured?

Mr. BALL. Senator, that is——

Senator CURTIS. Higher earning power.

Mr. BALL. No. The cost estimates for this program have assumed that wages do go up year by year, but it is assumed on the other hand—an assumption which produces a big safety margin—that even though wages do rise, we are going to keep the maximum base just the same. So this is a percentage of payroll that is constantly rising to the $6,600 base, and there it is frozen.

Senator CURTIS. Yes; but, of course, there is a hidden factor in there.

Here is an individual, and he may even be a social security recipient, partially employed—he makes $75 a month, or a hundred dollars.

Because of the ever-increasing inflation, he is paid $125 or $150 a month. There will be periodic changes in his work. That will bring in more money, won't it?

Mr. BALL. Yes.

Senator CURTIS. So assuming that wages somewhat reflect the general rise in all prices, as they increase, it means an increase in tax for everybody who does not earn $6,600 unless they go over $6,600?

Mr. BALL. That is correct. And under the cash benefit program, of course, they are getting more credit for cash benefits.

Senator CURTIS. Yes. And so while your estimates of what the percentage cost would be could be increased by these things under discussion, it does not take into account a rise in the taxable base?

Mr. BALL. No. If that were to be raised——

Senator CURTIS. It does take into account the increased earnings of people who make under $6,600?

Mr. BALL. That is exactly correct.

Senator CURTIS. That is a good share of the people in my State.

Mr. BALL. We would expect as wages rise, the base will have to be raised, and that will reduce these contribution rates. Contribution rates will not need to be as high as they are projected in the law.

Mr. Chairman, I think that some of the matters that the committee is questioning about are taken up later in the statement.

The CHAIRMAN. I was the worst culprit in the group in interrupting this statement. But I would like to get the statement made. So let's let the witness go ahead.

I hate to ask Senator Anderson to hold up on questions, because he is the grandfather of medicare on this committee.

Mr. BALL. I was speaking of why we had decided against the use of the average per diem.

We also decided against the use of the average per diem method of allocation because it is unfair as between one hospital and another. If a hospital has aged patients who by reason of selection are a particularly high-cost group, this should be recognized in reimbursement to that hospital, even though it is not typical of the picture nationwide. Admittedly, no method of allocation is perfect. But we believe we have adopted a method which is fairer than the average per diem approach, hospital by hospital, and which provides for more equitable allocation of costs between medicare and nonmedicare patients.

What we are proposing in the way of cost allocation is basically to divide allowable costs between medicare patients and other patients by measuring services actually used by the two groups. Two alternative methods of measuring these services are permitted under the principles and modifications of the alternatives are to be allowed in order to avoid difficult recordkeeping problems in the early stages of the program. The first alternative is to use the average per diem method for the roughly two-thirds of allowable costs that, on the average, represent room, board and nursing services and then to allocate the cost for ancillary services according to the ratio that charges made to medicare beneficiaries bear to the charges made to all patients. Although charges are sometimes not a precise measure of services rendered, they come much closer to being such a measure than anything else that is now available and are the basis on which many, if not most hospital patients pay their bills.

Over time, as indicated in the American Hospital Association principles, it is to be hoped that charges for individual items will be brought more closely in line with the cost of services and, therefore, become a more precise measurement of the services rendered.

The other alternative method of measuring services is to apply, on a departmental or cost-center basis, the ratio of charges made to medicare beneficiaries to charges made to all patients.

Because some hospitals may not be able readily to support the cost division between the production of room and board on the one hand and ancillary services on the other required by the first method, we intend at the beginning of the program to allow such a division to be made on the basis of estimates, using the experience of other organizations of like size and character. Hospitals will have the help of the fiscal intermediary and the hospital associations in carrying out this process. Under such a procedure any institution who has a charge structure can apply the first method described very readily and little in the way of advance planning is required.

The principles also provide for an allowance amounting to 2 percent of costs allowed under the other principles—with the exception of interest assessments—as an element of reasonable cost of services. One of the major principles of the law governing cost reimbursement is that we are to pay the full cost for medicare patients so that none of the cost of services to them will fall on nonmedicare patients and vice versa.

We believe this 2-percent allowance is necessary to carry out this objective. Difficulty in measurement, lack of adequate data and other considerations have precluded specific recognition in the formula of various elements which are germane to costs of services for beneficiaries.

For example, as indicated earlier, the other principles do not provide for specific recognition of a return on equity capital and it is recognized that historical depreciation may not be fully adequate for a determination of costs. Moreover, although the methods to be utilized by providers for allocating the cost to be attributed to beneficiaries are the best available, there is a lack of precision in the methods which may well result in understating the cost of rendering services to older people—for example, the likelihood of somewhat greater cost of rendering nursing and related services to older people.

It is the established practice of a significant number of large third party purchasers to include in payment for cost of services a factor in the form of an allowance to cover various elements not specifically recognized in the formula or not precisely measured. The 2-percent allowance provided for in our principles does the same thing. It is not a bonus but a part of basic cost.

The allowance is limited to an amount which might be justified as a minimum return for the use of equity capital, as discussed earlier. It is limited to an amount which, as a percentage of the provider's net investment, does not exceed the rate of return on Government obligations currently being acquired by the social security trust funds. In the determination of the amount of the provider's net investment, for purposes of applying this limitation, the cost of assets financed by Hill-Burton or other Federal funds will be excluded. The exclusion will be on the basis of the share of the cost financed by Federal funds after the adjustment for depreciation.

The 2-percent allowance applies alike to profit and nonprofit organizations. Thus the principles avoid the anomalous result that would arise from reimbursing a profitmaking organization more than a nonprofit organization for rendering exactly the same service—solely by reason of allowing return on investment in one case but not the other.

In addition to the formula itself, there are several matters related to the process of payment which are of importance to the equitable reimbursement of institutions. It is important that the payments be current and that we avoid the burden on institutions that comes from having to put up money for expenditures prior to reimbursement. Payments will be made for services throughout the year and final settlement on a retroactive basis will be made at the end of the accounting period. Continuing payments will be made as often as possible and in no event less frequently than once a month. The retroactive payments will take fully into account costs as they were actually incurred, determined according to the agreed upon principles of reimbursement—we don't retroactively change the principles—and settlement will be on an incurred rather than on an estimated basis.

The principles provide that payments will be made to hospitals as they make expenditures for services to medicare beneficiaries rather than the more conventional approach of making payments only after the bills are rendered. We have estimated that on the average payments will need to be made about 30 days ahead of reimbursement

after normal billing procedures in order to meet the goal of providing funds to institutions at the time of expenditure rather than at the time the patient is discharged and the bill submitted and paid.

This current payment procedure will be based on an estimate developed by the hospital and approved by the fiscal intermediary, related to one-twelfth of the medicare program share of annual operating expenses.

We would, of course, in any event share in the interest if the hospital borrows for current operating expenses and unless we make current payments at the time the hospital makes its expenditures, the hospital is given an incentive to borrow at a market rate of interest. Thus, insofar as the current payment approach substitutes for the borrowing of working capital, this approach would actually save money. In any event, unless we make such current payments the hospital is put in the position of losing the equivalent of interest on its money whenever it makes purchases from its own funds rather than from borrowing.

I would like now to call the attention of the Committee to the fact that since the principles on reimbursement were released at a press conference on May 2, we have made a number of changes in presentation and some changes of substance based upon comments we have received, including those of the General Accounting Office.

I am attaching to this statement a listing of the substantive changes. On the whole I believe these changes significantly improve the statement of principles by modifying certain substantive points, and, in some instances, by clarifying the language and the intent.

In summary, I would say that although the principles of reimbursement understandably do not satisfy everyone—and it is true that many hospital and nursing home people believe they should receive significantly greater reimbursement—we believe that we have arrived at principles that are fair, equitable, and workable.

Because of the concern that the American Hospital Association had as a result of our turning down their strong representations in support of (1) depreciation on a replacement-cost basis, and (2) the use of average per diem as a basis for cost allocation, as well as widespread concern about the absence of provision for a specific return on equity capital, Secretary Gardner wrote the President of the Association on April 24 pledging an early assessment of actual experience. He said in part:

> May I also at this time repeat the assurances I gave your Association during the meeting that I am deeply concerned that we have prompt evaluation of the fairness of the results of the application of these principles to the first year cost settlement. We are taking the steps to collect the data necessary for this evaluation and will work with you as well as the Health Insurance Benefits Advisory Council in the evaluation.
>
> We want to assure you that, although I believe we must proceed now with the basic principles as described in the attached, we will work with you on the assessment of actual experience in order to assure the most constructive long-run methods and principles for the reimbursement of costs under the Government program.

Mr. Chairman and members of the committee, we would be pleased to respond to any questions that you may have.

The CHAIRMAN. Let me just say this to members of the committee and those here.

I want to ask just a few questions. All those I have in mind asking will be directed toward Mr. Myers—because I have been in great

detail over this matter with Mr. Ball. And then Senator Smathers and I have decided it would be appropriate that Senator Anderson should chair this hearing for the remainder of the morning, because I am going to open the Senate.

I would like to ask Mr. Myers just a few questions.

Mr. Myers, as I understand it, you worked out the cost estimates for the program that we approved last year.

Mr. MYERS. Yes, Mr. Chairman.

The CHAIRMAN. You are the one who informed us what this would cost, and you had a breakdown of these costs, so you could give us your estimate of what you thought it would cost to do all of this. You advised us at every step of the way, including the conference between the Senate and the House, is that correct?

Mr. MYERS. That is correct, Mr. Chairman.

The CHAIRMAN. Now, I would like to ask you what new items or what items are in these cost figures that you didn't have in your estimates when you gave them to the committee and before the conference last year?

Mr. MYERS. Mr. Chairman there are three items that result in added cost. One of them is the 2 percent allowance that Commissioner Ball has mentioned. The second is the advance of funds to the hospitals before the normal course of payment. And the third one is the accelerated depreciation method—since in my previous estimates I had always assumed that depreciation would be handled more or less as has been done in the past by hospitals, on a straight-line method or some other method of somewhat lesser cost.

And together these three differences in the assumptions—the three differences in the factors and in the assumptions that I made would result, as Mr. Ball has said, in a 2½ percent relative increase, or an increase as a percentage of taxable payroll of a little more than .03 percent.

The CHAIRMAN. Now, in your cost estimates, what was your position, and what was your estimate with regard to the question of a fair return on net equity of proprietary institutions?

Mr. MYERS. In my estimates I had assumed there would be such a factor present—although whether it would or would not have been present would not have had any significant effect on the cost estimates for the hospital benefits, because only about 5 percent of the total hospitalization occurs in proprietary hospitals.

The CHAIRMAN. So when you get down to it, the cost of this is relatively insignificant. But may I just say this as a practical matter—to me it is just unbelievable to think that anyone would propose to use proprietary institutions without allowing a return on equity capital. It seems inconceivable to me—to anyone who believes in the free enterprise system—that if you have one fellow competing with someone else who paid not a nickel for his plant and equipment, had it all given to him by the Government, or had it donated, where the people even made money by donating it—we would suggest that they not allow him something on that.

Senator DOUGLAS. How many proprietary hospitals are there?

The CHAIRMAN. About 5 percent of the total, I think.

Mr. MYERS. The number of proprietary hospitals is somewhat more than 5 percent. But when you consider the number of beds in proprietary hospitals as a proportion of all beds, or the patient

income of proprietary hospitals as a proportion of all patient income, the ratio comes out to be about 6 percent.

The CHAIRMAN. Could I ask you this.

Why did you not anticipate these items in your original estimates or in February of this year when the costs data for the report to the Congress was prepared?

Mr. MYERS. Mr. Chairman, the cost data in the trustees report was merely the same cost estimates as were prepared when the legislation was enacted.

Now, as to the reason I did not consider these elements when the legislation was enacted was because in all the very lengthy discussions of this subject over the years, there had been no mention that these would be considered in the reasonable cost element. Accordingly, I did not take them into account.

The CHAIRMAN. I would just like to ask one more question. This is not of you, but of Mr. Ball.

As I understand it, all of our estimates were based on the thought that we would closely follow the principles recommended by the American Hospital Association and various groups of this sort. I believe that both you and I think that all good hospital administrators believe that if we do allow depreciation, that it ought to be funded, even though you think you don't have the power to require it. Otherwise that allowance, which is a very large amount of money, could be diverted to other purposes. It could be diverted to pay for other facilities, treatment of other patients, or any purpose, for that matter.

I take it that you do agree that it would be desirable, even though you don't think you have got the power to require, that this depreciation be funded, where it would be used for either new plant and equipment, or to replace the old building.

Mr. BALL. Mr. Chairman, I believe that a funding requirement is desirable if it were coupled with some sort of a planning requirement. I think it is not absolutely a clear-cut matter to require funding under circumstances where you then create funds for the perpetuation of all institutions just as they are. It may be that some institutions really should not continue to the extent that they are now set up to do. So that a funding requirement without planning, I think, has some objections. But the general idea of a funding requirement, if it were possible under the law, particularly connected with planning, I think would be desirable.

The CHAIRMAN. Thank you. Senator Anderson, will you take charge of things.

Mr. COHEN. Pardon me, could I say something before Senator Long leaves, Senator Anderson, because we might want to discuss this later—we are under the situation now, as the Senator indicated, of where we have already issued publicly these proposed principles. It is now 36 days away from the date that medicare must start, and most of the hospitals that want to make agreements with us have not signed written agreements pending our formal promulgation of these principles as regulations.

I would merely like to say to the Senator, since our procedures are to issue them as proposed regulations, giving people 30 days' notice for comment, it was our proposal now to go ahead and issue the proposed regulations in the Federal Register, subject to the 30 days for

comments, so that we might be able, within those 30 days, still to get the hospitals to sign an agreement and meet the July 1 deadline. And I thought I had better say that to the Senator before he left the hearing room—because I think unless we give the other people throughout the country the opportunity to make their comments and criticisms in the 30-day period, we cannot sign up the hospitals in order to go into effect on July 1.

Senator ANDERSON. Mr. Ball, if the same principle that you have talked about in these hospitals is applied to the rest of the Government, what would the increase in costs be? You have said $75 million for just the hospital program. What about all the rest of it?

Mr. BALL. Mr. Chairman, we do not have an estimate on that at this point.

I would like to comment on the fact that there are conflicting tendencies involved.

Let me just comment, for instance, on the present situation in California as far as medical assistance for the aged. They are operating on an average per diem reimbursement basis—the basis that we have turned down. They are now reimbursing on that basis in the assistance program for the aged. If they were to drop that, and at the same time pick up these other principles, I think the total cost for the program for older people would be less.

Now, on the other hand, medical assistance in California applies to younger people, too, but they don't use as much hospitalization as older people, and the net effect might still be a reduction, I am not sure.

I just don't think I am able to characterize the total situation at this point.

Senator ANDERSON. Do you feel if this is adopted here, there will be an increase in the cost under title 19?

Mr. BALL. I think there are these offsetting factors, Senator. What the net would be, I am not sure.

Senator ANDERSON. You don't think it would increase the cost any?

Mr. COHEN. Yes, I do. I think the cost, under title 19, is going to be increased, regardless of the specific principles adopted, because Congress wrote into title 19 that the States must pay the same reasonable cost for hospital care as it provided under title 18. And as you know, the States, on the whole, have been paying only a fraction of the reasonable costs. There is no question in my mind that whatever the standards are for title 18, costs are appreciably going to increase, both Federal and State costs under title 19. I don't know the extent, Senator, but I do agree it will be appreciable.

Mr. BALL. I think just to round out the record on this point, Mr. Chairman, we might add that it is not inevitable that the reasoning behind the 2 percent apply to the entire assistance load in title 19, because to a considerable extent the rationale relates to the special situation of the aged. Then as I say, if you substitute this for an average per diem, and do apply it to the aged, you have offsetting cost factors.

Senator ANDERSON. I don't want to read you any sections of that law that is fuzzy. But the section I am referring to is on page 37 of the printed text of Public Law 89-97, about reasonable cost.

In prescribing the regulations—

the Secretary shall consider among other things the principles generally applied by national organizations or established organizations which have developed such

principles in computing the amount of payments to be made to a person other than the recipients of services—furnished to such recipient by such providers.

It is usual to prepay this expense?

Is that the practice and is it customary?

Mr. BALL. First, I think it was a misnomer, and it was our error, to originally call this an advance. I believe that a much more proper term is a current payment related to when the costs are incurred. The whole point of the 30-day payment is to try to get the money to the institution on the average at the time they have to spend it for covered individuals.

The usual billing processes means that a person has been through the hospital, he has been discharged, and there is a bill made, and then reimbursed. All during that time there is a cost of working capital that is being carried by the hospital.

Now, our idea is not to make a payment before that, but to get the payment to them when they have to spend it. That is the objective.

Now, it is true, though—to very specifically respond to your question—that some third party payers on request do have arrangements for making payments before the billing.

Senator ANDERSON. Are they the majority of those who make such payments?

Mr. BALL. No, I don't believe so.

Senator ANDERSON. They are a very small minority, are they not?

Mr. BALL. I am not sure exactly how many. I would be glad to supply it for the record.

BLUE CROSS PLANS THAT PROVIDE, ON REQUEST, FUNDS PRIOR TO THE TIME THEY WOULD NORMALLY BE PROVIDED

Blue Cross plans that provide, on request, funds to hospitals prior to the time they would normally be provided are Group Hospitalization, Inc., Washington, D.C., Blue Cross of Western Pennsylvania, and Blue Cross of Greater Philadelphia.

Senator ANDERSON. If you follow the usual customary practice—would you follow the majority or the minority?

Mr. BALL. I believe the way we have interpreted that direction, Mr. Chairman, is that we are not bound to follow exactly the majority practice at the present time, but to examine and consider all of the practices that are going on, and the principles, and to make desirable modifications in them.

Senator ANDERSON. There is some testimony on a discussion which took place between Chairman Mills and Commissioner Ball:

Chairman MILLS. The point is this, as I understand it, Mr. Cohen. How did we get together with the hospitals to determine that the payments which are made under this title are the reasonable cost for such services?

Mr. BALL. The first thing that is required is a cost formula, and this is a matter which the Secretary is authorized to do after consultation with groups nationally that have had experience with this.

Mr. BALL. I would say that the adoption of these principles, Mr. Chairman, in very, very large measure does follow the national principles. There are some departures where we believe there is an improvement. But by and large, as I indicated at the beginning of my statement, a very long list of decisions were possible based solely on the American Hospital Association principles.

Senator ANDERSON. This is a statement in Modern Hospital for May 1966. "Among the changes was one that is unprecedented in

the history of third-party payments. Hospitals would in effect be paid before, not after, they provide care to medicare beneficiaries."

Do you think that checks with your statement they are going to be reimbursed in accordance with accepted practices? "Unprecedented" is the word used.

Mr. BALL. Whose word is that?

Senator ANDERSON. Modern Hospital.

Mr. BALL. Well, I believe that there are third-party payers who on request do make what are specifically advance payments. I would be glad to supply the number of situations for the record. But I am not arguing that the idea of paying currently for costs as they are incurred is widely practiced—it is not. This is, I think, a real improvement in that respect—but necessary, if hospitals are to get their full costs, and younger people are not to bear part of the costs that really should be attributed to medicare beneficiaries.

Senator ANDERSON. When testimony was being given on the bill, you said, "general principles used by national organizations," did you not?

Mr. BALL. Mr. Chairman, I certainly never intended that we would follow slavishly every principle that was already in existence.

Senator ANDERSON. Did you intend to devise principles?

Mr. BALL. We intended to look at that experience and follow them generally, and take them into account.

First of all, there would be contradictory ones. It would not be possible to follow them all exactly.

Senator ANDERSON. There have been statements here made about how difficult it is to enforce this new law—because of the fuzziness of it. Who created the fuzziness in this regard—the law or the Social Security Administration?

Mr. BALL. I think basically, Senator, the concept of what constitutes reasonable cost has sufficient leeway in it for reasonable people to differ as to what should be included.

Senator ANDERSON. My question is, Who caused the fuzziness here?

Mr. BALL. I think it is inherent—if you mean by fuzziness, different possibilities.

Senator ANDERSON. Other people have been talking about the fuzziness of the bill.

Mr. BALL. I don't believe we created any fuzziness.

Senator CURTIS. Would the Senator yield?

Is the question of some patients, when they enter a hospital, having to put down a cash payment, if they do not have evidence of current insurance protection, in anyway involved in this?

Mr. BALL. I think that is a good point, Senator. That is a very wide practice. Hospitals do protect themselves against the fact that they have to make expenditures before the individual is discharged in the way you suggest, as well as protect themselves against bad debts.

Senator CURTIS. But if the patient has his policy and his receipt showing it is paid up, are there any hospitals which say "We want a couple of hundred dollars before we'll admit you," or any other amount?

Mr. BALL. I believe there would be some if the policy had in it deductibles and co-insurance—they might want to be protected against that kind of situation. But in the usual Blue Cross contract they would not.

Senator CURTIS. Thank you.

Senator ANDERSON. In the hearing before the Ways and Means Committee, did Secretary Cohen submit a copy of the regulations of the American Hospital Association?

Mr. BALL. Senator, I am not sure whether Mr. Cohen did, but we certainly did submit it.

Senator ANDERSON. Did you yourself comment on it?

Mr. BALL. No question but what in general the testimony was that the principles of the American Hospital Association would be a main factor—would be one of the guiding principles——

Senator ANDERSON. I don't believe you said a main factor, Mr. Ball. I read your language. You said, "It is a 17-page description of the principles of payment for hospital care which the American Hospital Association has developed and which in general we would expect to follow."

Mr. BALL. That is correct.

Senator ANDERSON. What does that provide for—advance payments?

Mr. BALL. I don't believe they do say anything on advance. I would have to check to be sure.

But let me pursue the point just a moment, if I may, Mr. Chairman.

If we were to have accepted the view that the American Hospital Association principles are binding upon the Secretary in the determination of cost, we would have been confronted with a very difficult situation; they adopted a principle shortly after this law was passed which said that depreciation should be on a replacement-cost basis.

Senator ANDERSON. But that wasn't in the list submitted to the House Ways and Means Committee, was it?

Mr. BALL. No. That was a later adoption.

Senator ANDERSON. This is something subsequent. What you submitted was the 17 pages of principles to the Ways and Means Committee, and they did not include advance payments, did they?

Mr. BALL. I don't believe so. I don't carry that fully in my mind.

Senator ANDERSON. How much will it cost for these advance payments, and where does the money come from?

Mr. BALL. The advance payment, Mr. Chairman, adds to the long-range cost of the program .004.

Senator ANDERSON. Let me get it into dollars. About $200 million?

Mr. BALL. No, sir; that $200 million figure is the amount of money that is put into the hands of the hospitals sooner than it would if you followed a regular billing procedure. But the cost is the loss of interest to the fund of having that money expended sooner than would otherwise have been the case.

Senator WILLIAMS. How much is that?

Mr. BALL. In dollars I suppose——

Mr. MYERS. About $10 million a year.

Senator ANDERSON. That is right. Five percent of $200 million is $10 million a year. You take the money out of one pocket and use it for that purpose. That is associated with the fund. By what authority do you do that?

Mr. BALL. Because, Senator, if we don't do that, it is our belief that the hospitals are incurring a cost for these beneficiaries that they would shift over to younger beneficiaries. They need—just to make

this point clear—our theory on this is that unless they get that money at the time they make the expenditure, they will have to either borrow working capital, on which we would pay the interest, or if they used their own money for that, they are actually losing the equivalent of interest on that money while they are making expenditures before we pay it. The result is, Senator, that I believe that we would be violating one of the main principles of the law which says we are to pay the full cost, so that younger people don't bear any of the cost of older people.

Senator ANDERSON. Now, do they only have medicare patients in the hospital?

Mr. BALL. All of these principles relate to the medicare share of this.

Senator ANDERSON. Twenty-five percent of the patient days will be for medicare patients. How do the other 75 percent get financed?

Mr. BALL. Well, they will be financed in a variety of ways. To a considerable extent by Blue Cross, by private insurance, and by the patient paying his own way. As Senator Curtis suggested, when the patient pays his own way, there may be requirements that he make deposits when he enters, and in that way the hospital is protected there.

Senator ANDERSON. Yes, But it is nothing unusual to have to carry a bill for 30 days, is it?

Mr. BALL. No.

Senator ANDERSON. Do you reimburse him for interest on a customary business practice?

Mr. BALL. I would think it might be very helpful to the committee, Mr. Chairman, if Mr. Gordon, who is Chairman of the Advisory Council, went thoroughly into this matter, and also has an opportunity to comment on some other points. I think particularly that that last question of yours, perhaps he would be more expert——

Senator ANDERSON. Mr. Gordon knows my high regard for him. I recall the hours we spent in the last days trying to get the medicare bill in acceptable shape. I am happy to have his comments on it.

Mr. GORDON. On this question, Mr. Chairman, it was discussed at considerable length in the Health Insurance Benefits Advisory Council. I gave considerable weight in that discussion to the argument that some hospitals—certainly we don't know how many—in the absence of current payment by the Social Security Administration for the costs of medicare patients would have to finance their working capital needs by borrowing, and the interest payments on that borrowing would be reimbursable under the formula.

Now, if a hospital borrows, if it has working capital needs, it will pay a higher rate of interest than the Social Security Administration will lose by making payments on a current basis.

Consequently, in the case of a hospital which otherwise would have borrowed to finance its working capital needs, there will probably be not a cost to the program, but a saving to the program, equal to the difference between the interest rate that the hospital would have paid, and which would have been fully reimbursable under this program, and the interest foregone by the Social Security Administration.

Now, Bob Myers tells me that this $10 million cost estimate which he has given you does not take into account this particular savings that I have mentioned—that is the reduction in reimbursement by

eliminating the need for the hospital to borrow its working capital, and the reason it doesn't is there is simply no way of estimating it. But I think it is fair to say the actual cost of the program will be less than $10 million. How much less will depend on what practice the hospitals will have followed in the absence of current payment.

Senator ANDERSON. May I just suggest to you that I had to go out to a hospital in Georgetown a while ago to have a picture made of an artery. I was there overnight only. But they required a $150 deposit from me.

Now, I assured the hospital that I had money in the bank here and in New Mexico. It didn't make a bit of difference. I wrote a check for $150. They didn't need any outside borrowing, did they, for that night?

Mr. GORDON. No, indeed. I am sure if they require an advance deposit from you——

Senator ANDERSON. They get money on hand. They don't borrow on all this money. I just wonder why we are doing it in this particular instance, because if you start this, it can carry over to all our Government programs.

Senator WILLIAMS. One question that bothers me. We are speaking of these advance payments. For the moment, let's just forget the merits of it. Title 31 of the United States Code reads as follows:

> No advance of public moneys shall be made in any case unless authorized by the appropriation concerned or other law.

Now, will you tell me what section of the law and what language of the law gives you the authority to make an advance payment? I am speaking of the law that was passed.

Senator ANDERSON. We think it is barred.

Senator WILLIAMS. Just forget the merits of it for the moment. Where is the law?

Mr. BALL. Senator, I think we have to plead guilty to having misnamed this in our original release. We don't believe it is an advance. The intention of the payment is to be current as the costs are incurred.

Senator WILLIAMS. Let's not change the interpretation.

Do you have any authority under the medicare proposal as passed to make an advance payment?

Mr. BALL. If it were an advance, and determined to be an advance, we do not.

Senator WILLIAMS. You do not have the authority.

Mr. BALL. We do not believe this to be an advance. I think perhaps you might like to have our General Counsel comment on this point.

Senator ANDERSON. Isn't it true you changed the word "advance" after you found out there was objection to it?

Senator WILLIAMS. Are you going to pay them after or in advance, or what are you going to do?

Mr. BALL. We are going to pay them—as nearly as we can develop it—at the time that they are incurring costs for services to these beneficiaries. On the average that is estimated to be about 30 days before you would pay after the patient is discharged and the billing procedure completed. Our procedure results in current payment and the usual procedure, in late payments.

Senator WILLIAMS. One other question. Suppose the hospital goes broke, and you have made this advance payment. I noticed you describe it as not being a loan or interest bearing on anything else. So it would not be an obligation. Suppose the hospital goes broke before they have completed rendering the service for which you have made the advance. What happens, and who owes the money?

Mr. WILLCOX. I think, Senator, this, to my mind, is not essentially an advance of the kind that is referred to in the section of the Code you mentioned. It is an attempt, as Mr. Ball says, to pay punctually at the time the obligations are incurred.

There will of course be a running account with all of these institutions. The law specifically provides for retroactive adjustment at the end of an accounting period. So there will be cases where hospitals will have money, more than they are entitled to. That was specifically contemplated in this law. And I supposed that there may be some situation, if a hospital goes bankrupt, where the Government would sustain some loss.

Senator WILLIAMS. I just want to call your attention to the fact that two-thirds of the hospital bill is for wages, and those are not paid in advance, are they?

Mr. BALL. They are paid in advance——

Senator ANDERSON. Where? Where are wages paid in advance?

Mr. BALL. They are paid before the patient is discharged, and the bill is rendered.

Senator ANDERSON. How do you know? I was out in 24 hours. How do you know the wages were paid?

Mr. BALL. The average stay is 15 days.

Senator ANDERSON. That is not a month. Let me read you what Mr. Ball is supposed to have said according to "Modern Hospital." [Reading:]

> Among these changes is one that is unprecedented in the history of third-party payments. Hospitals will in effect be paid before and not after they provide care to medicare beneficiaries. As of July 1 Commissioner Ball indicated intermediaries can pay hospitals for the estimated cost of service to beneficiaries for the month ahead.

That is what he said in his press conference. Isn't that an advance payment?

Senator WILLIAMS. They are "before" payments, he said.

Senator DOUGLAS. Is it an advance payment or is it a current payment?

Mr. COHEN. It is a current payment.

Senator ANDERSON. He said it was an advance payment.

Senator DOUGLAS. Senator, we all know the difficulties we get into by the incautious use of phrases.

Mr. BALL. Whatever I said at the press confrence, Senator, I believe it is a current payment.

Senator ANDERSON. You believe what?

Mr. BALL. I said I believe the whole attempt here is to make the payment currently as the cost is incurred—not pay the hospital ahead of the time they have to spend money, but to hit the average time when they have to spend for these beneficiaries. Any other approach ends you up with paying a hospital after they have had to spend money, which creates a cost for them, which is transferred to other patients.

Senator WILLIAMS. Let's go back to the question that I asked you last.

Suppose you have made this advance payment, or "before" payment, or whatever you want to describe it as—it is a payment before the services are provided—and the hospital does not pay its employees, it goes broke. What happens?

Mr. BALL. Well, I presume if there were no way of recovering by way of the retroactive adjustment at the end of the accounting period—there is just nothing there—the Government in that instance would lose.

Senator WILLIAMS. You would not even have a claim, would you?

Mr. BALL. We would have a claim through the retroactive adjustment, I believe.

Senator DOUGLAS. How many hospitals go bankrupt?

Senator WILLIAMS. I am just raising the point.

Mr. BALL. I think the retroactive adjustment would give us a correct basis for getting anything from the hospital under the circumstances that you suggest that they have. If they didn't have anything——

Senator WILLIAMS. I am not quarreling so much with what you are doing as with how you are doing it.

Maybe you have justified fully what is being done. But I raise the question of changing the rules in the middle of the game in a manner which no one, not even the proponents of the legislation, understood at the time.

Senator ANDERSON. We recently had a whole chain of nursing homes go bankrupt in Massachusetts. They would be under this provision.

Mr. BALL. I just want to be clear, Senator, that we do believe that the retroactive adjustment provision would give us a basis in such a case to make a claim if—and the Government would have a prior claim—if the institution had anything that we could recover from them.

Senator ANDERSON. Senator Douglas has another point.

Senator DOUGLAS. I really should apologize, both to the committee and to the witnesses, for not being able to be here more than I have.

I wanted to ask a question in reference to the underestimated cost of three one-hundredths of 1 percent.

Is it not true that in the past estimates, that there has been an implicit safety factor, because you have assumed that earnings are to be constant, although in practice the earnings drift upward, and therefore receipts under the system increase at a more rapid rate than you originally estimated?

Mr. MYERS. Yes, Senator Douglas, that is correct, for the cash benefits program. There is the same sort of a safety factor here in the hospital insurance program, but in a somewhat different way; namely, that the cost estimates assume that wages and hospital costs will increase in the future, but it is assumed further that the earnings base, the $6,600 maximum will not change in the next 25 years.

Senator DOUGLAS. Not only that the maximum doesn't change, but that the average doesn't change—don't you assume that—that the averages do not change?

Mr. MYERS. We have two different bases for the assumptions for the cash benefits program estimates and for the hospital insurance estimates—both of them designed to include a safety factor because of the effect of the dynamic element of wages.

Senator DOUGLAS. Is this safety factor a result of the fact that earnings in practice, average earnings move upward, but that you assume a constancy?

Mr. MYERS. In the hospital benefits estimates, we do assume that wages go up, because this is the more conservative approach.

Senator DOUGLAS. At what rate?

Mr. MYERS. Three percent a year.

Senator DOUGLAS. So this safety factor is not as much under the hospital and nursing home program as compared with the cash benefits program for the aged?

Mr. MYERS. This assumption results in a safety factor for this system, because if we did not make such an assumption, it would be very nonconservative. It just happens to work out to be the reverse of the situation as it is with the cash benefits program. Accordingly, the actuarial cost estimates for the two programs were prepared on different bases, so that both of them have a safety factor in regard to the dynamic element of wage trends.

Senator DOUGLAS. But the safety factor in the hospital benefits system is much less than the one contained in the cash benefit for old age?

Mr. MYERS. It is a little difficult to compare the magnitudes. But there is a very significant safety factor in the hospital benefits estimates in that we assume that for 25 years the earnings base stays at $6,600, despite the fact that during those years it is assumed that wages will approximately double.

Senator DOUGLAS. What is the average now?

Mr. MYERS. The average earnings?

Senator DOUGLAS. Yes.

Mr. MYERS. The average earnings of a full-time male worker are now about $5,500 or $5,600 a year. And we assume that that goes up 3 percent a year, but that nonetheless, the $6,600 maximum taxable earnings base stays the same for a full 25-year period.

Senator CURTIS. At that point, the individual drawing $4,000 now, even if you do not raise the taxable base, is going to pay a lot more social security tax, assuming that his wages go up.

Mr. MYERS. That is correct, Senator, until he reaches the $6,600 point. Whereas the person who is now earning over $6,600, under the assumption in this estimate, would not pay on any more than the $6,600.

Senator CURTIS. So when you state that this is going to add to the payroll a certain figure, you exclude the idea of the Congress raising the wage base, but you do not exclude the fact that people with earnings now below the wage base will have increased wages.

Mr. MYERS. That is the basis of this particular estimate. I had also made a subsidiary estimate assuming that the earnings base would increase at the same rate as wages would generally. Under those assumptions, the cost of the program would be about 1 percent of payroll, as compared with the 1.23 percent shown in the final estimates.

In other words, according to this other assumption, the tax rate, instead of going up to an ultimate rate of 1.6 percent for the employer and employee combined, could level off at the 1-percent rate that goes into effect next year

Senator DOUGLAS. Thank you, Mr. Chairman.

Mr. COHEN. Senator Anderson, may I make one statement that I think might be helpful to the committee.

You are quite correct, referring back to your original statement, that we spent many many days in executive sessions in the Ways and Means Committee on this item of reasonable cost.

My recollection, however, is that the committee did not want us to absolutely abide by these so-called national guidelines of the national organizations. Neither did they nor we—because the committee had discussed at great length a number of points including this question of the relationship of costs for people over 65 and under 65. And as you know, they wrote in a specific provision in the law that the costs of this should be determined so as not to transfer costs from the people over 65 to under or vice versa.

So that I think I would like to make clear that we are abiding, I think, by the congressional intent, which is both expressed in the law and in the committee report, that while the principles of the national organization should be considered, that it was not necessary that we abide by them exactly—in a number of cases they were not precise enough to determine the allocation of costs between people 65 and over and under 65.

You must recall that this is a program that relates to determining a reasonable cost of not all people in hospitals, but people 65 and over in hospitals. That really establishes a new kind of cost determination for hospitals that is distinct from determining costs for all people. And I think that is embodied in the statute. And I think that we are adhering to that intent.

Senator ANDERSON. Secretary Cohen, my only concern about it is that we had many discussions in private groups and otherwise before the bill was passed. And the decision was reached a long time ago.

Now, you resurrect it and say, all the time we planned to do it, when all the time you didn't plan to do it.

There is nothing anywhere in the hearings that indicates the allowance of 2 percent would ever be considered. I have had people search the record, I have read back myself. I cannot find anything about that, anywhere. Yet you have agreed to it because the hospitals put pressure on you.

Mr. COHEN. I think the point, Senator, is that Congress did, in setting up the concept of reasonable cost, intend for us to reflect what the economic cost of hospital care was. And as Mr. Gordon says, if you were going to pay for the interest on borrowing the money it seems to us to be reasonable to try to reflect in the cost what is actually the incurred cost of a hospital when it has to operate. So while it was not discussed in those specific terms, I think it is absolutely consistent with the intent of Congress that what the program should pay should really reflect what the economic cost is for a hospital in providing these services.

Senator ANDERSON. I just could not disagree with you more. We discussed this over and over and over again, and rejected that in the committee. I just call your attention to the committee report, page 33:

> The cost of hospital services varies widely from one hospital to another, and the variations reflect differences in quality and cost. The same thing is true with respect to the cost of services provided. The provision in this bill for the payment of reasonable cost of services is intended to meet the actual cost.

"Actual." That is not economic or fanciful or anything else. We put it in there so they could not bring in the various things you are talking about now. How do you get around this?

Mr. COHEN. Well, I think this is the actual cost. I think when you are talking about economic costs——

Senator ANDERSON. If I go downtown and buy something that costs $2, and is probably worth $5, does it cost $2 or $5?

Mr. COHEN. Now, you are talking about the charge. When you use cost in that sense, you are talking about the charge to you. And Congress clearly wrote——

Senator ANDERSON. When I buy something, that is the cost to me—not the cost to the manufacturer at all.

Mr. COHEN. That is the charge to you.

Senator ANDERSON. I pay cash, and it is the cost.

Mr. COHEN. Let me say here, this is an extremely important point.

Congress wrote in part (b), on the physician services, that we should pay the reasonable charge. On the hospital, they said we should pay the reasonable cost. They made a very important distinction which we are trying to adhere to. When it comes to physicians' services, we don't pay cost in that sense—we pay the charge that the physician makes that is customary and prevailing. In the hospital area, we are paying what the cost of providing the service is, which I think should take in all the economic costs.

Senator ANDERSON. Just one more quotation from page 37 of the report which I think should have some importance to you. I really believe when a committee goes to the extent of preparing a report, and filing it, and telling the Congress and the people that this is what they mean, it is wrong to try to reinterpret it some other way.

> In paying reasonable cost, it should be the policy of the insurance program to so reimburse a hospital or other provider that an accounting may be made at the end of each cost period for costs actually incurred.

Not beneficiarily incurred, or anything else—"actually incurred." And if you don't pay interest on a debt, that is not a cost that is actually incurred.

Mr. COHEN. May I also refer you, Senator, to page 32 in the House committee report which says:

> In the determination of reasonable costs of services, consideration shall be given to all necessary and proper expenses incurred in rendering services including normal stand-by costs.

I think that——

Senator ANDERSON. What are standby costs? The costs of empty beds? That is a wholly different situation. This whole matter, I think—I want to suggest very respectfully, Secretary Cohen—raises a question about the philosophy of aiding hospitals such as under the Hill-Burton program by law which the Congress enacts, and in which we can put funding and planning requirements, or whether you do it by giving them a share of this money and letting them use it as they see fit. We find hospital after hospital that says, "This hospital has a new device, and we want the same thing."

Therefore there should be planning.

I fully subscribe to that. I wish it were possible to say that if you are going to give them depreciation, you can require that they fund it and plan it to take care of future expenditures carefully.

I think Mr. Ball is right in saying it cannot be enforced properly. But it ought to be.

Mr. COHEN. I would want to say, Senator, we are going to give consideration in the other health legislation that we have, to this element of planning with regard to the use of both Federal funds that may be involved and the depreciation.

I think those two points are valid in consideration of general health legislation.

I agree that we cannot make them as a requirement of the medicare program. But I do think we might well consider making them a requirement in other legislation. And we would be giving some thought to that—the Surgeon General of the Public Health Service who is here, and I think Mr. Ball and myself, all agree that we should give some consideration to how to work that out.

Senator ANDERSON. Some of us think you could require funding. I admit there may be thin legal grounds, but I believe nonetheless they are there. But that you can require planning I am not so certain about. If you cannot, you ought to come in with some legislation that makes it possible for you to do that, if you are going to have this sort of fund. All over the country hospitals are built by Hill-Burton Federal money, and local contributions, and it shocks some of us today that should be part of the cost figured in here.

Now, Senator Kennedy, from New York, introduced a bill a few days ago to provide $2 billion for hospital and nursing-home programs. I think you may see many of those bills. Then what are you going to do with your 2 percent? That is your growth factor.

Have you any assurances from any hospital that the 2 percent will be used for appropriate growth and development? Do you have any contracts?

Mr. BALL. No. That is not part of the agreement. The reasoning has been, Senator, that the 2 percent like depreciation being a part of cost, we are required to pay it and have no basis for a limitation on what they do with it.

But I am sure that many hospitals will actually fund depreciation—although we cannot require it. There is an incentive for them to fund it. They earn interest, which is not offset against the interest that we allow on borrowed money.

Senator ANDERSON. The American Hospital Association has written that the 2-percent factor for capital improvement is minimal. Does that indicate that if you start down this road, you are going to be back every time the Congress meets?

Mr. BALL. Mr. Chairman, I have no doubt but what—at each opportunity the hospital field and the nursing-home field will press again for major improvements in their reimbursement formula.

Senator ANDERSON. As a means of getting their money for new buildings through this routine instead of Hill-Burton financing or money of that nature. That is the real danger, I think.

Mr. BALL. Well, I don't believe really, Senator, there is enough in this 2-percent factor to be a very significant addition to capital expenditures.

As you have pointed out, this relates only to the older people, and it really boils down, as 2 percent of operating costs, hospital by hospital, to a relatively small amount.

Senator ANDERSON. Well, Mr. Myers, what do you think 2 percent plus depreciation would amount to? I think it amounts to a lot of money.

Mr. MYERS. The effect of the 2 percent and these other factors does amount, on the average, to about $75 million per year.

Senator ANDERSON. Well, you are going to have depreciation factors here that are new. I think you could do quite a bit with that money, too.

MR. BALL. Senator, I am not disagreeing with the fact that it would be preferable to have it subjected to funding and planning, but $75 million a year spent on the hospitals is not a big building fund compared to hospital capital needs.

Senator Anderson. On May 2 you said:

> In my opinion the overwhelming majority of the hospitals would participate without the 2 percent factor.

If that is true, why did you put it in?

MR. BALL. I believe it is necessary in order to carry out the provision in the law that says the full cost for older people should be met from medicare, and we are to avoid shifting any of the cost of older people to younger. The 2-percent factor is to make up for certain unrecognized specific real costs in the rest of the formula.

Senator ANDERSON. One of the real questions was this average per diem cost. Were you going to average it or take the actual cost for older people?

MR. BALL. Senator, the point there is that although we turned down the average per diem, in the argument about it, I think they made quite a valid point that our general principles do not recognize that the aged do cost a bit more for certain services in the hospital. We just had not recognized that. That is part of the reason to allow this 2-percent part of the real cost.

Senator ANDERSON. Do you have anything yourself to support that? We were given a whole group of figures just to the contrary when the bill was under consideration.

Mr. BALL. Not the contrary to that, Senator—contrary to the idea that average per diem would turn out all right for the aged. We were not persuaded that this was an offsetting factor completely. But I think we can give you some studies that the hospital people gave us that are only partly convincing. I think they did not prove nearly as much as they thought they proved. But I think they are persuasive on the limited point that time and motion studies show older people use somewhat more nursing services, it does take them somewhat longer to admit, it does take them a little longer to get through an X-ray process, and so on. And we have to admit that the specifics recognized in our formula do not take this into account—this is part of the basis for the 2 percent.

Mr. Chairman, at this point in the record, if you are going to something else, I thought it might be useful on the point we are talking about of how important this 2 percent is in terms of a contribution to capital expansion, to just put in an illustration.

If you took a 100-bed hospital with, say, a million dollar operating cost, that would mean, perhaps, $250,000 for the total reimbursement for medicare in that hospital. And the 2 percent of that $250,000 would be $5,000 a year.

If you were to fund that, it would take 3 or 4 years to build one additional bed for that hospital. I am merely making the point that this 2-percent factor is not a tremendous increase in the ability of the hospitals to control capital funds, it is relatively small.

Senator ANDERSON. I think my experience with hospitals is they find out ways of getting matching money. You can't tell how many times $5,000 would expand.

My point is do you want it done where you can control it, and make sure there is adequate planning, or want to give it to them and trust them to spend it in some fashion of their own? I think good social teaching will tell us it is much better to put it through the Hill-Burton program where it is considered carefully, and expansion has to be justified, than just to pay it to the hospitals.

Senator Williams?

Senator WILLIAMS. Mr. Ball, you speak of a situation which would require the funding of these depreciation charges. You are not suggesting that you have the legal authority to require any hospital to fund their depreciation charges, are you?

Mr. BALL. No, we believe we do not have the authority, and that it is not possible to require it under present law.

Senator WILLIAMS. I didn't think you had the legal authority either.

The staff handed us a memorandum here the other day which concerned me somewhat. The memorandum appeared in the May 2, 1956, issue of Insiders Newsletter. I am sure you are familiar with it. "An HEW official last week told nursing home owners how to avoid going broke under medicare. He suggested they pad their bills."

I will put this whole article in the record. "Bill S. Byrd, Chief of the HEW Health Insurance Professional Relations Division, suggested at a Midwest conference that nursing homes get around this problem by juggling their books a little. That is, by taking sums previously shown as profits and adding them to the administrator's salary, thereby qualifying them as costs reimbursable under medicare. Auditors and tax accountants frowned at the idea and so officially did nursing homes. The American Nursing Home Association is relying on Congress and kind-hearted social security administrators not to let the no profits policy last any longer than 1 year, but observers believe that any payment system that doesn't permit an official profit, even for a short time, invites subterfuge, loading of costs, and overcharging of nonmedicare patients."

I ask that the whole article be printed in the record.

(The article referred to follows:)

[From the Insiders Newsletter, May 2, 1966]

Accounting—Medicare style: An HEW official last week told nursing home owners how to avoid going broke under Medicare: He suggested they pad their bills. This advice doesn't represent official Government policy, but it does illuminate a payments problem that is in hot dispute. The Government will gladly pay private nursing homes (as well as hospitals) for the "reasonable costs" of Medicare patients—but so far the HEW defines "costs" only as out-of-pocket expenses for nurses, food, laundry, administration and the like. Nursing homes won't be able to figure any profit, or interest on investment, into the bills they present to the Government—and this is enough to make at least one state nursing home association threaten a boycott of Medicare patients. Bill S. Byrd, chief of HEW's health insurance professional relations division, suggested at a Midwest conference that nursing homes get around this problem by juggling the books a little; that is, by taking sums previously shown as profits and adding them to the administrator's salary, thereby qualifying them as "costs" reimbursable under Medicare. Auditors and tax accountants frowned at the idea and so, officially, did nursing homes. The American Nursing Home Assn. is relying on Congress and kind-hearted Social Security administrators not to let the no-profits policy

last any longer than one year. But observers believe that any payment system that doesn't permit an official profit, even for a short time, invites subterfuge, loading of costs and overcharging of non-Medicare patients.

Senator WILLIAMS. I would like you to comment particularly on this suggestion that they get around this problem until Congress does act by padding their bills and juggling their books. I would like you to start out by identifying Bill Byrd—what position he is handling, and whether he is here this morning.

Mr. BALL. Bill Byrd is on the staff of the Bureau of Health Insurance, Senator. He is not here this morning. I will get his exact title for you. It is: Chief, Professional Relations Staff, Bureau of Health Insurance, Social Security Administration.

I have discussed this matter with Mr. Byrd. Senator Anderson called this matter to my attention. And I wrote to the Senator about it. Mr. Byrd assures me that he did not state or imply what was reported by the "Insiders' Newsletter." And I would like the privilege of responding in the record more fully on this point, perhaps inserting the letter we wrote to Senator Anderson, if he were willing to have us do that.

Senator WILLIAMS. Along with that, insert a copy of his speech, and his remarks, because I understand they were taken down and transcribed.

Mr. BALL. I don't believe he had an actual prepared statement. But let me say this. The same speech was reported in the Chicago American and the Chicago Tribune, and Mr. Byrd tells me that the Tribune article presents a good capsule summary of the theme of his remarks.

He did say that, of course, the principles allow a reasonable salary paid to the administrator of a nursing home, including an amount of compensation for the personal services actually rendered by the proprietor in such a capacity, to be considered a reimbursable cost of operation. But any implication, as said in the "Insider" is their implication, not his.

Senator WILLIAMS. Will you put that article in the Chicago American in the record at this point, because I understand they too indicated there may have been that understanding left at the meeting—the Chicago American and the Chicago Tribune.

Mr. BALL. Yes, sir.

Senator WILLIAMS. In one of those articles, the Chicago American too indicated a similar understanding, that the statement had been made that they could get around this restriction perhaps by padding their accounts. Maybe you don't want to use the word padding.

But we get back to the question of advance payments and payments before they are due. Without trading on words—one of those newspapers in substance confirmed exactly what was in this letter.

Mr. BALL. We will insert both in the record.

(The letter and articles referred to follow:)

MAY 21, 1966.

Hon. CLINTON P. ANDERSON,
United States Senate,
Washington, D.C.

DEAR CLINT: I can assure you that the item that appeared in *The Insiders Newsletter* of May 12 does not reflect our policy. I have also been assured by Mr. Byrd that it does not accurately reflect what he said.

The *Newsletter* apparently based its story on an article that appeared in the *Chicago's American* of April 20. A copy of that article is enclosed. I am also

enclosing an article which appeared in the *Chicago Tribune* of April 19, reporting on the same talk. As you can see, it makes no reference to any suggestion or implication that nursing homes might juggle their books to evade the regulations on reimbursement nor to any indignation on the part of the conferees. Mr. Byrd informs me that the *Tribune* article presents a good capsule summary of the theme of his remarks.

Mr. Byrd tells me that in the course of his talk he did mention that the reasonable salary paid to the administrator of a nursing home would be considered a reimbursable cost of operation, not a profit, but that he did not state or imply what was reported by *The Insiders Newsletter.*

Sincerely yours,

ROBERT M. BALL,
Commissioner of Social Security.

[From the Chicago Tribune, Apr. 19, 1966]

NURSING HOMES HERE PLAN FOR MEDICARE

Half of the nursing home beds in the Chicago area will meet medicare standards by Jan. 1, 1967, the starting date of the extended care portion of the medicare program, a Chicago nursing home official said yesterday.

This will mean 5,000 beds will be available for the convalescent patient, said Frank E. Williams, president of the Chicago Nursing Home association.

Those nursing homes which do not meet medicare standards will provide custodial care under a state shelter care license, he said.

200 ATTEND CONFERENCE

Williams was among 200 persons who attended the opening of a two-day midwest conference on the impact of medicare on nursing homes cosponsored by the Illinois and Chicago Nursing Home associations.

Williams said that whether there will be a crisis will depend on the planning that is done and also on the development of adequate health care home visiting teams. The medicare act provides for 100 home visits a year.

"Nursing homes previously" were primarily geared to custodial care," Williams said. "They will have to change and become convalescent oriented to comply with the intent of the act.

"Some of them are starting to phase out certain aspects of custodial care, such as mental health, to boarding homes and shelter care."

HALF-WAY HOUSE

Bill S. Byrd, chief of the professional relations staff of the bureau of health insurance, social security administration, Baltimore, said medicare views the nursing home as a half-way house between the very intensive, expensive care of the hopsital and the patient's own home.

There is no reason for private nursing home owners to fear that government regulations will encourage the general not-for-profit hospital at the expense of the proprietary nursing home, Byrd said.

"There are on the statute books a variety of programs to encourage the further development and expansion of nursing homes," Byrd said.

The conference will continue today in the Sheraton-Chicago hotel.

[Chicago's American, Wednesday, Apr. 20, 1966]

NURSING HOMES SEEK MEDICARE RULE CHANGE

Embattled nursing homes thruout the country are appealing for congressional action to resolve their dispute with the Department of Health, Education, and Welfare over payment for medicare patients.

H.E.W. has ruled that homes will be reimbursed only on the basis of reasonable out-of-pocket expenses involved in the care of the nation's aged, with nothing allowed for a return on capital investment in nursing home buildings or equipment.

In revealing the appeal to Congress, Alfred Ercolano, of Washington, executive director of the American Nursing Home association, declared it was not the intent of the legislators to put private nursing homes out of business.

MIDWEST OPERATORS ANGERED

He said the aid of members of the powerful Senate and House finance committees, including Sen. Dirksen [R., Ill.], has been enlisted to get the ruling changed, hopefully before the regulations are officially published next week.

He spoke at a midwest nursing home conference in the Sheraton Chicago hotel.

Meantime Illinois nursing home operators were irate over the advice of an H.E.W. official which they said left them only two alternatives to shutting up shop—deceptive accounting or penalizing private patients to subsidize the government's inadequate payments under medicare.

CRITICIZED BY RABBI

Bill S. Byrd, chief of H.E.W.'s health insurance professional relations, speaking to the groups, had suggested that while neither profits nor interest would be allowed in payments for medicare patients, sums formerly designated as profits might possibly be included in such items as administrator's salaries.

Commenting on this, Rabbi Hillel Yampol, past president of the Chicago Nursing Home association, said:

"What they are really telling us is to find loopholes in the law and saying in effect, 'Don't worry, you'll find a way to get around the regulations.'

"It's not a fair or an ethical thing to do."

Aside from the fact that people who have invested money in nursing homes have a right to expect a reasonable return on their money, the rabbi said there would not be sufficient funds for nursing homes to operate if the government pays "unrealistic rates" for medicare patients.

Operators varied in their judgment as to what action should be taken should congressional persuasion fail.

Some said they would reject medicare patients. Others counseled a policy of "trying to live with the regulations" while trying to get them changed.

Those who took the view said that the boycotting of medicare by private nursing homes would signal a mass move for the building of nursing homes by hospitals with federal funds under the Hill-Burton act.

Senator WILLIAMS. Now, one other question here.

In the committee report, there is a statement made of an additional cost of about $230 million during the first year's operation of the expanded Kerr-Mills program in the various States—assuming that all of the States adopted the plan.

Now, in the Washington Post of last Sunday there appeared an article in which it was indicated that eight States have now adopted this plan, and that their projected first year's cost, alone, is going to be around $325 million, which is substantially more than it was before. And these eight States are going to use up almost in its entirety the increased amount estimated by the committee.

Now, Mr. Myers, would you care to estimate as to what it would cost if all 50 States undertook the expanded program that these eight States have now adopted?

Mr. MYERS. Senator Williams, I am sorry, but the cost estimates for this part of the program were not made by me. They were made by the staff of the Welfare Administration. I have only been responsible for the cost estimates for the various insurance programs.

Senator WILLIAMS. Mr. Ball?

Mr. BALL. In order to be responsive to the Senator, would it be acceptable if we attempt to secure such an estimate from the other constituent in the Department for insertion in the record? This is not under my jurisdiction, either.

Senator WILLIAMS. Can you have whoever it is down here who made this estimate before, and who can make the current estimate—maybe they can be down here this afternoon, or when you next testify. Because we have a situation here where just eight States implementing a program is going to cost around $300 million, and the estimate

given last year was that 50 States would be $238 million. And again I am somewhat confused as to just how these estimates are made.

Where do you get these estimates in the first place?

Mr. BALL. Senator, I just really am not informed on the estimating process in the welfare program. It is not primarily an actuarial process, such as under the insurance system.

Senator WILLIAMS. Would it be fair to say whoever made the estimate was likewise not informed?

Mr. BALL. I don't think I can say that, Senator. I am sure they used whatever information there was and did a conscientious job with it.

Senator WILLIAMS. You will find out who the person was who prepared the estimate and have him here. I think those are points which should be cleared up, because based on this, there is going to be a variation there, if it is extended, from $500 to $700 million.

Mr. BALL. I would say this, Senator.

It is very difficult in the area of the grant-in-aid programs to the States to make estimates, because it is a Federal offer to the States, and depends on what actions the States take, how much money it is. And you just cannot estimate what the reaction of the States is going to be.

Some States have moved pretty far in this program under the law, and it may well not have been anticipated.

Senator WILLIAMS. I understand that. I make some estimates myself occasionally. But I notice that this estimate is not $225 million or $250 million, it is not a rounded-out figure. The estimate is $238 million. So in order to come to this figure, which is not a rounded figure, whoever prepared it had to have a tabulation. And I would like for the gentleman to bring the tabulation which totaled the $238 million presented to the committee, because he must have had such a tabulation. If not, maybe he can bring an explanation as to how he just looked over in the distant future and picked up 38—why didn't he pick up 40, or a round figure?

Mr. BALL. I would be happy to convey that, Senator.

Senator CURTIS. Mr. Chairman, I will try to be brief, because we are going to have an afternoon session.

Referring back to the 2 percent, I believe a hospital publication referred to this as a capital improvement payment.

Your statement this morning refers to it as part payment for the lack of precision in determining costs.

Now, how much of it is lack of precision in determining costs, and how much of it is capital improvement payment?

Mr. BALL. Well, Senator, our rationale, and the rationale of the Advisory Council, for including 2 percent, was the failure of the cost formula to include all of the items of true cost.

Now, certainly, you are absolutely right that the American Hospital Association people and many others have argued that we should allow, in addition to cost, just a plain plus factor for expansion and so on. We did not do that.

Senator CURTIS. But they used that expression after the 2 percent had been agreed upon.

Mr. BALL. That is their interpretation, Senator, not our rationale for the payment.

Senator CURTIS. They say "In accordance with the standard practice of a number of large third party purchasers, this allowance in lieu of direct return on equity capital provided recognizes the continuing need for capital funds to secure, preserve, and improve service rendering capabilities."

"Although the methods to be utilized by hospitals for determining the actual costs of services provided to beneficiaries are the best available, some lack the precision, and the methods at the present stage of cost finding represents a contingency which is a further consideration for including this allowance."

But you would not have a breakdown?

Mr. BALL. No, Senator. I would not really have interpreted that earlier phrase as a contribution of significance to capital improvement as against this failure of historical depreciation to keep up to date, and to replace existing machines with machines of a new technology.

Senator CURTIS. Now, I want to ask you a hypothetical question.

Suppose an individual past 65 went into the hospital in March 1966. And he again goes into the hospital 6 months after the program goes into effect. We will assume he has the same problem, the same equipment is required, the same care, everything being identical—how much more will it cost for taking care of that individual 6 months after the program starts than it did, say, in March 1966? If you want to provide the answer later——

Mr. BALL. Senator, I don't think we can give an answer with any precision.

The cost of rendering hospital care has been rising over the last several years at an average rate of roughly 6 percent a year, and there is no indication that there is any slowdown on that so that I presume one could extrapolate that 6 percent average increase in the past to indicate that we could expect something like a 4-percent increase in the period covered by your example.

Senator CURTIS. I would be glad to know how much.

Suppose a hospital is a nonprofit concern, which has not tabulated depreciation costs for tax purposes. It has a piece of equipment that is still serviceable. If it had been a taxable institution, we will assume the equipment had been depreciated to the point where the basis would be zero—but it still has this equipment. And the law goes into effect. What will be the basis for depreciation under your formula?

Mr. BALL. The basis would be that the institution would be allowed just once, at the beginning of the program, to establish a new life for that asset, based on the best estimate they can make of how much longer that asset would actually be in use. This would, under the principles, have to be approved by the fiscal intermediary, that is the Blue Cross or the private insurance company, as a reasonable life. And then of course that additional life, combined with the part that had previously passed, would form a new basis for depreciation.

Senator CURTIS. Now, if they were a tax-paying entity, and depreciated it all out, and their basis became zero, but admittedly they could still use it for a few years, would you still allow them depreciation?

Mr. BALL. Yes, sir. The same principle applies whether it is nonprofit or profit—the theory being if the asset is actually used in the production of services under this program, the using up of that asset

is a cost to the producer regardless of whether or not he for other purposes has depreciated it.

Senator CURTIS. Suppose there is a hospital of a given size, and they have an artificial kidney machine. A very small percent of patients ever use an artificial kidney. But under common practice, they take the total cost of maintaining and running a hospital, and divide it by the number of patients they have, and that is the cost of running a hospital.

So under existing practice, the other persons who are ill and hospitalized subsidize the cost of an artificial kidney for another patient, because no individual could pay the cost of an artificial kidney by himself.

Will that practice continue?

Mr. BALL. In substantial degree it would, Senator, by reason of the fact that what we are relying on is the charge structure to measure the amount of services that are given to medicare beneficiaries as against the total number of patients in the hospital.

Now, the charge structure itself has in it the point that you make. That is the charge structure for the artificial kidney does not fully reflect true cost. Therefore, an allocation based upon the charge structure would still have in it some of this element of subsidy you suggest—that is the use of the artificial kidney would not be given as much weight as it should be in the allocation of costs.

Senator CURTIS. So if a patient goes to the hospital and he doesn't use the artificial kidney, his reasonable costs will still reflect the fact that the hospital has an artificial kidney available.

Mr. WILLCOX. I merely want to say, Senator, the committee report specifically indicates that stand-by costs should be included. I think a large part of the cost of the artificial kidney might well be classified as a stand-by cost.

Senator CURTIS. Even if an individual went in there for cataracts in the eyes?

Mr. WILLCOX. Yes, sir.

Senator CURTIS. Now, most private insurers do not agree to pay the hospital bill, but they agree to pay a fixed dollar amount, is that right? Private insurance companies.

Mr. BALL. The private insurance companies. There are today many, many contracts, Senator, that go both ways. There are many private insurance companies today——

Senator CURTIS. How about Blue Cross?

Mr. BALL. They are on a service basis typically but——

Senator CURTIS. How will the payment for a day in the hospital, assuming the same factors, same amount of illness, the same amount of care required—that the Blue Cross has been paying—compare with what you will be paying when this starts. Will you be paying more or less?

Mr. BALL. Well, it is hard to give an exact answer, because you know there are 72 different Blue Cross plans, they have different approaches from place to place. The aged are, we believe, quite a special group in terms of cost.

Senator CURTIS. I will confine my question to the aged. Suppose an older person is covered by Blue Cross. Is it going to cost him—is it going to cost this system, this Government system, more money when this program gets started than it will cost Blue Cross in the same hospital?

Mr. BALL. Well, for people over 65, since the reimbursement formula Blue Cross has used is typically the average per diem approach you were referring to earlier, and since, we believe, this formula does pay the hospital more for the aged than their true costs—for the reasons I explained earlier—therefore, in reimbursing hospitals for the aged, we would tend in comparison with such plans to be paying less on the average for the aged than Blue Cross has been doing.

Senator CURTIS. The staff informs me that a former high official in the Blue Cross says that under your proposed reimbursement regulations you may be paying about 10 percent more than Blue Cross pays on the average.

Mr. BALL. I would have to know on what he based that. I think, Senator, my answer stands—that as far as reimbursing for the aged is concerned, the Blue Cross plans that reimburse on an average per diem have in them the very defect we were talking about earlier, and reimburse the hospitals more for those aged patients than true cost, and to that extent they would be reimbursing more than we would.

Senator CURTIS. In other words, you are going to do this for less cost than the Blue Cross?

Mr. BALL. No; I am saying that the Blue Cross plans that use the average per diem method for reimbursing for aged people are paying more than the cost of services for those people, and we are going to pay true costs for those people.

Senator WILLIAMS. Do I understand that the hospital will receive less in payment when the patient is insured under your program than under Blue Cross?

Mr. BALL. In those plans that are on the average per diem basis, Senator, which are a very high proportion of Blue Cross plans, that is correct, and it is one of the reasons that the hospitals and the Blue Cross Association press so hard to get us to go on an average per diem basis. They realize that actually in terms of the people who are under Blue Cross that they would receive less reimbursement than they had been. And I might just say that we feel actually in total that being able to resist that and adding merely this 2 percent we talked of is a very good arrangement for the Government.

Senator CURTIS. Well, now, the Blue Cross plans do not allow depreciation.

Mr. BALL. I beg your pardon?

Senator CURTIS. The Blue Cross plans do not allow depreciation.

Mr. BALL. Some plans do and some don't. And the ones that don't frequently allow a percent of the operating cost which like our 2 percent is rationalized on the grounds that they have not specifically recognized certain other costs. For instance, it is not uncommon to allow 5 or 6 percent of operating costs because they did not allow depreciation. You might, Senator, be interested in knowing—as a matter of fact—that what the Government's own approach on joint form 1, in reimbursing for veterans and for the programs of the Children's Bureau, until quite recently, didn't specifically recognize depreciation but 6 percent, as I remember, was added to operating costs which was in lieu of that depreciation.

Senator CURTIS. We do not permit accelerated depreciation on joint form 1, however.

Mr. BALL. No, sir.

Senator CURTIS. Well, now, I have in mind a very well-run hospital some 30 miles from Omaha that gives excellent care, but is not a teaching hospital. Neither does it provide all pathological services.

As a result, the per diem costs are $15 or $20 less per day than a large city hospital which passes on some of its testing and teaching costs to all the patients.

Now, will your payment to the nonteaching hospital which does not have all the laboratory facilities or teaching program, will they have a different rate of payment than the hospital that has the teaching programs and the laboratory facilities?

Mr. BALL. Yes, Senator.

Any approach to arriving at the cost of rendering the services, whatever method you use, would arrive at the point that the hospital which had less in the way of service to provide would have a lower cost, and they would certainly be reimbursed less.

Senator CURTIS. A lot of people tell me that when they go to the hospital they are charged 25 cents on their bill for an aspirin. Are you going to absorb that?

Mr. BALL. The formula is entirely on a cost basis, and we would be paying the hospital—just as an example—not what charge they put on the patient's bill, but what the cost of the aspirin actually was.

Senator CURTIS. The cost would be less than a cent.

Mr. BALL. Yes, sir.

Senator CURTIS. So the hospitals that are now charging a patient 25 cents every time a nurse comes down the hall and gives him an aspirin will be doing it at their own expense?

Mr. BALL. Well, actually, Senator, I think in a situation that you give, the hospital is making a lot of money out of that particular service, and we would be paying them the cost, so they would be getting less income for that service, that is true, but——

Senator CURTIS. I know of many diabetic patients who go to the hospital. They would be very happy to bring their own bottle of insulin along. Some of them are capable of administering their own insulin in the hospital, because they have done it for years. The hospital, however, will not let them do that.

Then, when they get the bill, they find a good many dollars added every day for the administration and cost of insulin on a dosage basis.

How are you going to handle that?

Mr. BALL. Again, Senator, we are on a cost basis here, not a charge basis. We would pay only for the cost of drugs that were furnished by the hospital customarily to its patients.

Senator CURTIS. Customarily. Then you would keep up the same thing?

Mr. BALL. If the individual bought his own insulin?

Senator CURTIS. They wouldn't let him. They wouldn't let him send to the drug portion of the hospital to buy a bottle of insulin.

Mr. BALL. If that were done by the hospital, furnished by them, we would pay the cost of it, not the charge, and, Senator, as I am sure you remember, there is a specific prohibition in the act against our interfering with the conduct of the hospital, and the way in which they run their operation. And we just would not be free to interfere with that arrangement.

The Surgeon General indicates there are medical reasons for this.

Dr. STEWART. With your example of insulin, we would not like the patients to bring the insulin and administer it themselves, because very often when diabetics are ill for another reasen, they get out of balance, with their insulin.

Senator CURTIS. I know, it may cost $800 to send a diabetic to a hospital for 3 or 4 days.

Dr. STEWART. That is correct.

Senator CURTIS. Young people are going to have to pay the cost of this medical program for all the old people, including the very wealthy. And they are stuck with charges of 25 cents per aspirin and, they get stuck with a good many dollars for the administration of insulin. The figures I quoted are not unrealistic, and they are not unusual.

And I think that just as it is true that the other patients in the hospital have to subsidize welfare patients now, other sick people have to subsidize other patients in the hospital for the use of costly and unusual equipment, such as artificial kidneys. And I think that is ridiculous.

Certainly, the unusual costs the patient cannot bear himself should be borne by somebody else. But well people are better able to bear that, than the other hospital patients.

Would you submit for the record copies of all the papers, forms, applications that a patient under this program must complete before he enters the hospital, as he enters the hospital, while he is in the hospital, and as he leaves the hospital?

Mr. BALL. Senator, there are no forms as far as this program is concerned that the patients have to sign in any of the situations you have described.

Senator CURTIS. How do you know? Does somebody just go there and say, "I want in?" They say orally and under oath they are 65—but as a matter of fact, they may be under 65. Their citizenship may be in question. There are dozens of other factors.

Now, are you going to let an individual come to a hospital, who says "I want the provisions of part (a) and part (b) of the Medicare Act" stay there. There is nothing for them to sign?

Mr. BALL. Senator Curtis, the—many of the points that you are raising are necessarily predetermined in terms of our having taken an application from an individual and establishing——

Senator CURTIS. From whom?

Mr. BALL. The individual. But not when he enters the hospital—and determining his basic eligibility for social security, or whether he meets the provisions that cover people who are 65 who are not covered under social security.

Every individual covered by this program is being issued a health insurance card, which indicates right on it whether he is covered for hospital insurance or medical insurance or both. It is like a Blue Cross card. He shows this when he goes in but his eligibility has been determined beforehand.

Now, the staff reminds me there is one form—the in-patient hospital admission and billing form—that he does sign on entrance to the hospital. This indicates that he is asking that his bill be paid under the social security program, and he shows them this card that he carries with him, that he is eligible for this, and then he signs this bill, and that is the only thing that he signs.

Senator CURTIS. Will you insert that in the record?
Mr. BALL. Yes, sir.
(The information referred to follows:)

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
SOCIAL SECURITY ADMINISTRATION

INPATIENT HOSPITAL ADMISSION AND BILLING
HOSPITAL INSURANCE BENEFITS—SOCIAL SECURITY ACT

Form Approved, Budget Bureau No. 72-R134

1. PATIENT'S LAST NAME | FIRST NAME | MI | 2. HEALTH INSURANCE CLAIM NUMBER

3. PATIENT'S ADDRESS (Street number, City, State, Zip Code) | 4. DATE OF BIRTH | 5. SEX ☐ M ☐ F

6. HOSPITAL NAME AND ADDRESS | 7. PROVIDER NO. | 8. MEDICAL RECORD NO. | 9. NAME AND ADDRESS OF ATTENDING PHYSICIAN

10. DATE OF THIS ADMISSION | 11. NAME AND ADDRESS OF ANY INSTITUTION FROM WHICH DISCHARGED DURING LAST 60 DAYS (If this hospital, give dates of stay)

12. PAYMENT SOURCE FOR CHARGES TO PATIENT
☐ SELF OR FAMILY ☐ BLUE CROSS BLUE SHIELD ☐ PUBLIC AGENCY (Give name)
☐ PRIVATE INSURANCE ☐ EMPLOYER OR UNION ☐ OTHER (Explain)

13. PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.

SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed) | DATE

14. ADMITTING DIAGNOSIS | EMPLOYMENT RELATED ☐ YES ☐ NO | If yes, give name and address of employer

15. DISCHARGE DIAGNOSES OR CURRENT DIAGNOSES (Primary illness and secondary or complicating illness(es)) | Do not use this space

16. SURGICAL PROCEDURES (Related to primary illness and other—Show date of each)

17. STATEMENT OF SERVICES RENDERED	DAYS	RATE	TOTAL CHARGES	NON-COVERED CHARGES
A. 1-Bed			$	$
B. 2-3-4 Bed				
C. 5 or more Beds				
D. Intensive Care				
E. Self Care				
F. WHOLE BLOOD — PINTS FURNISHED / NOT REPLACED / CHARGE PER PINT				
G. Operating Room				
H. Pharmacy				
I. Laboratory				
J. Radiology				
K. Medical, Surgical and Central Supplies				
L. Anesthesia				
M. Inhalation Therapy				
N. Other (Describe)				
O. TOTALS			$	$
P. Inpatient Deductible				
Q. Blood deductible Pts. @				
R. Coinsurance				
S. TOTAL DEDUCTIONS				

I certify that the required physician's certification and recertifications are on file.

26. SIGNATURE OF HOSPITAL REPRESENTATIVE | DATE FORWARDED

18. STATEMENT COVERS PERIOD FROM TO | 19. TOTAL DAYS

20. DATE GUARANTEE OF PMT. OR UR NOTICE RECEIVED | 21. DATE BENEFITS EXHAUSTED

22. ☐ DISCHARGED ☐ DIED ☐ STILL PATIENT | 23. DATE DISCHARGED OR DIED

24. COMPUTATION OF INTERIM PAYMENT

Reimbursement Amount $

FOR INTERMEDIARY USE

25. VERIFIED PRIOR STAY DATES ☐ NONE FROM TO | PROVIDER NO.

27. APPROVED BY | DATE

Senator CURTIS. He signs nothing on release?

Mr. BALL. No, sir. Of course, the hospital itself has various procedures that are in effect now, and they are in control of the hospital. There is nothing required by the Social Security Administration or medicare other than what I am speaking of here.

Senator CURTIS. His entitlement to 90 days in the hospital is for a spell of illness?

Mr. BALL. Yes, sir.

Senator CURTIS. Suppose in the middle of that spell of sickness, he and his family decide that the hospital is not doing a good job, and they load him into an ambulance and take him to another hospital. Anything for him to sign?

Mr. BALL. Well, if that were to happen, Senator, on admission to the new hospital he would once again sign this admission and billing form—at the new hospital.

Senator CURTIS. Well, would you supply all the papers for the record that are required in connection with part (b)?

Mr. BALL. Yes, sir. Under part (b), we are really very proud of the form that has been developed there. It was done with the help and assistance of a committee of doctors of the American Medical Association. They were particularly helpful in developing this.

Here is the form. It is actually a two-purpose form. Under the part (b) part of the program, you can get paid in one of two ways. Either the patient can be paid directly, in which case he fills out the form and attaches receipted bills from the doctor, and then the organization—Blue Shield, or private insurance company—deals solely with the patient.

On the other hand, if the patient and the doctor agree there can be an assignment to the physician, and in that case the physician fills out this form and signs that he is willing to accept the assignment.

In either case, all that is needed for that entire process is this form, and in the event that the doctor doesn't sign it, the attachment of receipted bills.

Senator CURTIS. Would you insert that in the record?

Mr. BALL. Yes, sir.

(The document referred to follows:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

REQUEST FOR PAYMENT
MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT
(Type or Print all Information)

Form Approved.
Budget Bureau No. 72-R290

Copy from your HEALTH INSURANCE CARD

NAME OF BENEFICIARY *(Patient)*

CLAIM NUMBER

☐ MALE ☐ FEMALE

PART I—CLAIMS INFORMATION—TO BE COMPLETED BY PATIENT.

1. Describe the illness or injury for which you received treatment. *(You do not need to complete this item if your doctor completes Part II below)*

2. Was your illness or injury connected with your employment? ☐ YES ☐ NO

3. Are you attaching itemized receipted bills? ☐ YES ☐ NO

4. ASSIGNMENT: Do you want payment for an unpaid bill made directly to the physician or supplier? ☐ YES ☐ NO
AUTHORIZATION: I authorize release of any information required to act on this claim and permit a photographic or other facsimile reproduction of this authorization to be used in place of the original.
REQUEST FOR PAYMENT: I am requesting payment either to myself or to the party accepting my assignment for the medical insurance benefit, if any, payable for the reasonable charges for services or supplies described. Where payment is assigned, I understand I am responsible for the deductible and 20% of the remaining reasonable charges.

5. SIGNATURE *(Patient or authorized representative)* — DATE SIGNED

6. ADDRESS *(Street address, City, State, ZIP Code)* — TELEPHONE NUMBER

PART II—REPORT OF SERVICES—TO BE COMPLETED BY PHYSICIAN—

This Part, Including Physician's Signature, Need Not Be Completed If Paid, Itemized Bills Are Submitted.

7. A. DATE OF EACH SERVICE	B. PLACE OF SERVICE[1]	C. FULLY DESCRIBE SURGICAL OR MEDICAL PROCEDURES AND OTHER SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN	D. NATURE OF ILLNESS OR INJURY REQUIRING SERVICES OR SUPPLIES *(Diagnosis)*	E. CHARGES	Leave Blank
				$	

8. NAME AND ADDRESS OF PHYSICIAN OR SUPPLIER *(Number and street, City, State, ZIP Code)*

TELEPHONE NUMBER

CODE NO.

9. Total Charges	$
10. Amount Paid	$
11. Any Unpaid Balance Due	$

12. ASSIGNMENT OF PATIENT'S BILL *(See reverse)* ☐ I ACCEPT ASSIGNMENT ☐ I DO NOT ACCEPT ASSIGNMENT

13. SIGNATURE OF PHYSICIAN OR SUPPLIER *(A physician's signature certifies that physician's services were personally rendered by him or under his personal direction)* ☐ MD ☐ DO ☐ DDS OR DMD — DATE SIGNED

[1] O—Doctor's Office IH—Inpatient Hospital ECF—Extended Care Facility OL—Other Locations *(Specify in 7C)*
IL—Independent Laboratory *(give name and address in 7C)* H—Patient's Home OH—Outpatient Hospital NH—Nursing Home

FORM SSA-1490 (4-66)

INSTRUCTIONS—PLEASE READ BEFORE COMPLETING THE OTHER SIDE OF THIS FORM

GENERAL INSTRUCTIONS

MEDICAL INSURANCE PAYS—80 percent of the reasonable charges for physicians' services and medical supplies, **except the first $50 each calendar year** (called the $50 deductible). Reasonable charges are determined by the organization which pays the claim, taking into account the customary charges made by the doctor and the prevailing (usual) charges of doctors in the locality.

Example of Payment: A beneficiary has doctor bills of $500 during a calendar year. The first $50 will not be paid by medical insurance; the beneficiary is responsible for this deductible amount. Of the remaining $450, medical insurance will pay 80 percent, or $360, and the beneficiary is responsible for 20 percent, or $90.

DEDUCTIBLE—The $50 deductible applies each calendar year. **No expenses before the beneficiary's medical insurance coverage date can be used for the deductible.** This date is shown on the beneficiary's health insurance card. Be sure to read the full explanation of the deductible in YOUR MEDICARE HANDBOOK, especially to find out how expenses in the last 3 months of one year may sometimes be used for the deductible in the next year.

Since the medical insurance plan does not pay for any part of the $50 deductible, it is recommended that the first claim each year not be filed until the deductible has been met for that year.

HOW TO CLAIM—This form can be used to claim payment in either of two ways:

1. **Payment to the patient**—after he has paid his doctor or supplier; or
2. **Payment to the doctor or supplier**—for unpaid charges, if both the patient and the doctor or supplier agree to this method of payment, called the "assignment" method.

PAYMENT TO THE PATIENT

The beneficiary (patient) should complete Part I of this claims form. He should be sure to sign and date it. If he cannot sign his name, he should make an X and have it witnessed. The witness should show his own name and address on the signature line. If the beneficiary cannot make the claim for himself, his authorized representative should show the beneficiary's name and "By" followed by his own signature and address.

Itemized receipted bills, including bills for the deductible amount, must be attached to the claims form, unless the doctor prefers to complete Part II. If itemized bills are attached, THEY MUST SHOW:

- Name of person or organization furnishing the medical service or supplies. If they were not furnished by a physician, the name of the physician who prescribed the services or supplies should be shown.
- Name of patient receiving services or supplies.
- Each date services or supplies were provided.
- Place services were provided (home, office, hospital, etc.). If provided in an **independent** laboratory, its name and address must be shown.
- A description of the services or supplies provided on each occasion. If the bill is for ambulance service, it should show the origin and destination.
- The charges for each medical service or item.
- The receipt showing the bill was paid may be on the bill or attached to it. Please do not send cancelled checks.
- To help speed handling of claims, the claim number should be written on each bill.

PAYMENT TO THE DOCTOR OR SUPPLIER

If all or any part of a medical bill has not yet been paid, the patient may assign his medical insurance benefit payment so that payment can be made directly to the physician (or supplier). However, **both** the patient and the physician (or supplier) must agree to this "assignment" method of payment. Under the Social Security Act, the physician or supplier who accepts an assignment also agrees to accept the reasonable charge as his full charge. (Reasonable charge determinations are made by the organization which makes medical insurance payments.) The patient, of course, is still responsible for the $50 deductible and 20 percent of the remainder.

If this method is used, the patient should complete Part I of this claims form and check "Yes" in item 4. The physician (or supplier) should complete Part II and check the box in item 12 to show his acceptance of the beneficiary's assignment.

INSTRUCTIONS TO PHYSICIAN OR SUPPLIER FOR COMPLETING PART II

For each date in item 7, the physician should describe any medical or surgical procedure, attaching a supplementary statement if necessary. If more than one procedure or treatment was provided on a single date, describe each procedure separately. Include any charges for preoperative and postoperative care in surgical charges. If the services or supplies were not furnished by a physician, the supplier should show in item 7-D the name of the physician prescribing them whenever Part II is completed. A report for ambulance service should show the origin and destination in item 7-C. Space is provided for a physician identification number to facilitate processing of the claim by the organization making payment.

The doctor or supplier may attach itemized or machine-prepared bills which contain the same information required by item 7 of the form. The patient's claim number should be shown on each bill. The physician may show his diagnosis either on the bill or in item 7.

MAILING INSTRUCTIONS

Mail this form to the organization handling medical insurance benefits in the area where the medical services or items were furnished. The nearest social security district office will be glad to help anyone who calls, writes, or telephones for assistance in filing his claim. If it is more convenient, you may get help from the organization designated to handle medical insurance benefits for your area.

FOR MORE INFORMATION

For more information, please refer to YOUR MEDICARE HANDBOOK. If you have a question about the way a particular claim was handled, you should get in touch with the organization which made the payment or with the nearest social security district office.

Senator CURTIS. Is there any additional form necessary if he goes to more than one doctor?

Mr. BALL. This form—if the individual is himself making the claim—could be sufficient for his entire claim, attaching bills from different doctors. But if, on the other hand, each physician were to accept assignment, then in that process there would be a separate form for each physician.

Senator CURTIS. And when does he pay the deductible, in reference to the hospital portion?

Mr. BALL. Well, that will depend upon hospital practice, Senator. The hospital, in admitting him with this card, knows that he is liable for the first $40. As you were suggesting earlier in our discussion, some hospitals, perhaps depending on what they know of his financial responsibility, may require an advance from him at that time. In other situations the hospital may be content to collect that deductible at the time he leaves the hospital. In still other instances, the $40 will need to be paid by the Public Welfare Department if the individual doesn't have resources of his own.

Senator CURTIS. How many registered nurses are now working in hospitals in the United States?

Dr. STEWART. There are about 620,000 active nurses, and there are around 65 percent of them working in hospitals and other institutions. I would have to get the figures specifically.

Senator CURTIS. How many will be required as a result of this bill?

Dr. STEWART. Well, that is difficult to estimate, Senator Curtis. There is a shortage of nurses now.

Senator CURTIS. Do the best you can. Would it be more?

Dr. STEWART. Yes.

Senator CURTIS. How many registered nurses are now working full time in nursing homes?

Dr. STEWART. That figure I could not give you. It is not available. It is, of course, a small proportion of the 65 percent.

Senator CURTIS. Isn't it true that if nursing homes are to comply with your regulations, the number of registered nurses required would greatly increase?

Dr. STEWART. These will be required to have registered nurses. But we are not talking about all the nursing homes under this benefit. We are talking about an extended care facility, which is—which one might describe as a little higher order of medical care.

Senator CURTIS. I am restricting my questions to those which come under this program.

Dr. STEWART. Well, we do not know at this time how many this will be.

Senator CURTIS. But if they follow your regulations, it will take more nurses than they are using now?

Dr. STEWART. Well, if an institution meets the qualifications now to participate as an extended care facility, they will have the nurses now.

Senator CURTIS. Most of them are going to have to change, aren't they?

Dr. STEWART. I would say among the factors which institutions will have to meet in the standards, one of the more difficult will be having enough nursing personnel in that institution.

Senator CURTIS. In other words, the extended care institutions are using a great many other employees and practical nurses, people with some experience, as contrasted with registered nurses?

Dr. STEWART. Yes. But I don't want to imply they wouldn't continue to use practical nurses.

Senator CURTIS. But you are going to require that they use more registered nurses than they are using now?

Dr. STEWART. They will be using more, but not all of the nurses have to be registered nurses.

Senator CURTIS. They will be using quite a few more registered nurses, won't they?

Dr. STEWART. In the extended care facilities? I think in terms of total it is a small percent increase.

Senator CURTIS. Isn't that also true with reference to hospitals? To meet your requirements, they are going to have to have registered nurses to perform a lot of duties that as of today are being performed by people who are not registered nurses?

Dr. STEWART. If one makes the assumption that after this program is implemented there will be more service provided to the people over 65, it requires more nurses.

Senator CURTIS. No. The same number of people.

Isn't it true that your regulations are such that with the same number of patients, they are going to have to use more registered nurses than they are using now?

Dr. STEWART. If they do not have round-the-clock registered nurses now, yes, they would.

Senator CURTIS. Well, I don't know what the answer is, as to what they have now. But I think you should know.

The answer is yes, is it not? To take care of the same number of patients, they are going to have to have more registered nurses than they have now?

Dr. STEWART. In order to meet the standard of round-the-clock nursing, I think some institutions need some more nurses, yes.

Senator CURTIS. That is true of the convalescent homes?

Dr. STEWART. It is more true in the extended care facility than the hospital; yes.

Senator CURTIS. And we are short of registered nurses now?

Dr. STEWART. There is a shortage of registered nurses.

Senator CURTIS. This is going to increase the cost, isn't it—securing a registered nurse?

Dr. STEWART. Yes, I think it probably will. If you have more registered nurses afterwards than before, it will increase the cost a certain amount.

Senator CURTIS. Especially when you have a shortage, because the employer is not going to lose his registered nurses to another employer. It will become competitive.

Dr. STEWART. But nurses have been notoriously underpaid, too, Senator Curtis.

Senator CURTIS. How about graduate dietitians? Are you going to require more than are being used now in hospitals for the same number of patients?

Dr. STEWART. No.

Senator CURTIS. How about the convalescent homes?

Dr. STEWART. No, I don't think so.

Senator CURTIS. Well, now, isn't it true that there are job descriptions—if that is the proper term—in the present regulations which will require a convalescent home to have a graduate dietitian to perform some duties now being performed by other people?

Dr. STEWART. A job description?

Senator CURTIS. I don't know whether it is a job description or not. But isn't that the practical effect of your regulations?

Mr. BALL. Senator, could I ask the Director of the Bureau of Health Insurance to comment on this standard situation?

If I could just make one general statement before he does—in line with the general direction of the Senator's question, I think it was very clear in the act and the legislative history that the Congress wanted to be sure that medicare patients got care in quality institutions, and they directed the Secretary to establish standards with the advice of the Health Insurance Benefit Advisory Council that would make sure that the services that people received were in institutions that were safe and protected their health. And one of the requirements that has been established, which would apply really to relatively small institutions—because others would already have it—is the requirement of a registered nurse on duty around the clock, and the reason for that was that a hospital holds itself out to take care of very sick people, and emergencies can arise at any time.

So that standard was established.

Now it is possible, in situations where it is the only hospital that is available, for us for a time, at least, to make an exception to these standards.

But, basically, I feel it is quite important that we have good standards so that the care that people get under this program is protective of their health and safety.

But the specific question that you asked about the dietitian, I think Mr. Hess has the answer.

Mr. HESS. Senator Curtis—the dietary supervision standard says that a person is designated by the Administrator to be responsible for the food service, and if this person is not a professional dietitian, then the extended care facility must show that regularly scheduled consultation from a professional dietitian or other person with suitable training is obtained.

Now, it is up to the State health department to apply that standard appropriately to the particular institution. As Mr. Ball indicated, the size of the institution and the other circumstances of care will permit the State health department to indicate whether or not they believe there is substantial compliance with this requirement.

I might add, if I may interject, that we had very extensive consultation on all of these standards with work groups at which were represented members of the organized medical profession, the nursing profession, as well as State health officers and others, who felt that these were minimum standards in terms of this concept of substantial compliance.

Senator CURTIS. But there will be Federal standards as to what constitutes substantial compliance?

Mr. HESS. These are not really standards. They are participation requirements. And we are issuing some guidelines to the State agencies, basically the judgment as to whether or not there is substantial compliance is in the first instance a recommendation of the State health department to us. And the decision—the final decision rests with us to accept or not the State health department's recommendation.

Senator CURTIS. You can accept it or overrule it?

Mr. HESS. Yes, sir.

Dr. STEWART. Senator Curtis, the reason for a standard such as this dietary standard in the extended care facility, is that a great many of the beneficiaries who will be in an extended care facility need special diet therapy, and you cannot put this together with just anyone.

Senator CURTIS. Yes. But there are a lot of dietary kitchens run by devoted people who do an excellent job, getting some general instructions from the doctor and the other people involved, and they do a superb job. And I can take you to some city hospitals which have so much staff that you cannot walk through the hall, where they do a terrible job, and the diet for an individual having one illness is delivered on a tray to a patient with an altogether different illness and vice versa.

Dr. STEWART. That is why it was written in such a way that if it is being run well by the staff, and they have consultation—which is in a sense assurance that this is so—then they would meet that particular criterion.

Senator CURTIS. My point is this: These Federal statutes—I am not talking about the institution that is poorly run, that has no concern for the patients. I am talking about institutions which are doing a very good job, at low cost, and they are instructing devoted people, sometimes with limited professional training, to do a job, and they are doing a good job—for all of those institutions their costs are going to increase, in order to meet these standards.

Dr. STEWART. I think on the average this is correct—if they do not have this now.

Senator CURTIS. I am sorry to have kept you so long. My instructions are to adjourn the meeting to 2:30.

Mr. BALL. Mr. Chairman, could I ask at this point there be inserted in the record a memorandum from our general counsel with comments on these reimbursement principles that we have been discussing from the standpoint of their legality, since that has come up several times?

Senator CURTIS. Certainly.

Mr. BALL. Thank you.

Senator CURTIS. Will you please date the memorandum?

(The material referred to follows:)

MAY 24, 1966.

U.S. Government Memorandum To: Mr. Robert M. Ball, Commissioner of Social Security.

From: Alanson W. Willcox, General Counsel.

Subject: Health Insurance—Principles of Reimbursement for Provider Costs (As Released May 2, 1966).

You have asked me to put in writing our views, which we have given you from time to time orally, on the leaglity of the proposed principles of reimbursement. I will confine these remarks to those provisions about which a question of legal authority has been raised.

At the outset it is well to note that the health insurance legislation, particularly in section 1861(v), provides its own setting for the determination of the "reasonable cost" of hospital and other services, and largely divorces this determination from the legal framework applicable to governmental cost determinations for other purposes.[1] The legislative history makes it clear that this was done deliberately, with an eye to the difficulties inherent in finding the cost on a service-by-service or patient-by-patient basis, and to the patterns that have emerged from extensive study and experience in the private sector of our health economy.

A second general observation is that Congress has given the Secretary very broad discretion in prescribing regulations on this subject, contenting itself with the statement of principles and factors by which his judgment should be guided rather than specification of rules to constrain his discretion. Thus, he is expressly

[1] Although the question is not wholly free from doubt, I believe that payments to providers of services are not subject to the Federal Property and Administrative Services Act or to the Federal Procurement Regulations issued thereunder. Participating providers do not contract to render any service whatsoever. This is not the occasion for detailed legal analysis of the relation between a provider and the Government; suffice it to say that the payments in question are better described as statutory than as contractual in nature.

authorized to determine "the items to be included" in arriving at cost and the "method or methods to be used," including the use of estimates when he deems it appropriate, and including the choice among "per diem, per unit, per capita, or other basis."

One mandate, however, emerges clearly: that there be as precise a differentiation as possible between the cost of services to beneficiaries of this insurance system and the cost of services to other patients. Congress plainly intended that this program should pay the full cost—but should pay no more than the cost—of the services provided to the program's beneficiaries.

It is against this background that the several issues will be considered.

I. ALLOWANCE IN LIEU OF SPECIFIC RECOGNITION OF OTHER COSTS

This allowance, it must be emphasized, is to be included as an element of cost, not as a payment over and above cost. The Secretary's discretion, broad though it is, does not encompass the payment of anything more than cost, and unless the item in question can reasonably be considered as an element of cost it may not be included. As its title indicates, however, the allowance is designed not as an addition to cost, but rather to offset certain inadequacies from which the principles would otherwise suffer as a reflection of the "reasonable cost" of providing the covered services. These inadequacies result essentially from a lack of precision in cost measurement.

The first element on which I should comment is the imprecision of available methods, or at least of methods practicable of widespread application by providers, for allocating costs as between their aged patients and the rest of their patient populations.[2] The principles will ordinarily mean that the cost of room, board, and routine nursing service will be divided equally on a per-patient-day basis, but that laboratory and other ancillary services will be divided in proportion to utilization of the specific services (as measured by the hospital's charges for them).

The American Hospital Association has vigorously urged that payment for care of the aged be based on the average per diem cost for all patients, in accordance with the traditional method of reimbursement of hospitals under a number of grant-in-aid programs and Blue Cross plans. Since available evidence indicates that care of the aged costs considerably less per day [3] than the average for all patients, we concluded that this method was unacceptable because it would run counter to the clear indication in both the statute and the Committee reports that the insurance system is not to bear any of the cost of caring for younger patients. But just as it would be unfair to the Government to average costs for all services on a patient-day basis, so it would be unfair to the providers to average the cost of routine nursing services (and some other services) if, as the hospitals contend, these costs are significantly greater for the aged than for other patients. The extent to which averaging should be carried is clearly a matter of judgment, but it would not seem reasonable to apply averages where they work in favor of the Government while denying their use where they might work in favor of providers.

To what extent the principles are open to objection on this score it is difficult to say because of the meagerness of the evidence about the distribution of the costs, as between older and younger patients, of nursing and certain other services. There is some evidence, however, tending to support the position of the hospitals on this point, and in the exercise of his authority to use estimates it would seem clear that the Secretary may properly make an allowance on this account.

A second issue has been the contention that depreciation should be measured by current replacement cost rather than by historical cost. In some parts of the country the replacement cost method is in use in determining third-party reimbursement of hospitals. Because of the need of hospitals for constant updating of equipment, and to some extent of facilities, if they are to keep abreast of the rapidly advancing professional technology—because obsolescence is therefore often dissociated from the traditional concept of "useful life"—a substantial argument was made in favor of extending nationwide this method of computing depreciation. Partly on theoretical, partly on administrative, partly on fiscal grounds this contention was rejected; suffice it to say that the decision, which reduces materially the payments to be made to providers of services, may fall somewhat of according full recognition to this element of cost.

[2] To the extent that the 2 per cent allowance rests on this basis, it may be inapplicable, or not fully applicable, to payments under plans approved under title XIX of the Act because of the different age composition of beneficiary groups under such plans.

[3] Actuarial estimates submitted to Congress assumed that the per diem cost for aged patients would be about 92 percent of the cost for all patients.

A third item about which there has been divergence of views is the cost of the use of capital, sometimes discussed under the heading "imputed interest." Since the use of facilities and equipment is essential to the production of the services for which payment is to be made, there is a strong theoretical argument that, at least in the economic sense, a reasonable interest rate on the value of this capital constitutes an element of the cost of the services.[4] Since it is clear that Congress intended to recognize interest on borrowed capital as a cost, moreover, there is to some extent an anomaly in treating differently capital raised in other ways.

Several arguments have been advanced against the acceptance of "imputed interest" as an element of cost, but in view of the Secretary's authority to determine "the items to be included" in the cost formula I should not consider any of these arguments conclusive if it were not for the magnitude of the resulting cost increase and the absence of indication that Congress considered the inclusion of such an item. A relatively small allowance such as that here under consideration, on the other hand, if it should turn out to overcompensate providers slightly for other elements of uncertainty and thus to compensate them somewhat for the use of capital, would not seem to be objectionable on this score.

These items, each subject to difference of informed opinion, would in my judgment be sufficient in themselves to justify a percentage allowance arbitrarily arrived at, even if there were not precedent for such an allowance.[5] But in fact there is precedent for what is proposed.

A number of Blue Cross plans include a catch-all item, measured as a percentage of other costs, to cover the unidentified and the not precisely measurable elements that a rigid mathematical formula fails to reflect. The Government itself long permitted use of a similar method where an appropriate depreciation allowance could not otherwise be arrived at. The present proposal, in other words, is novel only in its immediate application.

The Secretary is authorized to use estimates, and he is instructed to take account of prevailing patterns of reimbursement. If he concludes that the allowance here in question is an appropriate way to avoid (as he is specifically directed to avoid) imposing on younger patients costs properly attributable to the aged, I see no doubt that the allowance is within his legal authority.

II. THE TREATMENT OF DEPRECIATION

Although the replacement cost method of determining depreciation was rejected, two questions have been raised about the treatment accorded that item by the principles as proposed by the Department: whether it is appropriate to allow depreciation on capital contributed under the Hill-Burton program; and whether that item, or perhaps any depreciation, should be allowed without conditioning the payment on the funding of the amounts received and their reservation for use in capital replacement or expansion.

The Committee reports enjoined the Secretary to take both of these points into account, a wording which I interpret as an injunction to give them especial consideration. This has been done; both points have been thoroughly explored and debated at length. The language of the reports does not purport to dictate the answers, and one cannot doubt that had Congress intended to limit the Secretary's discretion it would have made this intention apparent.

On the first point, the allowance of depreciation on Hill-Burton grants, the answer would be self-evident but for the question that has been raised whether it may lead to a double payment by the Government. But in an operation assumed to continue indefinitely, depreciation looks to the future, to the replacement of a facility at the end of its useful life. There is thus, in truth, no double payment. A Hill-Burton grant helped to provide a facility to be used, let us say, for forty years; depreciation will help to provide a facility to be used thereafter. If in practice funds in the depreciation account are used after ten or twenty years for purposes of modernization, they are still effecting a capital purpose not encompassed in the Hill-Burton grant.

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[4] The proposal under discussion was not for the inclusion of profit, insofar as profit represents a return for risk undertaken in capital financing. The value of the use of money, it has been suggested, is reflected in pure form by the return on Government bonds where there is no element of risk.

The classical distinction between cost on the one hand, and profit on the other, would certainly exclude from cost any factor of compensation for the risk incurred. Although for most purposes the value of the use of money is classified also as a part of profit, rather than as a part of cost, it is at this point that the issue becomes debatable, at least in economic theory.

[5] The rule against paying "cost plus percentage of cost," even though it has been applied to forbid use of percentage to determine a part of the actual cost, does not stand in the way of the present proposal. Believing that the Federal Property and Administrative Services Act is inapplicable, I find no legal inhibition on this score. The practice which was long followed in Government payments to hospitals, permitting use of a percentage of operating cost in lieu of depreciation, reinforces the view that this limitation is inapplicable.

The Government has not in the past excluded these grants in determining depreciation for purpose of paying the cost of hospital services. There is no persuasive reason that it should do so now. The supposed duplication of payment, I believe, is apparent rather than real.

The suggestion that payments on account of depreciation should be made only if the recipient undertakes to fund such payments, stands in a quite different posture. The objection to this proposal is simply that the Secretary lacks authority to impose such a requirement. The statute directs him, unconditionally, to pay providers the reasonable cost of services to beneficiaries, and confers no authority to control the use that the providers may make of the proceeds. Section 1801, indeed, specifically forbids him to exercise any supervision or control over the administration or operation of a provider. He may do whatever he can to encourage the funding of depreciation payments, but it seems entirely clear that he could not legally withhold payments from an institution that declined to do so.

III. RETURN ON EQUITY CAPITAL OF PROPRIETARY INSTITUTIONS

There is much appeal to the argument that proprietary institutions should be enabled to earn a profit by paying them, in addition to the cost of services, an item representing return on equity capital invested in them. Such a payment may well be thought desirable both in the interest of fairness and in the hope of attracting capital, especially for extended care facilities. As in the case of nonprofit facilities, moreover, the nonrecognition of the cost of use of equity capital combined with the recognition of interest as an element of cost creates an anomaly and may lead to artificialities in the financing of hospitals and extended care facilities.

As has been said, a strong argument was made for the inclusion of a factor for equity capital of all providers, proprietary and nonprofit alike, the decisive argument to the contrary being the cost of such a provision and the lack of indication that its inclusion was contemplated by Congress. Inclusion of this item for proprietary institutions alone would obviously cost very much less. In the case of new construction, indeed, recognition of profit might in large part lead merely to a different form of financing at no greater cost to the Government.

Despite these considerations, however, it is extremely difficult to rationalize a difference of treatment in this regard between profit and nonprofit institutions. The Secretary may not pay more than cost, and under the classical dichotomy this means that he may not contribute to a profit. He may, it is true, determine costs "for various types or classes of institutions," but this authority does not exempt him, with respect to any type or class, from the overriding limitation that he may pay only the reasonable cost.

To make the distinction suggested, then, would require the Secretary to say that whether the use of capital is or is not a part of the cost of services depends on whether the institution is or is not organized for profit. Perhaps a rationalization of sorts could be developed, on the theory that in the one case a return on investment is essential to draw and retain capital in the enterprise, whereas in the other case it is not. Perhaps an analogy can be drawn between interest legally required to be paid, which is recognized as an element of cost, and dividends (or undistributed earnings) which are a practical necessity if funds are to be invested in these institutions.

The arguments against such a rationalization are in my opinion far stronger. The classical and almost universally accepted usage treats cost and profit as mutually exclusive, and it would be only by departing from this usage that any cost attributable to the use of capital could be included as an element in the reimbursement formula. The economic theory underlying such a departure, however, would seem to be as applicable to nonprofit as to proprietary institutions, and to afford no basis for distinguishing between the two.

To make the distinction suggested would involve the Secretary, as it seems to me, in a logical contradiction. He would have to say to the nonprofit insitutions that the cost of the use of capital (even without any return for risk-taking) is an element of profit and not of cost, but say to the proprietary institutions that—because they are organized in the hope of profit—this same item is in their case an element of cost and not of profit.

It is true that payment of a profit to proprietary institutions alone would not add enough to the cost of the program to affect the actuarial calculations significantly, and that the decisive consideration against allowing an item of this kind to all institutions is not persuasive against the present proposal. But there is

nothing in the statute or in its legislative history, I believe, indicating that the definition of cost should include or exclude profit depending on the nature of the recipient institution. Congress on the contrary, in full awareness that proprietary institutions would be participating in the program, limited payment for all to the "reasonable cost" of the services. The only reference to profit that I am aware of indicates clearly that profit was to be excluded.

It might be possible, consistently with the text of the statute, to include within the concept of cost an allowance for the use of equity capital at some reasonable rate of return that excludes any compensation for risk. I can find no warrant for including such an item for some institutions and not for others.

IV. THE TIMING OF PAYMENTS TO PROVIDERS OF SERVICES

Another question that has been raised concerns the legality of the proposal with respect to the timing of payment to providers. The question arises from the general prohibition (31 U.S.C. 529) against any "advance of public money" unless authorized by an appropriation or other law.[6] The Comptroller General has said that "the primary purpose of such prohibition is to preclude the possibility of loss in the event a contractor, after receipt of payment, should fail to perform his contract and refuse or fail to refund the money to the Government." 39 C.G. 285, 286.

Title XVIII authorizes advances to fiscal intermediaries (sec. 1816(c)) and under contracts for carrying out any of the Secretary's functions (sec. 1874(a)), but it does not in terms authorize advances to providers of services. It does, however, provide that payments to them shall be made "at such time or times as the Secretary believes appropriate (but not less often than monthly)" (sec. 1815).

The proposal as I understand it is designed to make these payments as nearly contemporaneous as possible, on the average, with the disbursements which the providers must make in furnishing services to beneficiaries. Supplies must be bought before they can be used, and wages must be paid at regular intervals, yet hospital bills are usually rendered only on discharge of a patient or after a considerable hospital stay. At the start of the program there will necessarily be a considerable amount of preparation that hospitals must make before July 1, especially because more than the normal admissions must be expected at that time.

It is estimated that on the average about a month elapses between the making of disbursements and their recovery through the normal billing process. It is this delay, and the corresponding cost to the provider for the use of working capital, that the provision in question is designed to avoid.[7]

Although the principles as released described this proposal as the making of advances, the description seems of questionable accuracy and I understand is being changed. A payment made to a provider on the first of the month will compensate it for some disbursements made theretofore and for some to be made thereafter. Looked at item by item the payment may be considered in part a reimbursement and in part an advance; looked at in the aggregate it is a method of achieving punctuality in meeting the Government's obligation.

The process of reimbursement of providers will necessitate a running account between each of them and the Government, with payments to each made periodically, often on provisional figures subject to retroactive adjustment. The process will differ materially from the usual situation in which a question of advance payment may arise, and the present proposal differs materially from the typical advance payment for something to be done in the future. It is not clear that this proposal falls within the purpose of the general statute relating to advances, nor is it clear that payments by the intermediaries to the providers are in any event within its scope.[8] Advances to the intermediaries are expressly authorized, and control of the use to be made by them of the funds advanced would seem to fall within the broad authority of the Secretary.

In the case cited above, the Comptroller General approved the making of advances partly on the ground that it would save expense to the Government. Considering all the circumstances of the present proposal, including the cost of

[6] It may be noted that if the Federal Property and Administrative Services Act were applicable, the Secretary would have explicit authority, upon appropriate finding, to permit advances. As indicated above, I believe that that Act is not applicable, but the recognition by Congress of the need for some administrative flexibility is significant.

[7] If reimbursement were made 30 days later, for example, interest on funds borrowed for working capital would have to be recognized as an item of cost, and might well be more expensive to the Government than the proposed method of payment.

[8] In a relatively few cases hospitals will be paid directly by the Government rather than through an intermediary. It would not be reasonable, however, to apply a different rule in these exceptional cases.

borrowing for working capital needs, I believe that, even if the proposal is deemed to constitute an advance, a similar discretionary approval would be appropriate.

Senator CURTIS. The hearing is adjourned until 2:30 this afternoon.

(Whereupon, at 1:15 p.m., the committee was recessed, to reconvene at 2:30 p.m. on the same day.)

AFTERNOON SESSION

Senator ANDERSON. The hearing will be in order.

STATEMENT OF ROBERT M. BALL—Resumed

Senator ANDERSON. This afternoon, Mr. Ball, I would like to have the staff people, or at least Mr. Vail, the staff director, explain some of the things which are in his study. I think you questioned some of the things that are there, and others may also.

I thought if we had a statement of the staff position on this 2 percent, on depreciation, and maybe on the right to make what we call advance payments—it would be useful to have him do that, and maybe you can give us some comments on what he has said, now or later on.

If you don't mind, I am going to ask Mr. Vail if he will start off dealing with depreciation, with the 2 percent, and the advance payments.

Mr. VAIL. Senator Anderson, when we began to put this staff report together, we went back to reconstruct the legislative history as best we could.

We began with the hearings of the Ways and Means Committee. We have included in the staff report an exchange between the chairman of the Ways and Means Committee, and Mr. Ball, which indicated to us an intent—the first indication of an intent—that the medicare program was going to reimburse hospitals for the actual costs that they incurred in providing care.

This exchange is in the staff report. And the point that I would like to concentrate on is Mr. Mills' statement:

> You're not seeking to pay reasonable charges, you are not seeking to pay anything except what it costs the hospitals to take care of this particular patient. There is to be no profit in connection with your computation of what constitutes a reasonable cost.

Mr. Ball replied that that was right.

Senator ANDERSON. Is this on page 10?

Mr. VAIL. That is on page 10 of the staff report, and it is on page 149 of the House hearings.

There was another exchange the same day, again between the Chairman and Mr. Ball, that the principles generally followed by the American Hospital Association would be adhered to in working out the reimbursement formula under that program.

Now, when the committee over there went into executive session, we don't know over here what went on, but we do know that when they wrote their committee reports, they emphasized again that the reimbursement was to be for actual cost.

We have included a portion of the House report in our staff report. The same language is included in the Senate report. One passage from the House report which we did not include in our report appears on

page 37, where it said—this is the last thought of the committee in explaining this feature of its bill before it passed on to another issue:

> In paying reasonable costs, it should be the policy of the insurance program to so reimburse a hospital or other provider that an accounting may be made at the end of each cost period for costs actually incurred.

Now, that language appears in the Senate report also.

We understood from this legislative history that Congress was trying to reimburse the hospitals for an actual cost, and that at the time the legislation was under consideration, the hospitals understood that and agreed to it.

Now, the 2-percent factor which we have described in our staff report as a bonus factor, because it is on top of the costs that they can calculate, never appeared anywhere in the legislative history, even under the name of additional costs for unanticipated expenses or unknown expenses or as imputed interest or anything else. The legislative history is completely silent on that point.

We suggest that if the element of a profit or the element of a return on capital for nonprofit organizations, or the element of bonus had been in the minds of the framers of this legislation, they would not have been at a loss for words to have expressed that intent. And we draw some significance from the fact that it is not in the legislative history.

Now, one of the difficulties with this bonus factor, besides the additional cost involved, is the fact that it would relax a hospital administrator in keeping his costs down. We think that it might tend to push costs up. Because as costs go up, this 2-percent factor produces a larger amount for the hospital.

Senator ANDERSON. You mean the higher the cost, the greater the 2-percent factor would be?

Mr. VAIL. The higher the cost, the greater the 2-percent factor would be; yes, sir.

Now, the guidelines that were published by HEW rationalized this 2 percent on two bases. First, they say that it recognizes the continuing need for capital funds—capital funds—to secure, preserve, and improve service-rendering capabilities.

Now, at that point we had some difficulty with it because Congress has programs to provide capital funds for hospitals, and Congress has before it, I believe, a recommendation of the President to provide additional funds for hospital modernization.

We suggest that if any portion of this 2-percent bonus factor is in recognition of the continuing need for capital funds; then it may duplicate and overlap legislation that Congress has enacted to provide capital funds, and it turns what we understand to be a cost reimbursement program into a capital providing program.

It seems reasonable that if the committees had intended that the program be used to provide capital, they would have stated it.

Now, there is another point that the guideline uses in justification of this 2 percent, and that is to recognize the lack of precision in the methods at the present stage of cost finding.

To the extent that the 2-percent allowance is in recognition of a lack of precision, there is probably some flexibility in the legislative history that would permit an estimate to be made of some of these costs, provided that adjustments, retroactive adjustments, which are authorized by the statute, would recapture any excess payments, any

payments in excess of cost, or would provide for payments to hospitals to make up any shortage in costs.

The committee tried this morning to determine what part of this 2 percent represented the capital factor, and what part of the 2 percent represented the lack of precision factor.

Mr. Ball has indicated, I believe, that in his judgment, not a very large amount of it represents a capital factor.

I don't have any judgment on that. I do know that the hospitals themselves look on this as a capital bonus—they look on this as capital. They don't look on it in the material they have submitted to us in the last few days as reimbursing them for any lack of precision in estimating costs.

We were impressed in our research with some of the proceedings that had taken place in the Health Insurance Benefits Advisory Council (HIBAC). Mr. Willcox—at that point they were calling this item an imputed interest factor—Mr. Willcox advised HIBAC that there was a long history pointing against the inclusion of return on capital other than interest as an element of cost, and that Congress legislated in the light of that history.

Our findings agree with that. We think Congress did legislate in the light of that history.

We have included in the report a criticism of the 2-percent factor on the grounds that it would put pressure on other Federal hospital cost reimbursement systems, where there is no 2-percent factor today, to include one.

We pointed out that this might be true of the maternal and child health, and the crippled children's programs.

We suggested that it might put a burden on some of the States, under matching programs, in paying for their own share of hospital expenses, because the 2 percent would push the cost of the service still higher, putting a further strain on the States' programs.

Among the Federal programs, in addition to those mentioned, are the Veterans' Administration, the Indian health program, and the vocational rehabilitation program—apart from the impact on the title 19 welfare health program.

We wonder whether the provision in the statute that makes it clear, we think, that the costs of providing care for the aged are not to be borne by the other patients in the hospital, and the cost of caring for the other patients in the hospital should not be borne by medicare, will be carried out in the latter case.

We wonder if the 2-percent factor might have some overlap in that, and really result in paying the way for some of the people in the hospital who are not provided for under the medicare program.

In the work that we have done, we have examined a statement made by the Surgeon General on the need for hospital planning. We included his statement in the record of our report, and it has been included in the record now.

Senator ANDERSON. Why don't you just repeat it.

Mr. VAIL (reading from p. 18 of the staff report):

> Surgeon General Stewart stated—under hospital insurance, be it Social Security, Blue Cross, or any other, rich and poor pay equally for presumably equal benefits. But when capital depreciation factors are added to the insurance cost, rich and poor are paying equal shares of very expensive capital expenditures. The regressiveness of this taxing becomes more important as the proportion of the total capital so financed increases. Meeting capital needs through a reimbursement

formula presents another type of problem. That is, the hospital with the best plant will have entitlement to the largest factor, which will mean that they will draw a share of the funds reflected in their present advantaged condition in maintaining the status quo. This is both a national and a community problem. Public effort is increasingly directed to area-wide planning for the development of health services and facilities. Needs change, populations move, but a hospital board with money in its pocket can be expected to be more concerned with its institutional future than with the broad needs of the community. Unless those charged with an overview of community health needs have some financial leverage to help develop facilities geared to needs, the hospital rich will get richer and the poor will get poorer. To promote hospital construction meeting community needs the Hill-Burton formula now gives greater assistance to states with greater need out of general tax revenue.

Although the present formula has a rural emphasis which needs to be modified, the basic concept is sound. In contrast, the medical depreciation formula based on present value of hospital plant runs the danger of giving disproportionate amounts to the richer States and the more well-housed hospitals. Care would seem to be needed to assure that the share of the medicare dollar going to capital plant depreciation should benefit those States poor in facilities—at least as much proportionately as it benefits those which are most advantaged. Over the long run, with such powerful financial mechanisms, decisions in one of these programs cannot be independent of the other.

It seems essential that the impact on hospital construction of the Hill-Burton and the medicare programs reinforce each other rather than working at cross purposes, since the ultimate objective of both is to assure the availability of good health care to the people in all regions and in every community of the country.

Now, one of the points which we raised on this 2 percent factor was that even if you have a hospital that can perfectly determine its costs, so that there is no unreimbursed amount, that is, no amount unpaid due to lack of precision, that hospital still gets its 2 percent. And we find it difficult to see where, in that situation, it is anything but a capital factor.

Another point made in our report was that the 2 percent bonus factor is also applied to the depreciation that is allowed on Government money—such as Hill-Burton assets—and we sort of view that as an interest element that the Government is paying on its own money. We suggest that the committee, if it had faced up to that specific problem, would not have left it unanswered.

Another point that we thought would be helpful for the committee to have in mind in thinking about this 2 percent factor, is that it is 2 percent this year, and if the law permits 2 percent, the law probably permits 5 percent, 10 percent, or 15 percent.

Now, next year we don't know what it might be. We believe that if the Congress had intended that there be a factor of this sort and significance in the reimbursement formula, they would not have left it to administrative discretion, but would have provided for it in the statute.

For all of those reasons we came to the conclusion that we thought this particular issue might be beyond the congressional intent.

Dr. Herman Somers, who is I understand one of the top consultants to the Social Security Administration, made a speech on May 20, 1965, in which he said that over and above the question of what are and what are not recognized as costs in medicare there are some issues which may prove to be even more significant.

For example, there is the fervid claim of the hospitals to be paid what has come to be called a "plus" factor. This would be a specified percentage acknowledged to be over and above current costs, a means to assist the hospital to meet future capital equipment funding. Operating capital, it is usually called. The implications residing in this decision can be vast.

If, in the future, hospitals are automatically underwritten in advance for capital expansion or improvement, all the reins may be off and a mammoth inflation may be anticipated. The potential for improvement of hospitals—if they could have all things which its medical and administrative staff would ideally desire—is virtually infinite, if the funds were readily available. Moreover, most hospitals especially those with religious or other special group affiliations, have an apparent great drive for expansion, to be the biggest, as well as the best, in the community or in the state, and to be wholly self-sufficient. Overexpansion is one of the baneful sources of rising costs.

In addition, if repayment of costs, whatever they turn out to be, is to be virtually guaranteed—and Medicare is open ended in that respect—where are the incentives for cost control, difficult enough in any case, to come from?

As I said, the hospitals look on it as capital. The guidelines themselves rationalize it as partly capital and partly lack of precision in determining costs. Mr. Ball's statement today has concentrated on lack of precision in determining costs. We think that the provision in the medicare statute which provides for retroactive adjustments to make certain that institutions get their costs is insurance enough that the actual costs will be paid. In sum we raise the question of whether the 2 percent factor did come within the intent of Congress when they wrote the legislation.

Senator ANDERSON. Do you have anything else?

Mr. VAIL. On the depreciation allowance, we discuss in our staff report the question as to whether there should be depreciation allowed on Federal grants. We make the same point with respect to State tax revenues that go into hospital construction.

The legislative history and statute indicate that the medicare program is a cost reimbursement program, and where Federal or State tax revenues are involved, we don't consider that to be a cost to the hospital.

We look on those grants as other than a cost—as a non-cost. Since the hospital hasn't incurred a cost, it is difficult for us to understand why the hospital should be granted an allowance for depreciation on that public money.

Now, this committee, at least for 12 years, has followed the practice in the tax laws of not allowing depreciation on contributed property, or on property that is purchased with contributions.

We look on the Federal grant or even the State grant as contributed property, and under the tax law this committee would frown if depreciation were allowed on it.

Yet the medicare reimbursement guidelines allow for depreciation on those assets paid for with public money.

There are some peripheral issues on depreciation that should also be considered. One would be the use of accelerated depreciation. We think that if Congress wanted the hospitals to write this off real quick, and get a bigger reimbursement early, Congress would have said so.

We think there is a question the committee ought to face up to as to whether it wants to allow depreciation, as the guidelines permit on property which has already been fully depreciated.

If it is already depreciated, it seems to us that the cost has been recovered—there is no cost left in that facility to be written off. The guidelines take the position, I think, that what they are reimbursing for is the value of the service that is rendered to the medicare patient, and that that value includes part of the consuming up of the plant. Whether the plant is built with Federal money or with State

money or consists of property which has already been fully depreciated makes no difference under the guidelines.

The issue as we see it, is whether you want to reimburse for value or for cost. If the committee wants to reimburse for cost, it doesn't seem to us that they would want to allow depreciation on Federal or State contributions which come out of tax revenues and which are not a cost paid by the institution.

The committee went into the question of the advance payments in detail this morning. I don't believe there is anything I could add to what went on then.

Senator ANDERSON. The GAO seems to feel it is all right. Did your study convince you it is all right?

Mr. VAIL. Not really, no, sir. I think that under the statute, it is very questionable whether they can make an advance payment to institutions.

Now, in thinking about it, after hearing Mr. Ball testify this morning, there may be some justification for some payment because if it is true that the loss of revenue to the trust fund is less than the cost of interest if you went to a bank to borrow the money, there might be a net saving to the system.

The GAO did say that they questioned the allowance of one-twelfth of a year's advance, or 1 month's advance. They felt that one twenty-fourth, I think would be sufficient.

It seems to us that over the many years that hospitals have been operating, they have been managing, and they have probably built up working funds which they draw upon until they get their next reimbursement from the Blue Cross, insurance company, or patient. And that by allowing this advance, they will now have two funds—the fund that they have probably built up over the years, and the permanent fund that these guidelines would give them.

The remaining issue that the staff raised in its report to the committee concerned the question of whether there should be an allowance in recognition of capital used by proprietary institutions.

The guidelines treat both proprietary institutions and nonprofit institutions alike.

As I understand it, they take the position that you should not reimburse differently for the same service.

It seems to us that the statute probably requires a distinction. The statute does say that there can be different methods of payment for different types of institutions. It seems quite clear to us that a profitmaking institution is a different type of an institution than a nonprofit institution.

We had some difficulty rationalizing payment of a return to proprietary facilities that would be based on cost of operation, because we think that would lead to inefficiency in the program. We thought that a return on the capital that is invested by the proprietor in his business should be recognized however, and a return should be allowed on it.

Reimbursement is allowed for the cost of interest on borrowed money. And we really cannot understand why borrowed money would be treated more generously under the guidelines than the money that the man takes out of his pocket and puts into a business.

It seems to us that in studying this—particularly when we learned that the original cost estimates submitted to the Congress had included a return on the capital invested in the proprietary institutions—

that Congress would have meant a profitmaking institution to get a fair return on its capital—but that Congress would not have intended for a nonprofit institution to make a profit on its equity.

We came to the conclusion that you could justify an allowance in recognition of the capital invested by a proprietor in his own health facility.

Senator ANDERSON. I think that is of some importance when you are dealing with nursing homes as well.

Mr. Ball, do you have any comments on that?

Mr. BALL. Mr. Chairman, on most of these points in the staff report we have commented rather extensively in the testimony this morning and in the discussion, and on most of them I think there is very little to add.

Perhaps it would help the record, Mr. Chairman, if we were allowed the privilege of commenting specifically on the staff document in writing. And I have a few points that I think may be commented on now.

Senator ANDERSON. Without objection, you may make a submission to comment on the points raised by the staff.

(The information referred to follows:)

COMMENTARY ON ANALYSIS PREPARED BY STAFF OF THE COMMITTEE ON FINANCE "PROPOSED MEDICARE REIMBURSEMENT FORMULA"

The staff of the Committee on Finance have raised four main issues in connection with the proposed Principles of Reimbursement for medicare purposes. Social security staff have reviewed the committee staff document and have made a number of observations which may be helpful in the consideration of these issues. Section and page references to the committee staff document are shown to identify the matter under discussion.

Introduction: (p. ii) The committee staff assumption that the proposed medicare formula will be extended to Title XIX and other programs will probably prove to be correct, at least in large part. However, the degree to which this extension will result in an increase in costs of the welfare programs is not entirely clear. The payments under some, probably most, welfare programs will rise but in some it may be reduced. In California, for example, public welfare pays on the Blue Cross formula—i.e., an average per diem formula with depreciation on a replacement basis. Thus, the medicare formula could mean a saving for California welfare. In New York State, which together with California will represent a significant portion of the Nation's welfare hospitalization, a public welfare formula is now being considered, and is reported to be close to adoption, which appears to recognize "costs" to hospitals at about the same level as does the medicare formula.

Question 1. "Should depreciation be allowed on assets paid for with public funds?"

(Page 2) The committee staff suggests that "Because depreciation is not required to be funded, most of the depreciation allowances will probably be * * * applied toward current expenses." While no one knows exactly how much depreciation is now funded, and even though in most areas no funding requirements are applied, in fact many hospitals actually set aside depreciation funds for capital expenditures.

Internally-generated funds, equal to more than the amount of depreciation in a year, are expended on replacement of and additions to capital assets each year by hospitals. Federal funds represent about 30 percent on the average of the capital funds provided for the construction of hospitals that have Hill-Burton grants. Hill-Burton grants of over $200 million a year finance about 10 percent of total expenditures on construction of hospitals since most of hospital construction receives no Hill-Burton aid. (See Table 1.)

There is a very large backlog of need for capital expenditures on hospitals—especially in large metropolitan areas.

The current Hill-Harris legislation, even if supplemented by the pending hospital modernization bill, will not by any means fully meet hospital additions and modernization over the next 10-year period. Close to 10 billion dollars (not including interest) is the overall estimate of the total cost of modernizing the

Nation's hospitals during the next 10 years, taking care of the backlog up to this time and the accruing obsolescence over the period. The pending hospital modernization bill would provide approximately 40 percent of this capital outlay. The medicare formula would meet full current operating costs and would make only a very modest contribution to the preservation and improvement of service-rendering capability. Depreciation at the rate of 5 percent of total medicare expenses will yield about $125 million a year, including depreciation on assets constructed with the aid of Federal funds while the total capital additions to hospitals amounted to about $1½ billion in 1964.

(Page 2 bottom, and top of Page 3) The degree of Federal participation in medical research is very different from that in hospital capital expenditures—in 1964 Federal money paid 84 percent of costs of medical research and 11 percent of non-Federal hospital construction (a slightly smaller percent of total capital expenditures on hospitals). Furthermore, present Federal support of medical research appears ample and research, under the grant program, is subject to quality controls which probably could not be applied if medicare payments were substituted for some of the grants. In the case of construction, even with the medicare and other patient care funds which will become available for capital, a substantial Federal grant and community contribution will remain necessary and community planning influences can be expected to continue to develop and be applied.

(Page 3) The committee reports directed that consideration be given to Hill-Burton and funding factors in cost reimbursement but no conclusive congressional policy was established. The desirability of funding of depreciation, especially when expenditure of these funds is tied to community planning, is clear. Its absence in the medicare principles is due to lack of legal authority, not considerations of desirability.

(Page 4) The committee staff suggests that the Government pays twice when it pays depreciation on assets created by Federal funds. They are thinking of depreciation paying the cost of purchasing the original asset. In another sense, and this is the sense which supports funding, depreciation payments provide funds arising from the depletion of capital used up in producing services, so that the assets may be preserved, maintained, and replaced. Whether the Government will aid a hospital in financing the replacement of a particular asset in the future is unrelated to whether it did so in the past and is in general unpredictable. In any case, the amount of Government aid is obviously insufficient to support more than a minor fraction of hospital capital needs and depreciation payments and other sources of capital must be drawn upon to finance the remainder.

(Page 6) Funding is desirable in principle and consideration of enacting of legislation to make it a requirement appears warranted. There are certain issues with regard to compulsory funding that would have to be studied. Proprietary institutions are a special problem since compulsory funding may be considered to have the effect of depriving the proprietor of his own capital—capital may have been invested in a used-up asset and returned in the form of depreciation, but he would be unable to recoup his investment which would be tied up in a fund. The prerogatives of State and local governments to create or cease to create public facilities would have to be considered too. The mechanisms for achieving effective State or State sponsored planning which would *control* the disposition of *all* funded depreciation (or perhaps capital expenditures generally as in New York) would also require careful congressional and State decisions. Few localities now have effective planning organizations. A requirement that there be effective planning before funds could be spent might tie up the depreciation funds of much of the hospital system until a network of acceptable planning agencies is brought into existence.

It should also be noted that a requirement of funding does not mean depreciation funds will constitute the major source of capital; in Cleveland, one of the few areas where such a requirement has existed for many years, over a 10-year period capital expenditures were 4.3 times total funded depreciation.

(*Question 2*) "*Does the law authorize the Secretary of HEW to pay more than the actual costs of care?*"

This section of the committee staff document refers to a two percent allowance provided for in the principles as a "bonus." The allowance was provided for in lieu of specific recognition of costs not otherwise reimbursed.

(Page 10–11) The committee staff quotes a colloquy between Mr. Mills and Mr. Ball at a Committee on Ways and Means session at which it was agreed that no profit was to be paid to hospitals. The principles are in accord with this

policy (the committee staff, on the other hand, supports, p. 30, an extension of the principles to pay proprietary institutions a return on equity capital). The colloquy does not indicate that cost must be interpreted in the pure accounting sense or that economic costs which do not fit in the accounting definition should not be considered as part of "all necessary and proper expenses incurred in rendering the services." If the principles fail to recognize some significant elements of necessary and proper costs, the result prescribed by law would then occur, viz., cost the program should share in would have to be paid for by non-medicare users.

After prolonged study of the reimbursement principles the conclusion was reached that there were sources of possible cost that should be recognized but which could not be recognized explicitly, e.g., the certain requirements for continuing increases in capital requirement arising from technological obsolescence of medical procedures and equipment; the possibly higher usage of nursing care and other personal services by the aged for which payment will generally otherwise be made at an average rate, etc. Therefore, it was decided to make an allowance for these additional costs through the device of adjusting operating expenses arising from the computation of identifiable expenses, much as is done in the case of a number of Blue Cross plans.

(Page 12) The committee staff raises a question as to whether provision of the 2 percent factor is consistent with the committee reports. The reports require the Secretary in establishing reimbursement regulations to "consider, among other things, the principles generally applied by national organizations or established prepayment organizations * * *." Approximately 30 Blue Cross plans reimbursing hospitals on a cost-related basis added a percentage factor to specified operating cost. While such factors in the Blue Cross formulas are frequently referred to as "plus" factors, they generally take into account elements specifically recognized in the AHA principles and they as well as the 2 percent allowance under discussion are considered consistent with the AHA principles. In Blue plans such "plus" factors are ways of covering some cost elements not otherwise quantified.

(Pages 13 thru 19) The committee staff quotes a number of Department people who provided a strong argument against the payment of imputed interest. These arguments were not being made against the 2 percent factor as may be inferred from the context. Payment of imputed interest would have added some 6 percent to the cost of the program and would have produced a considerable advantage to new hospitals without substantial debt.

(Page 16) The committee staff points out that a number of Federal agencies which purchase medical care use an approach different in a number of respects from the proposed principles. The present system permits payment on an average per diem for all patients, even though the government's patients may not be typical. Its substantial revision has been under consideration for some time but has been delayed because it was recognized that many technical problems in cost reimbursement would need to be faced by hospitals in connection with pending medicare legislation and the necessary study was expected to yield results which could improve Federal reimbursement practices generally.

(Pages 19 and 20) The committee staff expresses concern that the 2 percent factor may yield funds which might thwart proper planning of hospital facilities. The amount of funds yielded by the 2 percent allowance applied to a typical 100-bed hospital would be about $6,000 in a year; for a 300-bed hospital something in the neighborhood of $15,000 would be involved. While these amounts are significant to the hospital as well as to the program, they may be compared with the more than $25,000 cost of adding a single hospital bed.

(Page 21) The committee staff states that it believes the "rate of return" would become a matter of great controversy. The committee staff refers to the 2 percent allowance and the maximum placed on the allowance—the maximum being based upon a rate reflecting the cost of money applied to the institutions' equity capital. It would quite generally not be necessary to require a refined valuation of the assets of the hospital to be able to say quickly that the limitation would not come into effect. In almost all nonprofit hospitals the 2 percent allowance will be very small as a percent of equity. In cases where the limitations would apply, it would usually not be a great problem to ascertain the equity value.

(Pages 26 and 27) The committee staff objects to the inclusion of Hill-Burton funds as part of equity capital for the purposes of this limitation. The principles have been rewritten to make clear that Hill-Burton funds are excluded from equity.

(*Page 23, Question 3*) *"Can reasonable cost include a return on investment for proprietary institutions?"*

The committee staff included in the document quotations from Ways and Means Committee hearings which we believe show that profit was not intended to be paid.

(*Question 4*) *"Should institutions be given one-month estimated cost in advance?"*

The revised statement of principles makes it clear that the principle is to provide current payment of costs at the point in time at which the services are provided to beneficiaries.

The level of payment and timing have been set under the revised principle to adhere to the current payment concept and no "advance" is to be provided.

TABLE 1.—*Financing hospital construction*

Total hospital construction costs in fiscal year 1965 were $1,972 million, of which $201 million (10.2 percent) was from Federal funds under the Hill-Burton hospital construction program. An additional $85 million came from direct Federal expenditures for hospital construction.

Under the Hospital and Medical Facilities (Hill-Burton) Amendments of 1964, P.L. 88–443, authorizations for Federal appropriations for new hospital construction alone were as follows:

Fiscal year ending June 30—	*Millions*
1965	$150
1966	140
1967	135
1968	130
1969	125
Total	680

An additional total of $160 million is authorized to be appropriated for modernization of all types of facilities eligible for Hill-Burton assistance (including, but not limited to, hospitals). (See page VII–E–5.)

Period	Hospital construction by source of funds										
	Millions of dollars						Percent of total construction				
	Total	Direct Federal	Non-Federal			Hill-Burton Federal share	Direct Federal	Non-Federal			Hill-Burton Federal share
			Total	Without Federal aid	Hill-Burton sponsor's share			Total	Without Federal aid	Hill-Burton sponsor's share	
1946	170	21	149	149			12.4	87.6	87.6		
1950	843	146	611	469	142	86	17.3	72.5	55.7	16.8	10.2
1955	651	22	588	531	57	41	3.4	90.3	81.6	8.7	6.3
1957	879	45	756	581	175	78	5.1	86.0	66.1	19.9	8.9
1958	990	35	842	569	273	113	3.5	85.1	57.5	27.6	11.4
1959	998	58	793	453	340	147	5.8	79.5	45.4	34.1	14.7
1960	1,006	56	793	473	320	157	5.6	78.8	47.0	31.8	15.6
1961	1,140	55	920	608	312	165	4.8	80.7	53.3	27.4	14.5
1962	1,267	55	1,028	700	328	184	4.3	81.1	55.2	25.9	14.5
1963	1,510	66	1,245	890	355	199	4.4	82.5	58.9	23.5	13.2
1964(p)	1,976	73	1,692	1,284	408	211	3.7	85.6	65.0	20.6	10.7
1964(p):											
May	165	5	142	109	33	18	3.0	86.1	66.1	20.0	10.9
June	172	6	146	108	38	20	3.5	84.9	62.8	22.1	11.6
July	175	6	150	112	38	19	3.4	85.7	64.7	21.7	10.9
August	179	6	154	116	38	19	3.4	86.0	64.8	21.2	10.6
September	179	7	153	115	38	19	3.9	85.5	64.2	21.2	10.6
October	173	7	148	112	36	18	4.0	85.5	64.7	20.8	10.4
November	167	7	142	106	36	18	4.2	85.0	63.5	21.6	10.8
December	160	7	137	105	32	16	4.4	85.6	65.6	20.0	10.0
1965(p):											
January	153	7	132	103	29	14	4.6	86.3	67.3	19.0	9.2
February	150	7	129	101	28	14	4.7	86.0	67.3	18.7	9.3
March	158	7	135	102	33	16	4.4	85.4	64.6	20.9	10.1
April(r)	153	8	129	96	33	16	5.2	84.3	62.7	21.6	10.5
May(p)	160	8	136	101	35	16	5.0	85.0	63.1	21.9	10.0
June(p)	165	8	141	106	35	16	4.8	85.5	64.2	21.2	9.7

Source: U.S. Department of Health, Education, and Welfare; Public Health Service; based on special reports prepared by the U.S. Department of Commerce, Bureau of the Census. *Title VI of the Public Health Service Act*, as amended, (42 U.S.C. 291-291e) provides the legal basis for the Hill-Burton program. Under a variable matching formula that takes into account local need and ability to pay, Federal participation may range from ⅓ to ⅔ of the total costs of constructing and equipping health and medical facilities. A current summary and analysis of the hospital and medical facilities construction program appears in Hill-Burton Program Progress Report, PHS publication No. 930-F-3, revised annually.

Mr. BALL. On the point that Mr. Vail raises about the possibility of allowing a profit for the profitmaking institutions under the history and the language, and not allowing anything comparable to the nonprofit—actually, we have felt that the term "cost" both in general usage and specifically in reference to this legislative history quite clearly excluded the concept of profit in terms of payment for risk—that is the economic concept of payment for risk. And I believe the General Accounting Office has also stated that they feel there is no basis for the payment of profit, so defined.

The exchange that Mr. Vail read between Chairman Mills and myself rather pins that down—that there was no expectation of a payment of any profit in the legislative history, as far as this is concerned.

We are dealing here with the definition of cost. I think there is a case—we have not allowed it—I think there is a case, though, for what we were talking about earlier this morning, of a minimal type of return for the use of money which is the equivalent of what you get without risk for the use of money, say, as measured by the return on long-term Government issues—what the economists call imputed interest.

But we have not allowed that. I am just making a distinction as to what seems to us to be a conceivable point under cost as against what seemed to be clearly ruled out in terms of actual profit—and to discuss this point a little further, Mr. Chairman, with your permission I would like to ask our general counsel to comment on his view as to the possibility, under the law, of making a payment for specific profit for the profitmaking and doing nothing comparable for the nonprofit.

Mr. WILLCOX. Mr. Chairman, I find it very difficult myself to see any basis for distinguishing the two kinds of institutions in this respect. I agree with Mr. Ball that a reasonable case could be made for some return for the use of money. I also agree that we could not in any case pay any profit in the sense of return for risk taking.

I see no basis for interpreting the term "cost" differently as applies to the two kinds of institutions. The fact that the Secretary is authorized to differentiate between classes of institutions does not, as I read the statute, give him any authority to go beyond cost for either class. I see no basis on which we could say that any return for the use of capital is a cost in the case of proprietary institutions without saying at the same time that it is a cost in the case of nonprofit institutions.

Senator DOUGLAS. Senator Anderson has been compelled to step out of the room.

I have never thought that interest and profits were identical. I had always thought that profits were over and above interest. I have also always thought that interest was a cost. It is an obvious cost when money is borrowed. But it is also a cost if earnings are foregone.

In these days of continuing deficits, certainly the Government borrows purchasing power, and pays interest upon it.

Now, maybe you cannot allocate this entirely to hospitals under Hill-Burton. But there is certainly some cost involved in this, and we are paying out now—what is it—close to $12 billion a year in interest. This is a cost to the community.

I have never felt that we should take the position that Government investments are costless. If the Government did not take the purchasing power from individuals, individuals could invest their purchas-

ing power and receive a return. I think the fact of Government expenditure does not make it costless. In some cases it actually costs them money. In some other cases it consists of earnings foregone by individuals from whom the taxes are taken.

I don't understand the full drift of Mr. Willcox' comments. But I take it that what he is saying is this should be a cost accredited to public institutions, nonprofit institutions, as well as to proprietary institutions. Isn't that your point?

Mr. WILCOX. Yes, Senator Douglas.

The only point I was making is that I can find no basis for distinguishing between the treatment that is accorded that element in the case of the public or nonprofit institutions, on the one hand, and the proprietary institutions, on the other.

Senator DOUGLAS. Then what would you do—give them none, or give to the public the same treatment as to the proprietary?

Mr. WILLCOX. The principles as they are proposed really give them none, except as some bit of this 2-percent item may reflect that for all participating institutions.

Mr. BALL. Senator Douglas, I think it was perhaps before you came in this morning that the point was made that the Health Insurance Benefits Advisory Council—the majority of them were very sympathetic to the general point you are making, and felt there was a good justification for allowing a return on equity for both profit and nonprofit which was equivalent to the use of money without risk.

Senator Douglas. That is a use of capital.

Mr. BALL. Yes. And they refrained from recommending that this first year because they were concerned, first of all, with its rather substantial effect on the cost of the program. To have done so would have increased the overall cost about 6 percent. And they also felt that it was really hard to predict what all the elements of this reimbursement formula and new grants and loans from the Government might have on total hospital financing.

So they wanted to be on the conservative side, and they postponed consideration of that idea for a year—just laid it on the table—but I can assure you with a lot of sympathy from the majority of the council.

Now, having passed that over, though, there was a recognition that since that was not allowed, that to that extent the principles that they have explicitly recognized could well be somewhat short of a true cost reimbursement. The principles they recommended were short of a real cost reimbursement to some extent, and in a couple of other places, too—when they turned down replacement as a basis for depreciation and went to historical. We stuck with the more conservative one, but said in doing so we recognize we may not be making full reimbursement of cost.

When we went to the method of allocation that was adopted as against the average per diem, we again recognized that there were some increased costs for caring for the aged as against younger patients that were not being recognized.

Now, the 2-percent factor that has been discussed was really a recognition in a broad and general way of the fact that the specific elements of the formula did not openly recognize some of these elements of true cost that perhaps should have been in the formula.

So that we have felt and the council has felt that this 2 percent is not a bonus, it is not a profit, it is not over and beyond the cost, but it is an essential part of the basic costs—recognizing the deficiencies elsewhere.

Senator DOUGLAS. Well, I think it was from 1938 to 1942 that I served as a private citizen on that advisory council. I don't think that their decisions should necessarily be taken as the opinions of Congress.

But with the shortage of time, personally, Mr. Chairman, I don't think we should tear this system up by the roots at this last minute. But I do believe that the issue should be faced as a permanent policy, and that you should not allow the temporary disregarding of interest as a cost to harden into a fixed policy, because I think—frankly, I think interest is a cost on public investment as well as on private investment.

Now, similarly, I think as a general principle that the cost of the hospital facilities used under medicare should be charged to medicare and not charged to taxes or to private philanthropy. Therefore it seems to me that you must have depreciation funds which medicare will provide so that a new facility can be constructed as the old one wears out.

Otherwise you are going to be thrown onto public funds or private gifts, and this will be a subsidy of the medicare program.

I think it is much more self-respecting and better accounting if the system bears its own cost.

Similarly, I am not at all certain but that the system should bear the cost of expansion.

We are having a rapid increase in population. There will be a continuing increase in the numbers of people over the age of 65. You will have to have an increase in the number of hospital beds.

Provided you can prevent profitmaking over and above cost, it seems to me the system should provide for its own expansion. Otherwise you throw a terrific burden on private philanthropy and upon taxes.

We will need private philanthropy and taxes to bear other portions of medical and hospital care.

I don't know how much value these observations have, Mr. Chairman. But in my judgment, we should let them go ahead for the next year, and not hold up their orders, but urge that within a year or so they come in with a general policy. And as of this moment, I would favor depreciation as a cost, if adequately determined, I would favor interest as a cost, if the 2 percent results in capital expansion providing there is no profit in the capital expansion.

Mr. COHEN. Could I say, Senator Anderson, in response to Senator Douglas' comments, Secretary Gardner feels that all of these questions are very appropriate, and in the meeting with the American Hospital Association executives, he said to them that we would very carefully evaluate this first year's experience—he felt there were some unknowns in this situation. You are embarking on a rather large-scale reimbursement of cost for 19 million people, and he felt, in giving his initial approval to our working with these people, that there may be some changes that have to be made. And he felt that they could only be made after maybe a year or two of experience. And he promised them that we would collect the necessary data, reevaluate the issues,

many of which are the ones that you indicated, and reopen the question in the next year or two.

So I think that we are in complete agreement with your point that these are valid questions, some of them should be looked at in terms of experience, both administrative, accounting, as well as what is the economic result of this. And then I think there were also several questions as to what the impact of this all would be on the expansion of the hospital system. The Surgeon General himself has indicated that he has some—he wants to know something about what the impact of this is on new construction and modernization provisions—particularly in the Hill-Burton program.

We would also, as I indicated earlier to Senator Anderson, explore those. And I think then we would be in a better position to come back a year and a half or 2 years from now with a much better picture and evaluation.

It may well involve some amendments to the law regarding reasonable cost going to the point that Senator Anderson stated—that there are some elements in this that are not clearly spelled out in the statute. And it may be that Senator Anderson is correct—that after this experience we should come back and probably attempt to clarify the status.

Senator DOUGLAS. Don't sweep them under the table, though. Don't use the period of delay as a means of postponing consideration.

Mr. COHEN. No.

Senator ANDERSON. That is one of the problems. You are going to settle some of these questions in advance, when it ought to be studied for a year. If you would take the question of advance payments and wait until the need was demonstrated, then I might have some sympathy for it. But you want to settle it before you know there is a need. You do the same thing with the 2 percent. There is a provision in the bill, I believe, that lets you go back at the end of a year and refigure your bills. If you find at the end of a year there was an underpayment you have authority to examine the situation.

But you want to pay them now, before you get into the year. You don't want to get experience on which to base it.

If you would put off these things for a year and study them for a year, there might be far less objection to the program.

Once you give this 2-percent sweetener, there is no reason why it cannot go up to 10 percent.

Senator Kennedy suggested a bill for a building program to take care of hospital and nursing home needs. You would solve it by putting this extra money in the pot. The Surgeon General very carefully pointed out you don't always get the best planning under those circumstances.

I lived for many years in a town with two hospitals. That town has not changed its population in 50 years—about the same size it was. And the two hospitals are quite sufficient. I moved to a town that had 15,000 population, and now has 350,000, in 30 years. They need more hospitals. So you have to have more than just money—you have to have planning and study.

But you are going ahead and put the money in and say you hope they build a hospital. Why not find out what they are going to do with it?

You are going to put the money in now and settle the question in advance. That is what most of us are worried about.

MR. COHEN. Senator Anderson, can I say this? I thought before we came to this hearing that we were really taking a very conservative approach. And I think I would still make the same point. If we had followed the rationale of what Senator Douglas I think has just said, and had in a sense accepted the idea of paying interest, it might well have forced Congress—either us or Congress in the position of paying interest both in connection with the proprietaries and the nonprofits, and that would have been a larger cost than what we have in our proposal.

Therefore, I think that on balance, rather than having pushed ourselves and Congress in an expensive direction, we are taking a conservative approach which, if our approach proves to be wrong, and the hospitals and Congress later want to take the other approach, we have, in the intermediate period, really been on the conservative side rather than the liberal side.

Senator DOUGLAS. So far as outlays by the system are concerned.

MR. COHEN. Yes—by the system are concerned.

So it seems to me looking at the different alternatives we might take—we didn't take the one to which if we had to modify, we would have to then be in a position that Congress would have to put in more money or change the contribution rate. But we are at a point where we think, with the present contribution rate, we have taken a conservative position. Congress and ourselves are in a position later on to reexamine it in a way that the economic pressures are not on the side of having to complete an action which you might not want to take later on.

Senator ANDERSON. Congress might think the conservative way to do it is the way contemplated in the testimony on medicare and is what the law calls for. You are saying things which were not discussed by anyone.

You heard Mr. Willcox say he sees no difference between what amounts to cost for a proprietary institution and a nonprofit one. I wonder if Bob Myers has some feelings about that.

Don't you recognize the difference in costs between the nonprofit and the proprietary institutions?

Mr. MYERS. I think that this is probably a legal matter, and I should defer to the General Counsel on that.

Senator DOUGLAS. It is the difference between out-of-pocket costs and economic costs. You don't have out-of-pocket costs on public investment—they are paid out of taxes. But there is an economic cost involved in devoting resources to this purpose rather than alternative uses.

Senator ANDERSON. I think Mr. Myers made a distinction in his original cost estimate.

Mr. MYERS. Yes.

Senator DOUGLAS. Well, he is dealing with out-of-pocket costs, money costs.

Senator ANDERSON. Would it help you any, Mr. Cohen, if we put a resolution through Congress indicating whether Congress approved paying interest on Hill-Burton funds and contributions? Would you like to have that done? Find out where the Senate really is? Of course not, because you know the Senate is against that.

Mr. COHEN. But we are not paying interest on the Hill-Burton funds, Senator.

Senator ANDERSON. When you get through examining this transcript, you will decide you are, I believe.

Mr. COHEN. I don't think so, sir.

Senator DOUGLAS. I would like to say to my good friend from New Mexico that this question comes up of course on irrigation issues, too, where the principal is paid but not interest. I think interest should be paid as well. Similarly, on flood control, we pay back neither the interest nor the principal.

Now, I well understand the interest and pressures which are involved in this issue. But I don't expect to introduce sound economics into the irrigation and flood-control measures for a long time, particularly in view of the strength of the river States and the dry States—aquatically dry, not alcoholically dry.

But I do say we might be rational in our treatment of hospital costs.

Senator ANDERSON. I only want to make——

Senator DOUGLAS. Don't think I am going to propose that you fellows out in the arid States pay back interest as well as principal. I would like to do it, very frankly.

Senator ANDERSON. You have tried it, and failed.

Senator DOUGLAS. And have not succeeded. And I won't succeed in the future—as the sun is setting. And I have not time enough to deal with that issue.

But we have got this issue before us.

Senator ANDERSON. Secretary Cohen, maybe I can explain what my view on this is.

We had a good deal of discussion about this bill, and many people talked about its unsoundness before it was ever adopted, the dangers inherent in it, the fact that costs would get too high. And Bob Myers made estimate after estimate as to how the thing would work out.

Over a long period of years we have trusted the estimates and relied on them tremendously, and I did then and do now.

But after he got through with his estimate, new things were introduced. And now how many things are going to be added?

Will there be 10 percent added finally? You said it is an issue you are going to study. Why don't you wait for 1 year, and find out what the real facts are, which you don't have now any more than you had before.

Why don't you wait to settle this question until there is a chance to settle it?

Senator DOUGLAS. If we are getting into practical considerations, let me say you have to give the hospitals a little grease to operate when they make the transition.

The wheels won't turn unless the axle has a little grease. And if there is grease in this—and I think in the long run there is not grease—if there should be grease, I would not object to a little grease the first year. Grease has been known to perform very useful functions in other branches of Government. I don't know why it cannot perform a useful function in medicare. If this seems too cynical for my colleague——

Senator ANDERSON. I am sure it could. But the actual term used by the American Hospital Association was sweetener.

Mr. COHEN. We used no such term.

Senator ANDERSON. Unless the formula was sweetened. Did you hear that at all from the American Hospital Association?

Mr. COHEN. I didn't hear it, but I recognize the term.

Senator ANDERSON. They said that, did they not? Until it was sweetened.

I have to agree with Senator Douglas it may be proper to sweeten it some, to sweeten it a little bit. But I would rather depend upon the Hill-Burton type of approach for authorizing the construction of hospitals, where the Government has some control over the planning of those hospitals, than take the sweetener approach you have in this bill. That is a matter of judgment. You may be right, and I may be wrong. But I would rather do it in the Hill-Burton approach, where the people make their representations, and planning is involved instead of the sweetener method.

Senator DOUGLAS. Now, then, we come to this question of the treatment of the depreciation fund.

Are you prepared to provide for funding within a State—not necessarily for each hospital—but that the depreciation be funded for actual replacement within the State, if not carried on or needed within the hospital?

Mr. BALL. Senator Douglas, we feel that it is a highly desirable objective to have funding if it is subject to planning.

I expressed some doubt earlier today whether it was even desirable to force funding if it is not subject to some planning, because you then perpetuate whatever exists.

But it seems quite clear from the statute that we do not have the authority to require funding, since depreciation is a part of cost, and we don't see how we can make that conditional under the statute as it is now written—because we are told to pay cost. And it certainly is I think quite out of the question to subject depreciation to a planning requirement under the law as written.

Senator DOUGLAS. The same question comes up on interest charges on publicly furnished facilities.

Couldn't you provide that the interest be paid, but not necessarily credited to the specific institutions—that it go into a general fund to be used for new construction?

Senator ANDERSON. Is there anything in the law that forbids the requirement of planning? I realize there is nothing at all that says you have to do it a certain way. But we have long since adopted the policy of making certain grants if certain other things are done.

Now, is there anything in the law that forbids you from putting in a regulation which says there must be planning along with funding?

Mr. WILLCOX. There is nothing in this statute that authorizes it, Senator. We are directed to pay the costs. And there is also a provision specifically forbidding us to interfere with the operation or management of the hospitals.

Senator ANDERSON. You are giving them a sweetener. When you give them a sweetener, is there anything at all that says you cannot give it to them with some strings on it? That is all I am trying to say. This will remove a lot of my objections to this particular provision, if I thought you had control over the planning of it.

Mr. WILLCOX. Is this the 2 percent you are talking about?

Senator ANDERSON. No—depreciation allowances.

Mr. WILLCOX. Senator, I simply don't see any authority to do it. The statute directs us to pay the reasonable costs. This item either is or is not a part of the reasonable cost.

Senator ANDERSON. Therefore, if we are going to have any control over the planning, we have to stop this whole provision, then, do we?

Mr. WILLCOX. I don't know whether that will give you control over planning.

Senator ANDERSON. I am talking about the thing the Surgeon General talked about far more eloquently than I could in his comment. That was a good statement, and a very sensible statement, and I want to follow it if I can, by saying if there is any funding, it ought to be done with sensible planning. And the very finest reasons I have seen are in the statement your own Surgeon General has made. I have no quarrel with it at all. I think it is excellent.

I am only trying to find a way to tie it down.

It seems to me if we give money to a State for building roads, and say those roads have to come to a certain standard, we ought to be able to say we are going to give you money for depreciation which you have to set up in a fund and plan for it properly and have your plans approved. If you do that, a lot of my objection disappears.

Senator DOUGLAS. What you are saying is that you don't have authority to do that?

Mr. WILLCOX. I cannot find any authority in this statute.

Senator ANDERSON. But he cannot find any prohibition.

Mr. COHEN. Senator, we have read the provision saying we should not interfere in the internal administration of the hospital——

Senator ANDERSON. Now, Wilbur Cohen, you know that is not interfering in the affairs of the hospital.

Mr. COHEN. I think it is a very sensitive thing to say that the money that you get you can only spend in accordance with some requirement on planning, because planning for what, and in what direction?

Senator DOUGLAS. Planning whether the expansion is to be carried on in that hospital or in other hospitals.

Senator ANDERSON. Senator Douglas——

Senator DOUGLAS. Excuse me for breaking in.

Senator ANDERSON. The report on the amendments for 1965 says:

> Reasonable cost should include appropriate treatment of depreciation on buildings and equipment taking into account such factors as the effect of Hill-Burton construction grants and practices with respect to funding for depreciation.

Now, I think that is almost enough to tie your hat on to. If someone doesn't want to take the money on that basis, they can turn it back to the Federal Treasury.

I would say when there is no prohibition on putting controls on these things, you ought to try to put it on, and let somebody take it into court and see if they can take it off. I think they would have a hard time doing it. But at least you would have tried to do something that is in accordance with ordinary, reasonable precautions; namely, if they are going to get money to replace buildings, it ought to be for approved construction or equipment. Otherwise you are going to have a cancer machine in every hospital, regardless of need.

I think you ought to plan for these things. There should be some central control over it.

Mr. COHEN. Could I ask the Senator there a question?

When you use the word that there ought to be some approved type of planning, you mean by a State agency or Federal agency or both?

Senator ANDERSON. I believe a State agency would be appropriate. I understand Hill-Burton money is handled by the State. In my particular home State they made some money available for a fine hospital so nobody is quarreling with what they have done, because they have said to hospitals don't try to do what everybody is doing, but try to serve the whole community. And that is very important, to me, at least. And I would like to see you do your best to see if you cannot require it. I think you could. I admit that the statute does not specifically say that social security shall do this. There is nothing of that nature. There is merely a provision to allow you to make this money available for depreciation, and I think it is tied closely enough in the reports to Hill-Burton funds so you could say "subject to the same requirements that the Hill-Burton money is now disposed of in a State." If you do that, you are going to eliminate a whole lot of opposition.

It ceases to be a sweetener then, and becomes something valuable for the future.

I quite agree with you that there ought to be reasonable construcsion of new buildings when the old ones wear out. But I want to be sure they a.e the right kind of buildings, in the right place, for the right purpose.

Senator DOUGLAS. I would agree.

Senator ANDERSON. I am not trying to tear down your playhouse.

Senator DOUGLAS. I would apply that to interest charges, too.

Senator ANDERSON. I think you would find a tough battle on that.

Senator DOUGLAS. I am sure—because of the precedents involved. But capital is not costless. That is the point. And it is productive. Neither costless nor unproductive. It is productive.

It should be compensated for its work, just like labor is compensated for its work.

We do not say that capital is dead labor which, vampirelike, lives by sucking live labor. We do not say that.

Senator ANDERSON. You only imply it.

Senator DOUGLAS. I won't identify the author of that, but I think it is fairly obvious.

But let the record show that we refute that.

Mr. BALL. Mr. Chairman, perhaps the record should show at this point that the memorandum that the Surgeon General has introduced—and he may want to comment on this—was directed at a point in the council's discussions where what was under consideration was to apply depreciation on the much more generous basis of keeping the value up to date—that is the replacement cost—and the Surgeon General, as I understand it, was not objecting to the inclusion of depreciation as such in a cost formula, but raising a question whether if one went so far as to do it on this more generous basis, considerations of planning and so on would not argue against it.

Dr. STEWART. This is quite correct. I was writing this memorandum against a discussion of replacement cost depreciation. And as far as I go along, I think I agree with you, Senator Douglas, that depreciation is a cost.

What I was really trying to point out is there is inequality in facilities, distribution of facilities in the country now. If you let

capital formation develop where services are provided now, you perpetuate that—unless you can get the planning factor into it so you replace facilities in the right places.

Senator DOUGLAS. I quite agree.

It has been a long time since I studied depreciation theory. But as I understand it, the common practice has always been that depreciation is based on original cost and not on replacement cost. Isn't that true?

Dr. STEWART. This is the more or less standard practice now; yes, sir.

Senator DOUGLAS. And it may be that replacement cost is preferable. But it is not followed in private industry. Isn't that true?

Dr. STEWART. I don't really know, sir.

Senator ANDERSON. Some new things have been added, Senator Douglas. This provision they have here would allow you to have——

Senator DOUGLAS. You mean accelerated depreciation. I think there is a real question as to whether you should go for accelerated depreciation. I think the straight-line method is better, very frankly.

I hope you have not got your feet in so far that you would have to agree to accelerated depreciation.

Senator ANDERSON. I think Mr. Ball testified in favor of it this morning.

Senator DOUGLAS. The straight-line method?

Senator ANDERSON. No, the accelerated depreciation. Did you not testify to that?

Mr. BALL. Yes, Senator. The principles allow, at the option of the hospital, for them to take accelerated depreciation methods if they wish. The reasoning there was that in the case where the capital was borrowed, that it would frequently require accelerated depreciation to meet the mortgage payment. And, on the other hand, where it was their own capital, it was at least in some small part a concession to the argument for replacement cost and against historical cost.

Senator DOUGLAS. I know we have accelerated depreciation in our tax policies, over my opposition.

Senator ANDERSON. I disagree completely with Mr. Ball on this thing. I don't think this is a desirable way to do it at all. This is another sweetener.

It is like the advance fund of $200 million—just a sweetener. If they are getting along all right now, paying the mortgage now, what do they need accelerated depreciation for? I think it is a mistake. And they will find it is a mistake.

Many merchants who got accelerated depreciation say: "If I had used straight-line depreciation how much better off I would have been."

Mr. COHEN. Senator, could I return to your point with regard to the planning?

Senator ANDERSON. Yes, surely.

Mr. COHEN. I think there is no disagreement absolutely on the matter of principle. I think our concern is simply whether there is the legal and legislative history with regard to this type of planning commitment in this program.

I would like to suggest that we have pending in the Senate two bills that relate to hospitals—one to hospital modernization, and the other with respect to comprehensive State planning by the State

health authority. And if you felt that—and those two bills, I would hope, would be acted upon this year. They are part of the President's program. And if you felt that planning—since this involves practically all of the hospitals in the Nation—it is true not only for the aged—but we also have title 19 in which hospital costs are across the board—you could, in those bills, if you wanted to, as a matter of public policy, make as a condition of the Federal money that there be a State agency which had the more general responsibility of the Hill-Burton provisions for planning of all of these health services in the State.

Now, that would be a logical, it seems to me, requirement to make, if you added medicare, title 19, the modernization funds, and the grants for the State health functions all together—to say, look, we have all these pieces of legislation that have an impact upon facilities and services, and we wish to require perhaps even franchise, like I think they do in New York—a form of franchise legislation for hospitals, plus planning—I think we would all agree in principle that would be a great step forward, and you could rationalize it in terms of the totality of Federal money and legislation.

Senator DOUGLAS. Well, the jurisdiction on that would pass out of our hands.

Mr. COHEN. That is the Senate Labor and Public Welfare.

Senator ANDERSON. It ties——

Mr. COHEN. It seems to me, Senator Douglas, it is very germane to that legislation, which does create out of general revenues, too, the expansion of the Hill-Burton and this other function, in which planning, I think, is absolutely—I think the Surgeon General would be very delighted to see that happen, would you not?

Dr. STEWART. I think this does two things. I think it accomplishes the—it puts this type of capital formation into a planning system which has been in existence and is being expanded. Secondly, it allows planning for the total hospital rather than the expansion or replacement of that portion which is used by people 65 years and over.

So you get it into a context of a whole rather than a piece.

Senator DOUGLAS. Is there such a thing as joint jurisdiction, Mr. Chairman?

Senator ANDERSON. I want to say, Senator Douglas, that I think there is enough authority in the bill now to go ahead and do it—there is plenty of legislative history. The principles of the American Hospital Association make provision for it. Someone might take you into court, but he might have quite a day in court before he got through. I would like to see you try it.

Senator DOUGLAS. You want to make them do it prior to July 1?

Senator ANDERSON. I think they ought to put it in their guidelines. All these things fit together—the 2 percent, the accelerated depreciation. They are all sweeteners for the hospitals.

Modern Hospital has a story in its May issue:

The HEW Secretary's promise was made in a letter to Philip D. Bonnett, in correspondence initiated by the AHA after a stormy meeting in its headquarters in April—

Did you attend the stormy meeting?

Mr. COHEN. It was not stormy. I thought it was an interesting meeting, an exchange of ideas.

Senator ANDERSON (reading):

obtained assurance that AHA would make a last-ditch fight with the Government about the reimbursement proposals.

They did make a fight, didn't they?

Mr. BALL. There may be two different meetings in mind. They may be referring to a meeting in Chicago.

The CHAIRMAN. They are.

Mr. BALL. I gather that was stormy.

The CHAIRMAN. If you think it was not stormy—we have some letters to indicate it was stormy.

Mr. COHEN. I misunderstood. I assumed it was a meeting in which I participated, and I was not at any stormy meeting. But I think, Senator, going back to what Senator Douglas said—I think you also have to keep in mind that the hospitals did come in and make representation to Mr. Ball and the Secretary for proposals which were very substantially beyond what we are now talking about in the guidelines that we issued.

Senator ANDERSON. It was 19 percent and settled for 2. But there was a proposal they take 2 percent.

Mr. BALL. Senator, they had over several things at the same time. They had the idea that 2 percent would be desirable, that it would be desirable to also have depreciation on a replacement basis, that it be desirable to have the average per diem. And the only point in dispute that we later agreed with them on—in these major cost matters—and then on a different rationale than theirs, was the 2 percent.

Senator ANDERSON. The story is a pretty accurate story in most details. [Reading:]

The most noteworthy change was, however, a disappointment to California hospitals. They had insisted on payment for a "growth and development factor," and had asked for 6 percent. Hospitals were granted the factor, but it was 2 percent as first proposed by AHA.

Do you deny that?

Mr. BALL. No, Senator.

Senator ANDERSON. They asked for 2 percent in the beginning, and when you turned them down they raised it to 19, and then you went back to 2, and they took it.

Mr. BALL. No, sir. The 2 percent was never a single position of the AHA. They were always for—the minimum position they ever had was for average per diem, which is a 9-percent increase plus 2 percent, and at various times they were for these other points I suggested. They were never just for 2 percent.

Senator ANDERSON. They were for a first lien on the Treasury.

Mr. COHEN. I thought, Senator, having sat in many conference committees, that one side asked for 19 and we settled for 2, was a very, very reasonable, conservative solution.

Senator ANDERSON. No great problem is settled until it is settled right. If they asked for something wrong, 2 percent is as bad as 19 percent.

I know you believe in the compromise. But sometimes we don't.

Senator DOUGLAS. You have a much stronger bargaining position now with the hospitals after Senator Anderson's position.

Senator ANDERSON. Now you raise the question of the HIBAC decisions being discussed in camera.

We asked for the HIBAC minutes in February. We did not get them. The American Medical Association knew what was in them—the AHA knew what was in them. But the staff of the Senate committee could not have them. That is what you get into. And, is there any order out now that people in the Department who discuss these matters with members of the staff have to make out a memorandum of what they discussed and put it in the files?

Mr. BALL. No, Senator.

Senator ANDERSON. No? Now, think carefully.

Mr. BALL. Let me answer your first point first.

Senator ANDERSON. Somebody does have that instruction.

Mr. BALL. About 3 or 4 years ago I asked people to let me know in general, not related to this—about outside contacts, but not a memorandum in the file on what was discussed—merely what contacts were made as part of my overall responsibility to know what was going on.

Senator ANDERSON. Hasn't that requirement been introduced in the last 2 or 3 weeks?

Mr. BALL. No, sir. I have no idea what you are referring to.

Senator ANDERSON. I am referring to the fact that some people have been told if they discuss anything outside the Department to make a memorandum of it.

Mr. BALL. Not by me, Senator.

Senator ANDERSON. Do you know of anybody who requested it?

Mr. BALL. No; I do not.

Mr. COHEN. I know of no such instructions, either, Senator.

Senator ANDERSON. Let me talk to the witness first.

Mr. Myers, it has been estimated that as presently constituted and based upon all available information, medicare first year costs will exceed the original estimate given to the Congress by at least $150 million. Is that possible?

Mr. MYERS. I think it depends what is meant in this question by medicare.

If you include just the hospital insurance program, the figure is $75 million. I have heard figures that title XIX, or medical assistance, might add another $75 million. But I have not worked on that aspect.

Senator ANDERSON. I referred to the hospital insurance program, where there are variable factors, such as utilization which may increase costs. We were just wondering how much the cost has gone up. I know you say from 1.23 to 1.26 percent of payroll isn't much jump. But if it starts in that direction, it sometimes goes a long way.

Mr. MYERS. It is quite true, Senator, this whole question of what the cost of the program will be is nothing that we know completely precisely now. But I have seen no reason to change the cost estimates that I gave last year, other than for this 2½-percent increase, or the 0.03 percent of taxable payroll that we have been talking about.

Senator ANDERSON. The 0.03-percent increase of taxable payroll—if you didn't give it to the hospitals, how many additional days of hospital care could be added to the benefits?

Mr. MYERS. I can give you two alternatives—if you had an additional 0.03 percent of taxable payroll to finance additional benefits. First, you could extend the present 30 days of hospitalization—beyond the first 60 days—where there is a $10 payment by the

individuals to probably 120 days—so a total of 180 days of hospitalization would be covered, with $10 daily payments beyond the 60 days. Alternatively, you could drop the $10 daily payment requirement for days beyond 60, and probably pay for complete coverage for up to 100 days—that is, after the $40 deductible.

Senator CURTIS. In lieu of what, Mr. Chairman? I came in late.

Senator ANDERSON. If they did not give the sweeteners of all kinds to the hospitals, and went back to the hospital bill as we contemplated it in its original passage. This 0.03 increase could be used to give additional benefits. I am wondering if it is not better to give those benefits to the patients rather than to the hospitals.

Senator DOUGLAS. I would say they have to get the system underway, and they have to get the cooperation of the hospitals. I don't object to the tentative sweeteners, or grease, as I call it. I think that ultimately if you recognize interest as a cost, it is going to be much more than this, as I believe it should be. But then I think—what are the funds to be used for? What are the depreciation funds and the interest charges to be used for?

Mr. BALL. I think that, Senator, is one of the main reasons that the Health Insurance Benefit Advisory Council recommended postponing that issue of interest for a year, because it increased costs enough that it would have raised a question, first of all, about the contribution rates under the program, and secondly, it raised the question that the Surgeon General addressed himself to, of planning for the use of that fund.

Two percent is very substantially less than what allowing imputed interest would cost, and didn't raise in their minds the same question.

Mr. Chairman——

Senator ANDERSON. When you postpone one of the things for a year—why don't you postpone all of these controversial questions? Why not pay benefits for a year and see what happens?

Mr. BALL. We truly believe that the failure to allow the 2 percent would actually mean that we were paying less than cost for these services.

Senator ANDERSON. What does the law require?

Mr. BALL. That we pay cost.

Senator ANDERSON. If you find out you haven't paid cost—you have to pay it then. Why don't you find out about it?

Mr. BALL. I don't think that the retroactive provision contemplates going back over the year and changing the principles. I think what is contemplated is that you pay first on the basis of advances, that is estimates—not advances—an estimate——

Senator ANDERSON. No, "advance" is all right. I follow you.

Mr. BALL. We have changed that. That is not an advance. But you make an estimate at the beginning of the year on the basis of these principles. Then at the end of the year you settle up, on the basis of the principles put out.

It would hardly seem reasonable at the end of the year, after hospitals had entered into an agreement with you on the basis of certain principles, to shift all the principles for retroactive settlement in terms of how you compute a cost. I don't think that was contemplated at all.

Senator ANDERSON. Well, why cannot a hospital find out what its costs are at the end of the first year?

Mr. BALL. Well, the question of what are the costs is a matter of what principles are agreed upon as the basis for cost determination. As you know, it is not——

Senator ANDERSON. You are putting the 2 percent in for additional costs not now defined?

Mr. BALL. We are paying 2 percent as a recognition that the careful definition of the rest of the cost leaves out some things that are not specifically included—and I have enumerated them before.

Senator ANDERSON. If you left out some things, why don't you put them back in?

Mr. BALL. Because they are not things, Senator, that you can arrive at specifically.

Senator ANDERSON. If you cannot arrive at them specifically, they are not in the law, are they?

Mr. BALL. Yes, I think the law says that you are to pay costs—and let me give you an illustration.

If it is true, as I believe it is, that older people do require a little bit more in the way of nursing services on the average, that it does take them longer to have an X-ray made, that it does take them longer to get through an admission office, our approach to cost finding here does not specifically recognize that difference. We have just not allowed for it. And to that extent we are understating what we should reimburse a hospital for.

In the same way, I believe that there is a case to be made that replacement costs actually are justified in part, at least, as compared with historical costs.

But instead of recognizing that explicitly, which would have been much more expensive, we recognized that there was some part of it that should be allowed, some part of the other that should be allowed.

Senator Douglas pointed out about a return on equity capital at interest. This was not specifically allowed. But there is recognition that failure to allow it may be somewhat understating cost.

All these things together justify, in our judgment, the 2 percent, and make it a part of basic cost—not something over on top of cost. As a matter of fact, it is minimum recognition of such cost—you could easily justify something beyond that had you not been held back by the considerations of the Council—of the cost estimates not allowing for such things as interests on equity capital and the concern that there would be about such a major increase in expenditures over what had been estimated.

Senator, I thought I should also reply to your point about the HIBAC minutes for the record, if you would like me to.

Senator ANDERSON. I know what the story is. The story is that everybody knew what was in it. Why couldn't the Senate Finance Committee know what was in it?

Mr. BALL. Senator, I never had a request from any Senator or any request at all in writing——

Senator ANDERSON. Mr. Hess, did you get a request in February?

Mr. HESS. Mr. Constantine told me he would like to have a set of the minutes for you. At that point we had a restriction from the Council itself that, unless we had a request to the Council, we would not do anything.

Senator ANDERSON. You didn't think Mr. Constantine coming from the Finance Committee had a right to request for the Finance Committee?

Mr. BALL. I would have thought, Senator, for us to overcome the vote that the Council had made, that we would have wanted to have a direct contact or a letter from the committee, or some formal request.

Senator DOUGLAS. I don't think you should take that position.

Senator ANDERSON. Certainly not.

Senator DOUGLAS. I have been defending you most of the afternoon. But I don't believe that you have to get a letter from the chairman of the committee, and so forth. After all, Congress must act ultimately on these matters. We cannot act without adequate information. I don't think we should be sealed off, or our staff should be sealed off from getting this information.

Senator ANDERSON. If they had been told that a letter was required, Mr. Constantine would have gotten it in no time at all. Senator Long would have given him the letter. But it was just said it could not be given out, period.

[Matter omitted.]

Mr. BALL. No, I do not. Certainly it is true, Senator, that the substance of the decisions of the Council were known to outside groups. I doubt—to my knowledge, the minutes themselves were never transmitted to any outside group.

Now, if some member of the Council did it, I don't know.

Senator ANDERSON. I asked you whether you thought they had them or not. Haven't they referred to them right along?

Mr. BALL. I do not know that, Senator. I do not know they had the minutes at all.

Mr. HESS. They have referred to some of the substantive decisions.

Senator ANDERSON. Certainly, they have referred to what is inside of them.

Mr. HESS. We have no evidence that they had the minutes at all.

Mr. BALL. The minutes, Senator, are a long recitation of the discussion, as well as the action. I never had any indication that they had the minutes. The Council itself had voted on two different occasions that they would like to have their discussions off the record so that everybody could feel free as they were making up their mind to just talk back and forth. That was the basis for not giving them out.

But I might say to you had I known that this was a matter of concern to you, it might have come to a very different decision.

Senator DOUGLAS. Well, in the future will he recognize a request from the staff here as coming from the committee?

Mr. BALL. Senator, what I would like to do is to follow the suggestions earlier. If we had any doubt about its being a matter that the

committee was specifically interested in—in order to overcome an action of the Council—I would like to call and check on——

Senator DOUGLAS. Call who?

Mr. BALL. I would like to ask Mr. Vail or Senator Long or someone as to the validity of this request. Because you don't deal lightly with an advisory council that has taken an action, and said it would like to have its discussions off the record. I would like to have assurances, and I am sure I could get them from Mr. Vail, if that were the situation, that these would be kept completely confidential.

Senator DOUGLAS. Confidential in what respect—that Members of the Senate should not see them?

Mr. BALL. No; I meant with respect to the committee's own action.

Senator ANDERSON. Well, I was distressed, Mr. Ball, very frankly, because I know Mr. Constantine had my full approval. The request was made to Mr. Hess. When he was turned down, he tried to call it to your attention. He had to call two different times. And no call ever came back.

I think under the circumstances if he tells us what the reason is, we could reach our own conclusions on it.

Senator Douglas, do you have additional questions?

Senator DOUGLAS. I have no more questions. I have to leave.

But I don't see how we can compel the Social Security Administration to revise its formula at this late date. I think we have to let them go ahead with what they have done. But I think there should be a public discussion of half a dozen points involved, and that sometime during the year the committee should—this committee should—if it can agree—should express its point of view, so as to be a guideline for revision.

Senator ANDERSON. Senator Williams?

Senator WILLIAMS. Mr. Ball, earlier today I asked you to give us an estimate as to the cost if all of the 50 States implemented the title 19 program. I was referring to the article which appeared in the Washington Post for May 22, in which they pointed out that eight States have implemented it so far, and those eight States are costing far more than was given as the total estimate at the time that the bill was passed on by the committee. I have two questions.

First, how did you arrive at the $238 million as the overall cost if and when they all implemented it?

And secondly, what is your revised estimate today as to the projected 10-year cost of that particular section of the bill if it is implemented in its entirety by the 50 States?

Mr. BALL. Mr. Hawkins is here with us, Senator.

Mr. HAWKINS. Senator Williams, as the committee report indicates, the estimate of $238 million represented the amount of Federal funds that would be available to the States given the number of State and local dollars that they were currently putting in. In other words, as compared with the existing formulas for Federal matching, the $238 million represented the Federal funds over and above the number of dollars.

Now, there is a footnote at the bottom of that table on page 86 which says:

> If State and local expenditures were reduced, the Federal expenditures would be correspondingly lower, while increases in State and local expenditures would also result in increases in Federal cost.

Of course, this was also true under prior law. If a State wished to double its expenditures under the Kerr-Mills program, it could have gotten twice as much Federal money.

Our actual experience with these programs under title 19, the programs in January represented an expenditure of Federal, State and local funds of about $20 million. February it was also about $20 million. In March it was about $45 million—but all but $7½ million of that $45 million represented transfers from prior programs, so that the $7½ million represents all of the additional cost of the program in March. We have not yet had enough experience to make a projection of what may happen. The estimates that appeared in the Washington Post were ones made by the States. Whether they will ever be realized, when they will be realized, we are not yet in a position to evaluate.

Senator WILLIAMS. New York State has passed a law, some of the other States have passed a law to implement Title XIX. Do you take exception to the figures given for those States?

Mr. HAWKINS. I don't think we have had enough experience to say with certainty these are the figures. Now, there is another element in the situation.

Senator WILLIAMS. If these figures are reasonably accurate, it is going to mean that instead of $238 million it is going to run around a billion dollars, based on the same variation if projected.

You projected $238 million extra cost in a year. California was getting $75 million before. They estimate that they will get $180 million. Hawaii, $1.2 million, goes to $2.4 million. That is a 100-percent increase. Illinois, from $17.7 to $40 million. Minnesota, from $23.1 to $39 million. North Dakota, from $3.3 million under existing law to $18.4 million. Oklahoma, from $13.7 to $15.6 million. Pennsylvania from $22.3 to $100 million. And Puerto Rico, from $680,000 to $22 million. And I understand there is no limit on payments to Puerto Rico.

Now, these States are passing laws. A quick tabulation shows that on those eight States alone costs are about $250 million to $260 million more than it was before implementation.

What is your estimate of the increased costs if all of the other 42 States do likewise?

Mr. HAWKINS. We do not have an estimate at this time, Senator.

Senator WILLIAMS. Would you dispute the estimate I have seen that it would cost, at a minimum a billion dollars more than your estimate?

Mr. HAWKINS. I think we have no indication that it is likely to run to anything like that.

Senator WILLIAMS. What do you think it will run, because it is $250 million already—you don't dispute those figures on the eight States. I grant you that those are the larger States.

Mr. HAWKINS. I neither dispute nor accept them, Senator. We saw some estimates by States on Kerr-Mills programs that never began to be realized in terms of actual experience later.

Senator WILLIAMS. That was because the Department was discrediting the Kerr-Mills bill, discouraging it, and in some instances refusing to tell the States how they could get it. Don't deny that too quickly, because we had quite an experience in Delaware—so much so that my opponent, who is a very able and worthy man, the Governor

of the State, came down after the campaign was over and said, "I will swear I thought I was right. I listened to the Department." The difference now is you are selling the program, and it is costing money.

Mr. HAWKINS. There are two other elements involved in this estimate.

One, the legislation last year included participation in mental and TB institutions. Practically all of these plans included here have mental institutions provision in them. So there is another $75 million first year estimate that can be added to the $238 million.

Certainly, insofar as there is new State and local money it will cost more.

Senator WILLIAMS. And if the other States continue on the same scale as that of these eight States, it could readily move up to and approach the middle figure, could it not?

Mr. HAWKINS. I would question this very seriously.

Senator WILLIAMS. You would be afraid to say it could not, wouldn't you?

Mr. HAWKINS. I could not say it couldn't. We have had a growth in the existing medical care programs of about $80 million a year, without any change in the law or anything else. The expenditures for medical care costs in fiscal 1965 ran about a billion and a quarter dollars. In recent years it has been going up about $80 million a year.

Now, over a period of time——

Senator WILLIAMS. This is not considering the $80 million a year of growth. This is beyond that. And that growth factor will still be there, on top of these figures.

Mr. HAWKINS. I would suspect these figures include the growth factor.

Senator WILLIAMS. The growth factor would still be there.

Mr. Myers, have you made any estimate in this connection?

Mr. MYERS. No, Senator Williams, I have not made any cost estimates in the area of public assistance.

Senator WILLIAMS. Do you have available the tabulation which developed the $238 million?

Mr. HAWKINS. Yes, it is right in the Senate Finance Committee report.

Senator WILLIAMS. I would like to have that incorporated in the record at this point, Mr. Chairman, along with a copy of the list in the Post, which lists the eight States implementing this, where their increase alone runs up to $238 million.

(The article and committee report table referred to follow:)

Public assistance: Increased Federal funds available for medical payments under title XIX [1]

[In thousands of dollars]

State	Increase available under title XIX [1]	State	Increase available under title XIX [1]
Total	$238,005	Missouri	$350
		Montana	27
Alabama	1,045	Nebraska	1,511
Alaska	5	Nevada	263
Arizona	19	New Hampshire	1,931
Arkansas	3,905	New Jersey	5,559
California	20,411	New Mexico	1,634
Colorado	2,689	New York	46,580
Connecticut	3,922	North Carolina	2,890
Delaware	8	North Dakota	3,809
District of Columbia	344	Ohio	2,871
Florida	684	Oklahoma	14,752
Georgia	363	Oregon	1,291
Hawaii	898	Pennsylvania	3,098
Idaho	477	Rhode Island	2,437
Illinois	18,395	South Carolina	2,133
Indiana	2,136	South Dakota	148
Iowa	5,315	Tennessee	324
Kansas	5,808	Texas	1,237
Kentucky	262	Utah	3,028
Louisiana	3,950	Vermont	330
Maine	781	Virginia	159
Maryland	141	Washington	2,290
Massachusetts	16,614	West Virginia	2,260
Michigan	3,715	Wisconsin	17,031
Minnesota	27,578	Wyoming	280
Mississippi	317		

[1] Based on expenditures for vendor medical payments from State and local funds for all programs combined in January 1964. If State and local expenditures were reduced, the Federal expenditure would be correspondingly lower, while increases in State and local expenditures would also result in increases in the Federal cost.

[From the Washington Post, May 22, 1966]

TRIGGERED BY N.Y. ACTION—NATIONWIDE STORM LOOMS ON "SOCIALIZED MEDICINE"

(By Eve Edstrom)

New York's legislature is brewing a new national storm over "socialized medicine."

The cauldron is being stirred by the enactment in Albany of a wide-open, Federally supported program of health care for the needy that could mean free and unlimited hospital, medical, dental and nursing care to 7 million of New York State's 18 million residents.

New York's action is finally focusing public attention on why the least known provisions of the Nation's new medicare laws are potentially the most revolutionary.

The New York program is so liberal that families of four with annual net incomes of up to $6000 annually and savings of $3000 can qualify.

State medical societies are denouncing the new program as a "Government give-away."

This is ironic because the New York program implements a Federal law that initially was enacted to scuttle medicare for the aged on ground that it would bring about socialized medicine. And the strongest support for that law—commonly known as Kerr-Mills—came from the American Medical Association.

Now, New York medical spokesmen and industrialists are demanding repeal of the plan that Gov. Nelson A. Rockefeller signed into law April 30.

Upstate New York legislators are urging that the Department of Health, Education and Welfare withhold approval of the New York program—a most unlikely happening because HEW is delighted with New York's magnanimity.

Gov. Rockefeller is hopeful that a public hearing Tuesday in the State Capitol will clear up confusion over the program. But health care experts predict that this will be just the beginning of a national debate that will be echoed in every state legislature and the United States Capitol before long.

In the public's mind, medicare is the Social Security insurance system of hospital and medical benefits that will be available to more than 17 million persons, aged 65 and over, beginning July 1.

But at the same time that the medicare insurance system was established, Congress approved an enormously liberalized version of the Kerr-Mills program of Federal-state health care benefits.

That program became effective Jan. 1 and is the real sleeper of the medicare legislation. No longer limited to the aged as it was when enacted in 1960, all age groups, with special emphasis on children, are potential beneficiaries of it.

And because medicare under the Nation's social insurance system is limited to the aged and its benefits will probably pay no more than 60 per cent of an individual's health bills, there will be increasing reliance on the expanded Kerr-Mills program to make certain that no American who needs health services is denied them.

SCANT ATTENTION

However, until New York dramatized the potentially extensive scope of the new program, scant attention was paid to the liberalized Kerr-Mills benefits. This was because initial experience under Kerr-Mills was so unsatisfactory. States set such low income limits for eligibility that the program was of little help except to aged paupers.

But now many of the more offensive features of the original Kerr-Mills law have been wiped out. The means test to determine eligibility has been radically altered.

Arbitrary income limits that excluded people regardless of the size of medical bills have been ruled out. Irksome relative responsibility provisions have been greatly narrowed.

But, as in any Federal-State matching program, the number of eligible persons will vary greatly from state to state, depending on the generosity or stinginess of state legislators. And with all state treasuries strapped financially, no other state is expected to be as benovolent as New York.

Seven other states and Puerto Rico already have Federally approved programs, and their income qualifications range from a low of $2448 to a high of $4000 for a family of four.

OPTION LEFT TO STATE

States have an option on how they may begin the program, and initially they could limit it to persons who qualify for Federally-supported relief payments. However, this has not been done in any of the states that have adopted the program.

Furthermore, the law requires the states to make a series of progressive improvements so that across-the-board health care services will be available to all of their medically needy residents, regardless of income, by 1975.

Just what this means to the Federal Treasury—at a time when the Nation is arguing over guns or butter—can be seen from estimates made by the first seven states and Puerto Rico.

The following table shows what the states received in Federal matching funds for the medical care of the needy during a full year before they adopted the liberalized program, and what they estimate the Federal share of first-year costs will be now:

[In millions]

	Before	Now
California	$75	$180.0
Hawaii	1.2	2.4
Illinois	17.7	40.0
Minnesota	23.1	39.0
North Dakota	3.2	18.4
Oklahoma	13.7	15.6
Pennsylvania	22.3	100.0
Puerto Rico [1]	.68	22.0

[1] In 1965, Congress eliminated overall dollar ceilings on the amount of Federal funds that Puerto Rico and the other territories could receive for medical care. Under the new matching formula, Puerto Rico now qualifies for greatly increased funds.

When the liberalized bill was enacted, its potential impact on the public treasury was grossly understated.

ADDITIONAL BILL ESTIMATED

The report of the House Ways and Means Committee, based on data provided by the Department of Health, Education and Welfare, estimated that the additional Federal bill for the expanded Kerr-Mills benefits would amount to $238 million during the first full year of operation.

The $238 million was to be the total Federal increase if all states took advantage of the program. But the $238 million has already been exceeded in the projected first-year costs made by the first seven states and Puerto Rico.

And these costs can be expected to keep going up as more and more states come into the program and as they make the progressive improvements required by law.

One of the most significant improvements is aimed at obtaining health care for all of the Nation's medically needy children under 21. This ultimately could aid more than 50 percent of the children who live in urban areas.

But whether the Nation is actually committed to providing the financial follow-through to make this a reality is at the heart of the public argument to be heard in Albany this week.

Senator WILLIAMS. What concerns me is not whether this is right or wrong, but the fact that you have one program here which has changes increasing costs by $75 million a year—changes which are being made over and above what the committee expected or over and above the estimate. Coupled with this, it looks to me like you have got another bill passed by the Congress which over the next 10 years is going to cost at least—I am almost afraid to say it. But if it is going to be like these eight States here, running $262 million over the original estimate—in 10 years that is two and a half billion dollars. You have a multibillion-dollar error in your estimated cost of this proposal. And that concerns me.

Mr. HAWKINS. Senator, these estimates are made on exactly the same basis as any other estimate given to the committee in the public assistance area.

Senator WILLIAMS. These other estimates are made on the same basis, are they not?

Mr. HAWKINS. No; they are not.

Senator WILLIAMS. Haven't you examined what these States have done to see what it is going to cost the Federal Government in matching funds? Are we committed under that law to match these in accordance with the formula outlined here?

Mr. HAWKINS. We are committed to participate in the payments—if that is what the payments under the State plan amount to.

Senator WILLIAMS. If the States want to implement these plans, we are committed under title 19 to match them. And we are committed—if each of the other 42 States wants to implement the same type of program, we are committed, under title 19, to match it. And that could run up, based on this initial experience, to where it is going to cost you $2 to $5 billion in 10 years more than the committee estimated, or was given as an estimate at the time it was adopted.

Mr. COHEN. Senator, could I say something?

Senator ANDERSON. I ask unanimous consent at the close of the hearing to put in a statement and resolution by the AHA.

Mr. COHEN. While I don't know the quantitative answer, the Senator in my opinion is correct. Title 19 does involve a very, very heavy and growing financial responsibility by the Federal Government to meet its commitments. And if the Senator will refer to section 1903(e) which was written into the bill in the House committee, and in the final law, he will see that the congressional intent

is clear—which bears out his point—where it says that the Secretary shall not make payments under the preceding provision or section to any State unless the State makes a satisfactory showing that it is making efforts in the direction of broadening the scope of care and services made available under the plan and in the direction of liberalizing the eligibility requirements for medical assistance with a view toward furnishing by July 1, 1975, comprehensive care and services to substantially all individuals who meet the plan's eligibility standards with respect to income and resources, including services to enable such individuals to attain or retain independence or self-care.

As I recall the discussion in the House committee, the executive sessions, and in the affirmation of this in the final legislation, it was the intent on the House side to develop a comprehensive medical assistance program for practically all persons with low incomes in the United States. And that feature was written in by the House committee. And, therefore, with the open-end formula mechanism that is in here, I think the Senator is correct that substantially more Federal costs are involved in title 19 during the next 10 years than certainly were anticipated during the first year on the assumption that only existing State and local expenditures were to be matched.

Senator WILLIAMS. Well, that is the point that I am trying to get, Mr. Cohen. I appreciate your making the statement. I am not debating here that implementing this is illegal. I realize that it is in the law. The point that I am making is that it is now almost clear to anyone that the $238 million given us, which over a 10-year period would be two and a quarter to two and a half billion dollars, is unrealistic in the light of the experience we are having as far as these States are concerned.

Mr. COHEN. I think you are most likely to be correct.

But let me explain, so you will understand, what the basis, at least over in the House committee, which was then transformed in the Senate committee report, has always been on State programs that involve State implementation.

That is, they have always gone on the assumption that the only estimate that seemed to be—I won't say the only one that seemed to be reasonable—but the best estimate they had is what would be the Federal cost if you would use all of the State and local funds that I think then were available for these purposes.

Now, beyond that I think if you look in the committee report, it says that if the States put up less money than this, or more money than this, as I recall it, it would cost more than this estimate.

But no estimate was made what would happen if the States did something different than what they were then doing with State and local money.

But I agree with you in your conclusion. The net result will be that title 19 is going to, over the next 10 years, have a substantially increased annual cost over what was presented in the committee report on that assumption.

Senator WILLIAMS. And again we are dealing with an assumption. Conceivably no other State would implement this. But on the assumption that the other States do implement it to the same degree that is proposed in these eight that we mentioned, their cost, instead of being $238 million a year, could exceed a billion a year.

Mr. COHEN. Yes. I think that I would say, without knowing the fact—I think it could be more than that or less than that, because the essential element is what do the States do with regard to three factors.

What is the scope of medical care that they put in their program? What are the eligibility conditions? and, How much State and local money do they put up?

Now, if they have a high income provision, a comprehensive scope of medical care, and put a lot of State money in that wasn't anticipated, it is going to cost the Federal Government more.

Senator WILLIAMS. I appreciate that. And there is no way, really, for anyone to sit down and make an accurate estimate, because we don't know what any one of these other States are going to do, or whether they will be as liberal or more liberal in their programs.

But I just thought we should recognize the fact that if these States carry it out, the other States are going to figure they can get some of this Federal money, too. And it will end up with have a program which is many, many times more expensive than was contemplated at the time the Congress passed this particular proposal.

Now, I am not debating the merits right now. The law has been passed. And the fact whether we as individuals voted for or against it is beside the point. It is passed, it is the law, it has to be financed. And once these States implement this program, as I understand it, we have no choice, except to match the money.

But I think we should recognize—and I am not sure that enough attention was given to just how far reaching this could have been in describing this to the committee.

I am wondering whether at the time the increased cost was estimated at $238 million, if the possibilities of what is going on shouldn't have been pointed out. Maybe nobody could foresee it. But if not—it is a billion dollar blunder, anyway—as far as estimating is concerned. I think we are going to have to raise this money.

This, as I understand it, is paid by appropriation.

Mr. COHEN. Yes. This is paid out of general revenues.

Senator WILLIAMS. It is taxpayers' money.

Mr. COHEN. Yes. I want to say this, Senator.

I would not want to in any way comment on what the expectations at the time of the Senate Finance Committee were. But I think as far as the House committee is concerned, they intentionally wanted the program to be very broad, and very comprehensive, because they were trying to develop a program that they thought would very comprehensively take care of the medical care of all of those people who were in these medically needy groups.

I don't think the House was unaware of the implications of very substantial Federal costs.

Senator WILLIAMS. Perhaps they were not unaware of it. But in the report they did not put a big dollar sign on it which now is going to have to be put on it.

I appreciate your help in getting this in the record, because I don't see any need for kidding ourselves. We are at this point. The law has been passed. And as long as it is on the books, we are going to have to match this money as these various States come in. I am just trying to get a reasonable estimate as to what we are confronted with over the next few years as we try to raise the money in some manner to pay for this program. And I think it would have been far

better if at the time it was passed the American people could have seen the price tag, rather than later going to the store seeing a $5 price tag and then getting a bill for $25.

The point is that we are dealing in millions and billions in this particular case.

Senator CURTIS. Just a few questions for the record.

In the past, isn't it true that, by and large, the cost of providing hospitalization has been borne by the public to quite an extent?

I will illustrate.

In every town and city, most every town and city, public-spirited groups conduct hospital drives and raise great sums for hospitals; is that correct?

Mr. COHEN. Yes, sir.

Senator CURTIS. And a number of hospitals are county hospitals, and city hospitals, and State hospitals, isn't that true?

Mr. COHEN. Yes, sir.

Senator CURTIS. Now, because of that subsidy, from charitably minded individuals, in some cases organizations, perhaps churches or lodges, and local tax sources—the individual who entered the hospital—I am not talking about an aged person necessarily, but including the aged—when he paid his hospital bill, he didn't pay the full cost, did he? He paid what was necessary in addition to the tax funds, and the hospital drive funds and the sponsoring church funds or lodge funds. Isn't that correct?

Mr. COHEN. I think you are correct when you make the assumption that the money which was primarily raised for construction was not necessarily fully reflected in the charges per diem for service.

Senator CURTIS. Well, it is not only construction. It includes equipment, too, doesn't it?

Mr. COHEN. Yes. But I mean capital costs.

Senator CURTIS. And to some extent the operation, isn't that true?

Mr. COHEN. I think on that very little, Senator.

Senator CURTIS. Well, if you include depreciation as an operating cost, they let the hospital go until they have another hospital drive, isn't that correct?

Mr. COHEN. That may be. I think the major point where I would see public funds entering in on the service side, on operation cost, would be paying for welfare clients.

Senator CURTIS. Yes. And also members of religious orders working for less than the cost of equivalent services.

Now, in general that situation has been different in respect to convalescent homes, hasn't it—particularly the proprietary ones?

Mr. COHEN. Well, what makes me stop to think is I do remember the figure that—if you are referring to nursing homes now——

Senator CURTIS. Yes.

Mr. COHEN. As I recall——

Senator CURTIS. I am referring to the category of institution which will qualify or attempt to qualify to provide extended care.

Mr. COHEN. I see. Well, I do recall the point, though, that as of a year or two ago, I think about 40 percent of the total income of nursing homes in the country came from public welfare agencies paying for welfare clients.

Senator CURTIS. But that is not a subsidy that inures to the benefit of others——

Mr. COHEN. No; as a matter of fact many of them were not paying even their full cost.

Senator CURTIS. So you do have a difference between nursing homes and hospitals. There may be exceptions to it both ways. But in general, public spirited, generous people in a community periodically raise great sums of money to establish hospitals, and to renew hospitals, and equip hospitals. Is that correct?

Mr. COHEN. Yes, sir.

Senator CURTIS. And we have some which have received help either in the form of voluntary labor or direct money from religious and fraternal organizations. And in general that has not been true or nearly so true in respect to nursing homes—isn't that correct? Most nursing homes have been proprietary in nature—where the individuals running it, owning it, had to pay out on their own.

Mr. COHEN. That is correct.

Senator CURTIS. I think that is something that should be taken into account in determining what the reasonable cost is—having someone in a hospital, and what that reasonable cost is, and having someone in a nursing home and determining what that reasonable cost is. Because certainly the past practice, as well as the very nature of ownership, has been different, varying in localities and between institutions. Isn't that correct?

Mr. COHEN. Yes, sir.

Senator CURTIS. Now, as I review today's testimony, the definition that you are about to follow in determining the cost of hospitalization is going to place upon the hospital program a portion of the cost that was previously borne by others.

Mr. BALL. Senator, I think insofar as many, many hospitals were concerned—the aged were not paying their own way—welfare and charity cases for example.

Senator CURTIS. Some of them were paying their own way. A person might be 75 years old, and if he goes into a hospital, and that hospital is the recipient of generous drives on the part of the community—it may be a hospital conducted by a religious order or a fraternal society. It may even be a county or State hospital—regardless of his age, he has not been paying the full cost, has he, in the past—in the purview of the definition that you are now about to follow.

Mr. BALL. Well——

Senator CURTIS. Isn't that true?

Mr. BALL. Senator, I have a great deal of difficulty in answering categorically on this, because the situations differ so from place to place.

Many, many hospitals have a charge system that actually is in excess of cost, and they use the charge system purposely to accumulate capital for expansion and for renewal over and beyond depreciation. This is quite typical of nonprofit hospitals in areas where there are public charity hospitals.

So it is very hard to answer the general question—have people been paying less than the cost of care?

It is true they have not in many places, and in other places they have been paying more than the cost.

Senator CURTIS. Where they have been paying less than the cost, under the guidelines and definitions you have adopted today, they will pay more than that, or the full reasonable cost?

Mr. BALL. Yes, sir.

Senator CURTIS. Now, doesn't it follow, then, that all patients who enter the hospitals, including those under 65 years of age, are going to have an increase in their hospital costs by reason of this program?

Mr. BALL. No, sir. It seems to me that the evidence points to the fact that when we pay the full cost for the aged, that will relieve those under 65 of the subsidy that they have been typically bearing for the aged. And I call to your attention that——

Senator CURTIS. But that subsidy has not always been for the aged. Someone goes to a children's hospital. They are the beneficiary of countless gifts and drives that have been carried on for that children's hospital. And now you are switching to a program where the full cost—including depreciation, and this 2 percent, all of these things—are to be charged. Do you anticipate that hospitals are going to charge less per day for an individual 64 than they do for an individual 65?

Mr. BALL. We will be reimbursing on a cost basis, Senator. And insofar as younger people have been subsidizing older, which may not be your point but it is nevertheless correct——

Senator CURTIS. That just relates to the welfare cases.

Mr. BALL. No; not entirely. Take Blue Cross, for example. Let me give my own State of Maryland. In the Blue Cross of Maryland, they have covered older people typically at the same rate that they have charged younger people for the premiums. And the result of that is that the younger people have been paying a subsidy to the older people.

Senator CURTIS. So far as the hospital is concerned, there hasn't been a variation in the charge per day because of someone's age, has there?

Mr. BALL. No. But when you use the average per diem approach, it follows also in reimbursing the hospital that for the aged the hospital gets more than the true cost.

Now, if we step into this picture under this program and pay the full cost, it depends on what the situation has been. On the welfare and the charity cases, as you say, the result of our paying full costs will be to pay the hospital more.

As far as the hospital is concerned, if they have been reimbursed on an average per diem under Blue Cross they will actually get less for older people when we pay than they did previously.

If I just can round out the Blue Cross picture in Maryland—as far as individuals are concerned, a very interesting thing is happening. The Commissioner of Insurance there has ordered a reduction in the general rates of premiums under Blue Cross because the medicare program will now be paying the full cost for older people, and they no longer have to carry that subsidy.

Senator CURTIS. As a matter of fact, a great many employers are totally terminating their insurance, or that part of their insurance that is covered by medicare, isn't that right?

Mr. BALL. Yes. What I am talking about, though, is that their rates for younger people will now be less, because they don't have to subsidize the older.

Senator ANDERSON. I think you may have missed his point, Senator Curtis. He says that a man 40 years old will probably pay

less for Blue Cross because the contributions for old people will no longer be involved.

Senator CURTIS. My point is he is going to pay more to get in the hospital, because when the Government assumes this responsibility, you are going to shut off other public funds, you are not going to get the zeal to go out and raise a huge sum for a hospital drive, because the Government is going to do it. And patients of all ages, including those under 65, have received the benefit of that private giving in the past.

That is the point I was making.

Mr. COHEN. Well, let me say this. I had not thought about how this would affect people 65 and over, because I still think there is plenty of room for private fundraising and philanthropy for hospital expansion. You see, this doesn't pay—this program doesn't pay for all the capital expansion that is involved for population increase, or utilization. So if your assumption is that this is going to possibly drive out private contributions for capital replacement or capital expansion, I don't see any evidence of that yet. I am not saying it won't happen. But I don't see any evidence that it would result from the proposed formula with respect to the 25 percent of hospital utilization.

Senator CURTIS. Under your formula, the medicare system is going to pay a greater amount for hospital care for an aged person than if that same aged person went in and paid his own bill for substantially the same care in the past.

Mr. BALL. No, sir; I don't believe that is the result, Senator.

If I can make the point again—the typical situation in a charge system is to charge somewhat more than cost, and quite typically I believe that hospitals have been getting—when they collect the full charges—a little bit more than cost.

Now, in Blue Cross, they use the average per diem method of reimbursement of the hospital quite widely—not always, but quite widely—where they pay the average per diem for the older person, because of the reason we explained earlier of the length of stay being twice as long—the result is that they pay more for the aged people under that approach than we will be paying since we are paying actual cost for the aged—because we did not adopt the average per diem method. Thus, we will be paying less than Blue Cross did for older people in many cases.

Senator CURTIS. I think it is going to result in an increase in the cost of hospitalization for those people not under the program. I think it is very clear that the cost for someone staying in a nursing home after the period of time elapses that this program takes care of will very clearly be increased, because of the standards that you set. There will be duties that will have to be performed by a registered nurse that have been performed by someone of lesser skills. There will be duties that will have to be performed by a graduate dietician that have been performed very adequately by someone with a lesser amount of training.

I won't belabor the point. Everybody is impatient here today. But I think it is going to be inevitable. I want the record to show this morning that when I made reference to hospitals charging 25 cents for aspirin, and charging a sizable sum for insulin when the patient could take his bottle of insulin along with him—I am not critical of

the individual hospital that has done that. I expect the administrators have been so worried about how to make ends meet, they have to grab it where they can.

But it certainly has not been a reflection of costs.

That is all.

Senator ANDERSON. I agree with the Senator. Being a diabetic, when I go to a hospital I get insulin treatment four times a day. I have been taking it for 26 years. They get $2 a shot. I can do it for 50 cents.

Senator CURTIS. You can buy a bottle for $1.75, and it will last you 10 days.

Senator ANDERSON. Without objection, the record of these hearings will include the text of certain articles referred to earlier in this hearing. I want to thank all of the people who have been here for their patience. I think the staff has done a fine job. I think you have done a fine job of answering.

Thank you a lot.

(Whereupon, at 5 p.m., the committee was adjourned, to reconvene subject to the call of the Chair.)

APPENDIX A

REPORT TO
THE COMMITTEE ON FINANCE
UNITED STATES SENATE

REVIEW OF
PROPOSED PRINCIPLES OF REIMBURSEMENT
FOR PROVIDER COSTS
UNDER PUBLIC LAW 89-97

SOCIAL SECURITY ADMINISTRATION
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

BY
THE COMPTROLLER GENERAL
OF THE UNITED STATES

MAY 1966

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-142983

MAY 24 1966

Dear Mr. Chairman:

In response to your request of May 3, 1966, we have reviewed the "Principles of Reimbursement for Provider Costs under Public Law 89-97" prepared by the Social Security Administration, Department of Health, Education, and Welfare. These proposed principles are intended to provide the basis for regulations governing the payment by or on behalf of the Social Security Administration of the reasonable costs of medical care services provided to beneficiaries under the health benefit insurance program authorized by part A of title XVIII of the Social Security Act, which was added by section 102(a) of the Social Security Amendments of 1965 (79 Stat. 291). In the course of our review, we have given specific consideration to certain legal and policy questions which have been raised in relation to the principles as proposed, and have also reviewed the provisions of certain other principles which we believe present substantive questions and problem areas relating to policy and administration which should be given further consideration before the principles are promulgated. The results of our review are summarized in this letter and are discussed in greater detail in the accompanying report.

Specific questions were raised as to the legal authority of the Secretary of Health, Education, and Welfare to provide for including in reimbursable costs a general two percent of costs allowance stated to be in lieu of costs not otherwise specifically covered, and to allow depreciation on assets financed with Federal or other public funds without requiring such reimbursements to be funded for use only in the improving, replacement, or expansion of medical care facilities. Question was raised also with respect to whether the Secretary may authorize the making of advance payments to providers of services under this program in the light of the general prohibition against advances of public monies contained in section 3648, Revised Statutes (31 U.S.C. 529).

After giving careful consideration to the purposes of the program to which the proposed principles relate, the relationship between the Federal Government and providers of services covered under the program,

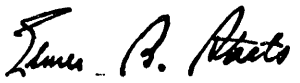
and to the broad discretionary powers granted to the Secretary by the governing legislation to determine the elements to be included in the reasonable costs of covered services and to determine the timing of payments for such services under the program, it is our conclusion that we would not object on legal grounds to the provisions of the pertinent principles as now formulated. We have, however, discussed in our report certain aspects of these particular principles which we believe, from the standpoint of policy and administration, are deserving of further consideration in the determination of whether these principles should be promulgated in their present form.

We have included also in the report comments concerning provisions of certain other principles which we believe present substantive questions and problem areas relating to policy and administration which should be given further consideration before the principles are promulgated.

The more significant of these other comments relate to (1) the appropriateness of the provisions of principle 1-1A, which would allow the initiation of the use or a change to accelerated methods of computing depreciation with respect to other than new assets for the purpose of determining allowable costs, (2) the questionable need for and the desirability of provisions under principle 1-1B, which would permit inclusion in allowable costs of an allowance in lieu of depreciation on assets acquired before 1966, and (3) the failure to include in principle 2-2 the conditions requisite to the use of certain estimating methods where actual cost data is not available. We have in the course of our review, discussed these aspects of the principles with responsible officials of the Social Security Administration who have indicated that our views will be carefully considered.

In the interest of making a timely response to your request, we have not obtained written comments from the Department of Health, Education, and Welfare on the contents of our report.

Sincerely yours,



Comptroller General
of the United States

Enclosure

The Honorable Russell B. Long, Chairman
Committee on Finance
United States Senate

Contents

REPORT ON REVIEW OF PROPOSED PRINCIPLES OF REIMBURSEMENT FOR PROVIDER COSTS UNDER PUBLIC LAW 89-97 SOCIAL SECURITY ADMINISTRATION DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

INTRODUCTION

Pursuant to a request from the Committee on Finance, United States Senate, the General Accounting Office has reviewed the "Principles of Reimbursement For Provider Costs Under Public Law 89-97," which were announced by the Commissioner of Social Security on May 2, 1966.

In the course of our review, we examined into the general information and background material which was readily available at the Social Security Administration and which was given consideration by the Health Insurance Benefits Advisory Council (HIBAC) and the Department of Health, Education, and Welfare (HEW) in the development of the principles. In addition, we have discussed certain aspects of the principles with officials of the Department.

BACKGROUND

Part A of title XVIII of the Social Security Act, which was added by section 102(a) of the Social Security Amendments of 1965 (79 Stat. 291), provides for health insurance benefits for the aged. Under this act, HEW has the responsibility for establishing regulations which will include the principles to be applied in determining the reasonable cost of services provided to beneficiaries. The Commissioner of Social Security, at a press conference on May 2, 1966, made public the proposed HEW principles of reimbursement. These principles are proposed to be the basis for

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the pertinent parts of the health insurance benefits program regulations.

The Secretary is authorized by the act to enter into an agreement with national, State, or other public or private agency or organization (intermediaries) that may be designated by any group or association of providers of services, to determine the amount of payments required, provide consultation services to providers, serve as a channel of communication from providers to the Department, make audits of the records of providers as may be necessary to insure that proper payments are made or to perform such other functions as are found to be necessary. Payment for the reasonable cost of provider services as determined pursuant to the Department's regulations will be made to providers of service either directly or through intermediaries.

The Department estimates that approximately 17 million insured individuals and 2 million uninsured will qualify for basic hospital health insurance benefits on July 1, 1966. Benefits and administrative expenses under the basic plan would be about $1 billion for the 6-month period in 1966 and about $2.3 billion in 1967. The costs for the uninsured (paid from general funds) would be about $280 million for the first full year.

Separate payroll taxes to finance the basic plan, paid by employers, employees, and self-employed persons, would be earmarked in a separate Hospital Insurance Trust Fund established in the Treasury. The same contribution rate would apply equally to employers, employees, and self-employed persons.

FINDINGS AND CONCLUSIONS

Our findings and conclusions on the basis of our review are presented in the following sections of this report. These findings and conclusions relate only to certain of the proposed principles which we believe present substantive issues from the standpoint of law, policy, or administration, which would be appropriate for consideration before the principles are promulgated in the form of regulations. We have discussed certain of these issues, as indicated in appropriate sections of this report, with responsible officials of the Social Security Administration, who have generally indicated that our views thereon would be carefully considered.

PRINCIPLES INVOLVING BASIC LEGAL AND POLICY ISSUES

Three of the proposed principles to govern the determination of the reasonable costs of providing services covered by the health insurance benefits program involve factors and considerations which raise substantive legal and policy issues. Because of the considered importance of these issues, they are discussed in the following sections of this report together, where appropriate, with our conclusions with respect thereto.

Principle 1-11 Allowance in Lieu of Specific Recognition of Other Costs

Principle 1-11 would provide:

> "In lieu of specific recognition of other costs in providing and improving services, an allowance amounting to 2 percent of costs allowed under the other principles (with the exception of interest expense) is includable as an element of reasonable cost of services, subject to the limitation that the allowance not exceed a reasonable long-term interest rate on the provider's equity capital."

Legal considerations

The comments on this principle prepared by the Social Security Administration state as follows:

> "In accordance with the established practice of a number of large third-party purchasers, this allowance, in lieu of a direct return on the equity capital of providers, recognizes the continuing need for capital funds to secure, preserve and improve service-rendering capabilities.
>
> "The allowance under this principle is limited to an amount which, as a percentage of the provider's equity capital, does not exceed the rate of return on government obligations currently being acquired by Social Security Trust Funds.
>
> "Although the methods to be utilized by hospitals for determining the actual cost of services provided to

beneficiaries are the best available, some lack of precision in methods at the present stage of cost finding represents a contingency which is a further consideration for including this allowance."

Question has been raised as to the legality of payments to be made under this principle primarily on the basis of characterizing such payments as a "bonus" or "profit" over and above the reasonable cost for providing services. We would agree that if this allowance, in fact, constitutes a bonus or a profit in the true sense it is not authorized under the act. However, whether or not the allowance is either is subject to some speculation.

Section 1861(b)(1) of the act provides that in establishing cost reimbursement principles the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations. The act further specifies that the principles may provide for determination of costs of services on a per diem, per unit, per capita, or other basis and that estimates of costs of particular items or services may be used. We understand that in the negotiations and considerations which led to establishment of the cost principles there was a considerable difference of opinion as to whether average per diem costs of all services for all patients would reasonably reflect true costs when applied to the elderly patients covered under the act. The Secretary took the position that since the stay of elderly patients is generally longer than the stay of younger patients and since the use of ancillary services such as x-ray and laboratory is not proportional to the length of stay, averaging all costs on a per diem basis and applying this average to patients covered by the program would, in fact, overstate the true cost

which the program should properly bear. The cost principles, therefore, provide that only "routine" costs are to be averaged out on a per diem basis with "ancillary" costs to be allocated on the basis of actual use.

We have been advised, however, that the Secretary received evidence which tends to support the conclusion that although an average per diem rate for all costs applied to elderly patients would overstate the true cost of services rendered to these patients, application to elderly patients of an average per diem rate for only routine services, in fact, understates the true cost of the services rendered. This is stated to be so because elderly patients generally require more attention than younger patients.

We cannot, of course, precisely determine the appropriateness of the allowance in terms of its recognition of costs of the nature described. However, in our opinion, there is sufficient merit to the concepts involved when viewed in the context of the statutory provision authorizing the use of estimates to preclude our concluding that the allowance in question is illegal, at least to the extent which it reasonably reflects the amount of costs it is intended to cover.

But even assuming that some portion of the allowance constitutes a return on the provider's equity capital dedicated to the function of providing medical services, we do not think that the Secretary may be said to have exceeded his authority under the act in providing such a return where, as here, it is limited by a reasonable long-term interest rate.

It is abundantly clear that the act does not contemplate the payment of a profit to providers of services. It is also clear from the act and its history that, although, a return on equity

capital can readily be viewed as a profit, the Congress did not specifically address itself to this question, except to the extent that in speaking of cost reimbursement it would appear that the Congress was contemplating cost in a traditional sense. And return on equity is not a cost, at least in the traditional sense of that term. This much would seem to call for a conclusion that an allowance for return on equity may not legally be made under the act.

But the act and its history show clearly that the Secretary is to have wide discretionary authority in establishing methods of payment and items to be included in the context of the term "reasonable cost." The question is then whether there is any basis upon which a return on equity may reasonably be construed as reasonable cost. If so, it would be difficult, in the absence of a specific statutory prohibition to conclude that payment for such a reasonable cost is not authorized. The act recognizes that in determining reasonable costs, methods and items to be included might well vary by types and classes of institutions. In dealing with the question of return on equity as a cost, it is appropriate to examine the underlying issues in light of certain differences between profit making institutions on the one hand and nonprofit institutions on the other.

For the profit institution, the use of capital clearly represents a cost in the economic sense if not in the accounting sense. Without expectation of a return on capital it would not be dedicated to a particular use. Indeed, it is normally the expectation of a return greater than that available through investment in risk-free securities that capital is funneled into any particular channel. In a very real sense, the investor must regard the forebearance of the risk-free long-term interest available to him as a

cost in terms of deciding whether to use his capital for a particular purpose. It is only with respect to the return he receives over and above risk-free interest available to him that he may be said to have profited in the economic sense from his decision to utilize his capital for other than investment in securities. Recognizing these fundamental concepts upon which private profit seeking capital is utilized, we would not question the legal authority of the Secretary to apply the cost principle in question in profit-making institution situations.

However, for nonprofit institutions expected return on capital is not relevant to its use. Here, return on capital is not necessary as an incentive for the dedication of capital to a particular purpose. Therefore, in this context, "reasonable cost" must be viewed in a light different from that in which we have considered it thus far, if we are to conclude that return on capital is a factor which may be considered by the Secretary.

If nonprofit medical institutions are viewed as operating on a static basis, with no element of growth or increasing sophistication in facilities and equipment involved, a return above actual costs in the traditional accounting sense would not be appropriate. But these institutions cannot operate statically if they are to provide the kind and level of medical services on a continuing basis to which patients should be entitled. There is a constant need for additional capital to keep pace with medical advancements. In practice, this additional capital is provided through donations and borrowings. Theoretically, at least, it would not seem unreasonable to conclude that charges to patients should contain an element toward meeting this need for continual capital accretion. And in this context, it would further seem reasonable to construe a charge

toward meeting this need as a "reasonable cost" of providing medical services.

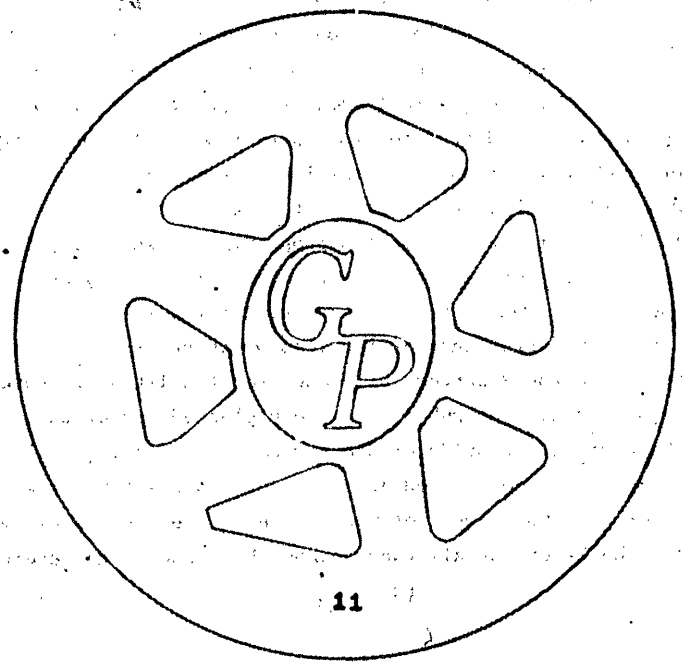
Moreover, disregarding now the distinction between profit and nonprofit institutions, the legislative history of the act shows a clear intent to be fair in establishing the cost reimbursement principles. If return on equity is to be allowed for profit institutions and interest expense on borrowed capital is to be allowed irrespective of the character of an institution, it seems reasonable to question the fairness of not making some allowance for nonprofit institutions whose capital structure avoids the necessity for interest expense. While it is true that interest expense is an actual cost in the traditional accounting sense whereas imputed return on equity capital is a cost only in the economic sense (perhaps more so in the case of profit-making institutions than nonprofit), payment for interest expense and for return on capital to the profit institution is payment for items not directly related to the furnishing of medical care. That is, the amounts of these payments are effectively lost so far as concerns their availability for improved medical services. Capital is used whether it is owned or borrowed, and a return on equity for the nonprofit institution at least has the virtue of retaining the funds involved in the sphere of improving the quality or quantity of available medical care, whereas interest costs and return on equity for profit institutions which are paid are lost to the medical complex.

We would add that ordinarily, we would not rely upon such a rationalization as we have presented to permit a return on equity as being within the term "reasonable cost" were that term contained in the statute in an isolated context. And we appreciate that the rationalization itself is subject to differing viewpoints.

However, recognizing that some undetermined portion and perhaps all of the allowance in question relates to true actual cost; that the act vests in the Secretary extremely broad authority with respect to establishment of cost principles; that the use of estimates was sanctioned; that the cost principles were to be established through consultation with various national organizations with an underlying concept of achieving fairness to all concerned; and viewing the question of cost in the overall context of a continuing program in a dynamic expanding situation rather than one which is static, we conclude that the allowance in lieu of specific recognition of other costs in providing and improving services is not so unreasonable as to warrant a finding that it is beyond the legal authority of the Secretary to provide. This conclusion is separate and apart from any policy considerations relating to the desirability or necessity for providing the allowance and is based essentially upon such determinations inherent in the allowance itself.

A related question has been suggested as to the propriety of the allowance in terms of a percentage of costs. While section 254(b) of title 41, United States Code, precludes the use of cost-plus-a-percentage of cost systems of contracting, this prohibition is applicable by the terms of section 252(a) of title 41 only to purchases made by the General Services Administration and other executive agencies pursuant to delegation from the Administrator of General Services. The services being paid for under the Medicare program not being within the scope of the procurement toward which the prohibition is directed, there would not be any basis for concluding that basing the allowance as a percentage of costs is illegal. Moreover, we must recognize again the wide discretion vested in the Secretary regarding the methods of

determining costs, and we understand that allowances based on percentages of costs are currently provided under a substantial number of medical insurance plans. Finally, we would note that there is some question as whether the incentive to increase costs toward which the prohibition is directed would even be operative, since under the program only a portion of total costs are reimbursed and any attempt to increase costs for the purpose of obtaining more by way of the allowance based on cost would result in nonreimbursed costs more than offsetting the increased benefit. However, as more programs and greater patient loads come under the cost principles, this dampener on the incentive to increase costs would be reduced.



Other considerations

Although we conclude that we are not required to object to the 2-percent allowance on legal grounds, there are certain policy considerations which we believe it desirable to outline briefly. These considerations derive from the fact that, at least in part to varying degrees among individual providers, the allowance will provide and is intended to provide funds for the improvement and expansion of medical care facilities.

In the past and at present, primarily under the Hill-Burton and similar legislation, financial assistance by the Federal Government for the expansion and improvement of medical care facilities has been in the form of grants under program criteria requiring consideration of the relative need for such assistance in the geographic distribution of available funds. Such criteria would play no part in the distribution of funds under the 2-percent provision. Rather, because medical care costs tend to increase as a result of higher levels of medical care, the application of the 2-percent provision would tend to distribute relatively more funds to providers and to geographic areas which have the most adequate facilities and offer the higher levels of care.

Similarly under the Hill-Burton program, individual applications for grants are required to meet the test of priority needs on a State-wide basis. Under the proposed principle 1-11 in its present form, individual providers of services would be free to use the funds derived from the 2-percent allowance for facilities improvement and expansion without subjecting their planned use of the funds to the tests of areawide or State-wide priorities.

Accordingly when considered as a form of Federal financial assistance for the improvement of medical facilities and care, we believe that the 2-percent allowance cannot be expected to result

in as efficient use of funds as would be possible under programs of the Hill-Burton type.

Additionally, without any requirements imposed upon the provider of services as to the use of funds made available, there is no positive assurance that the funds will be directed to the improvement of medical care facilities or services. For example, such funds might be directed to the conduct of medical research not closely related to patient care. As recognized by principle 1-5, funds for this purpose are provided under many Federal programs and by other tax supported agencies and a quality review should be assured as a condition of governmental support for research.

It might be possible, of course, to attach conditions and restrictions governing the use which can be made by providers of funds made available under the 2-percent provision. We doubt, however, whether the development of the administrative machinery which would be requisite to the proper administration and enforcement of such conditions and restrictions would be either practicable or desirable as a part of the health insurance benefits program.

In summary, as other forms of Government financial assistance for the growth and development of medical care facilities employ controls designed to direct available resources to the areas of greatest relative need, the provision of funds for this purpose without such controls would, in our view, represent a significant change in the mode of such assistance. Accordingly, in this context, we believe that if funds are to be provided for this purpose through the health insurance benefits program, it may be desirable that the Congress specifically consider the merits of this form of financial assistance at an early date and perhaps before such assistance is initiated.

Also for consideration in connection with the 2-percent provision is the desirability of computing the amount of the allowance on the basis of a percentage of operating cost. The determination of payments on a cost-plus-a-percentage-of-cost has long been discouraged as a matter of Government policy and has been specifically prohibited in the case of contracts entered into under the authority of the Federal Property and Administrative Services Act of 1949 (41 U.S.C. 254 (b)). The general Government policy in this regard stems from the incentive provided by this basis of payment to let costs rise unnecessarily. Although the principle provides for an overall limitation, in terms of a percentage of provider's equity capital, on the amount of the allowance computed as a percentage of cost, we understand from our discussions with administration officials that this limitation is not expected to come into play in the majority of cases. Because of the implications of this type of payment formula, we believe that, from a policy standpoint, the desirability of its use deserves careful consideration.

In connection with the limitation on the allowance, we believe an additional factor requires consideration. The principle would limit the amount of the allowance to a reasonable long-term interest rate on the provider's equity capital. The comments on this principle state that for the purpose of applying the limitations, the cost of assets financed by Hill-Burton or other Federal funds, adjusted for depreciation, will be excluded from the provider's equity capital.

The principle does not, however, define the manner in which equity capital is to be determined. It is not clear whether equity capital is to represent the net worth of the enterprise as shown on its financial statements or the cost of tangible fixed assets net of depreciation and long-term debt. Although Social Security

Administration officials have stated to us that the net worth concept of equity capital was intended, the comments on the principle which relate to excluding Federal equity contributions indicate that the net depreciated asset concept was intended.

Also, principle 1-1C, relating to depreciation on assets which are fully or partially depreciated at the commencement of the program, would permit the adjustment of the remaining estimated useful life of such assets to establish an undepreciated balance of asset cost for the purposes of the program. The principles do not provide for the manner in which any increases in the undepreciated balance of asset cost resulting from this restatement is to be treated for the purpose of computing the provider's equity. Which ever concept of equity is used, the increase would, if entered into the provider's accounts, increase the provider's stated capital equity. We were advised by Social Security Administration officials that it is not intended that the increase be entered into the accounting records, but only given consideration in computing allowable depreciation for the purposes of the program. Although this approach is somewhat inconsistent with the requirement of principle 1-1A that to be allowable as a cost depreciation must be identifiable and recorded in the provider's accounting records, it would be effective in excluding the increase from equity capital if the net depreciated asset concept of equity is used. Under the net worth concept of equity, however, the exclusion of the increase from equity would be only temporary and partial. This would occur because to the extent that the increase is recovered through charges to the program the net worth of the provider would be increased.

In our view, if this principle is to be retained, and if advances are to be made under principle 2-4 to cover the working capital needs for covered services, the net depreciated asset concept of equity--that is, the cost of tangible fixed assets net of depreciation and long-term debt--should be used for the purpose of applying the limitation on the allowance under principle 1-11. It appears to us that this concept would provide the best measure of capital which is devoted to patient care, inasmuch as it would exclude assets such as investments which are not currently being devoted to such use. The amount arrived at under this concept should be appropriately adjusted to exclude assets which serve activities, such as research, the costs of which are not includable in allowable costs under the principles. It should also be adjusted, as appropriate, for the cost of assets financed with the Federal funds. The equity amount could be further adjusted to exclude the increase in book value of assets resulting from the application of principle 1-1C, if this increase is recorded in the accounting records of the provider.

Principle 1-1D Allowance for Depreciation on Assets Financed with Federal or Public Funds

Principle 1-1D would provide:

> "Depreciation will be allowed on assets financed with Hill-Burton or other Federal or public funds."

Legal considerations

The comments on this principle prepared by the Social Security Administration state as follows:

> "Essentially there is no substantial difference between assets financed with Hill-Burton, other Federal or Public funds, and other donated depreciable assets. These assets, like other assets, become a part of the provider institution to be used in providing services. Irrespective of the source of financing of assets, if they are used in the providing of services, they are, in fact, a cost of producing those services. Therefore, assets financed by Hill-Burton or other Federal or Public funds are to be treated as any other assets and their cost reflected in depreciation."

Question has been raised as to whether depreciation of assets financed with public funds, particularly Federal funds, constitutes a proper cost for reimbursement purposes under the program. We agree with the "comments" section quoted above. Rather than constituting payment for an asset twice where it is financed with Federal funds and later "paid for again" through depreciation charges, the reimbursement of depreciation charges merely recognizes consumption of the asset in providing services and serves to preserve intact the funds initially dedicated to hospital use. If depreciation charges were not allowed the result would be that the initial grant of funds would effectively be recovered back. A simple example might be helpful in illustrating the principle involved.

A makes a gift of a $5,000 truck to B. In appreciation, B agrees to construct a house for A at cost. In constructing the

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house the truck is entirely consumed. If B does not charge depreciation of the truck as a cost, he will have completed the house and be in a worse position than had he not undertaken the project. In effect, he will have donated the value of the truck back to A and the very basis for his generous offer is lost to him. On the other hand if he does charge for the depreciation of the truck as a cost, both A and B are in exactly the positions they intended for themselves. Because B now has $5,000 instead of his truck, it may not be said that A has paid for the truck twice.

While it is true that both the House and Senate reports on the bill contained statements to the effect that "Reasonable costs should include appropriate treatment of depreciation on buildings and equipment (taking into account such factors as the effect of Hill-Burton construction grants and practices with respect to funding of depreciation) ***," we cannot construe these statements as removing depreciation on federally financed institutions from consideration as reasonable costs under the act.

Subsidiary questions have been raised as to whether depreciation on federally financed assets are to be considered as costs but only if funded and if there is no requirement under the act for the funding of depreciation on such assets may the Secretary nevertheless initiate such a requirement in his cost reimbursement principles. The act contemplates reimbursement of costs and contains no requirement, indication, or implication that the Government will control the use to which such reimbursements will be put after they have been made. We find no legal basis for distinguishing reimbursements for depreciation costs related to federally financed assets from reimbursements for any other costs. As to whether the Secretary may properly make such a distinction, we would have to say that in view of the fact that the program is a voluntary one so far as concerns the participating institutions and there is nothing

that would compel them to enter the program on such a basis there is some ground for the conclusion that such a distinction could be made. However, if such a distinction were made any federally financed institutions coming into the program which did not meet the funding requirements laid down would not be reimbursed their reasonable cost as contemplated by the act. Accordingly, we believe it is highly questionable that any distinction may be made for depreciation purposes between institutions on the basis of the source from which their assets were financed.

Other considerations

Aside from the question of whether depreciation on assets financed with Hill-Burton or other Federal funds may be allowed as a reasonable cost of providing covered services, there is for consideration, as a matter of policy and administration, whether providers of services should be required to set aside funds representing the recovery of the asset cost, as a result of charging depreciation as a reimbursable cost, for use for improvement, expansion, or replacement of facilities either with or without a corollary requirement that the provider use such funds only with the approval of an area, State, or Federal authority to protect against the inefficient use of the funds.

In this connection, assuming that the Secretary has the authority under the law to impose such requirements, we believe it must be borne in mind that the health insurance benefits program is designed specifically to make payments to providers of services, through an insurance program, for medical services provided to covered beneficiaries. The financial assistance provided under the Hill-Burton and other legislation, was intended to increase the availability of adequate medical care facilities to the nation's

population generally, and no requirements were provided in such legislation to govern the use of such funds as might be derived by the provider through the recovery through revenues of the original cost of the facility. This in itself raises some question as to whether it would be appropriate to impose such restrictions incidental to the health insurance benefits program.

In addition, as previously stated with respect to a somewhat analogous situation in connection with the 2-percent allowance which would be provided by principle 1-11, we doubt whether the development of the administrative machinery which would be necessary to properly administer and enforce such restrictions would be either practicable or desirable as a part of the health insurance benefits program.

In our view, the appropriateness of placing restrictions on the use of funds derived through the recovery of depreciation charges on assets financed with Federal funds might best be considered by the Congress in conjunction with legislation of the Hill-Burton type, which has as its primary purpose the improvement, replacement, or expansion of medical care facilities in an efficient and orderly manner.

Principle 2-4 Payments to Providers

Principle 2-4 would provide:

> "Providers of services will be paid the reasonable cost of services furnished to beneficiaries. Interim payments approximating the actual costs of the provider will be made on the most expeditious basis administratively feasible but not less often than monthly. A retroactive adjustment based on actual costs will be made at the end of the reporting period. At the request of the provider, interest-free advance payment will be made annually on the basis of one month's projected costs of covered services."

The issues discussed below relate only to the portion of this principle which would make available to providers, at their request, interest free advance payments on the basis of one month's projected costs of covered services.

Legal considerations

The comments on this principle prepared by the Social Security Administration state in pertinent part as follows:

> "Advance Payments to Providers
>
> "Prior to rendering services and submitting bills for such services, providers as a matter of course need to make cash outlays from their own funds for necessary equipment and supplies, and for the services of supporting personnel. In the case of new providers and providers desiring to institute new or improved services, such outlays place a special burden on their finances.
>
> "The intermediary will process interim payments for services rendered to beneficiaries as expeditiously as possible. Nevertheless, whatever the billing schedule of the provider and however promptly the intermediary processes the request for payment, there is a period of time during which the provider has some of its funds tied up in services to beneficiaries for which the program is obligated to pay but has not yet paid.

"In recognition of the fact that providers must make such outlays of funds in order to render services to beneficiaries of the program, it is appropriate that the health insurance program should provide funds to providers at the point in time when such outlays are necessary. This would place providers in a stronger position by reducing the burden upon the provider of financing the lag between outlays and collection for services.

"Among the possible effects of advance payments which would be of advantage to providers and the program are the following:

"1. Improvement in the ability of the institution to earn discounts offered by suppliers.

"2. Permitting reduction in accounts payable and more advantageous purchasing.

"3. Contributing to ability to refinance indebtedness to obtain more advantageous terms.

"Advance payment will be available to providers upon request. Such payment does not constitute a loan and is interest free."

Question has been raised as to the legality of providing the advances covered by this cost principle statement, in light of the provision contained in section 529, title 31, United States Code, that:

"No advance of public money shall be made in any case unless authorized by the appropriation concerned or other law. And in all cases of contracts for the performance of any service, or the delivery of articles of any description, for the use of the United States, payment shall not exceed the value of the service rendered, or of the articles delivered previously to such payment. ***"

While section 1816(c) of the act authorizes advances to fiscal intermediaries to facilitate payments, no such authority is provided

with respect to advancing payments to providers. So far as concerns payments to providers, the act would seem to contemplate payments on a reimbursable basis after rendition of services.

In considering the applicability of the cited prohibitions, it is first necessary to examine the nature of the payment principle in question to establish whether it does, in fact, provide for advance payments. Let us assume a monthly billing and payment cycle and let us disregard for the moment any payment on July 1, 1966, with the payments under this principle commencing on August 1, 1966. It is clear that the August 1st payment would not constitute an advance payment but, rather, would be in the nature of an estimated provisional payment subject to later adjustment at the end of August on the basis of determined costs. But between July 1st and August 1st the provider will have incurred costs and rendered services which have not been reimbursed.

It is true that any payment on July 1st would constitute payment in advance of services rendered. But it is also true that immediately after July 1st, unreimbursed costs for services rendered begin to accumulate until the August 1st "provisional" payment is made. Recognizing the continuing nature of the medicare program; the fact that its basic design is to provide medical services for third parties through providers under a cooperative arrangement with the Government as opposed to a situation where the Government is procuring services for its own use in a proprietary sense; and recognizing the congressional desire to effectuate payments under the program as quickly as possible, it would seem that at least to the extent payments under the principle in question are realistically designed to account for the inevitable lag in reimbursements, they would not be contrary to the intention of the

Congress. With a monthly billing and payment cycle, it would appear that an "advance" averaging one-half of a month's estimated reimbursable costs would be sufficient and, of course, as the billing and payment cycle is shortened the amount necessary to account for lag in reimbursements would correspondingly decrease.

In addition to providing for the lag in reimbursements, the principle recognizes that providers must expend funds prior to the rendition of services in order to be in position to effectuate the program purposes and that it is appropriate for the program to provide funds at the point in time when such outlays are necessary, particularly in light of certain benefits which would flow to the program as well as to the providers. Although payments in recognition of this would not be in advance of costs incurred, they would be in advance of services rendered and thus subject to conflict with the provisions quoted above.

However, the accounting officers of the Government have, in the past, acceded to non-application of the literal terms of the statutory prohibition against advance payments. We have stated that the primary purpose of the prohibition is to preclude the possibility of loss in the event a contractor, after receipt of payment, should fail to perform his contract and refuse or fail to refund the money to the Government. Consequently, we have, under certain circumstances, authorized advance payments to state and local governments having regard for their established responsibility and minimal danger of loss. See 39 Comp. Gen. 285 and cases cited therein. While we have not, heretofore, extended exception from the prohibition to any group other than state and local governments, our failure to do so has been predicated to some extent on the

absence of any compelling necessity or particular advantage to the Government. See 42 Comp. Gen. 659.

Also, it should be noted that the Congress, in connection with procurements by the Government generally, has specifically provided authority for the making of advance payments under certain conditions and subject to certain limitations. Section 305 of the Federal Property and Administrative Services Act of 1949, as amended, 41 U.S.C. 255. In Senate Report No. 2201, 85th Congress, 2d session, it is stated at page 4 with respect to amendment of section 305 to include advertised as well as negotiated contracts that:

> "*** Advance payments have been valuable in achieving difficult procurements and should be available, under suitable administrative regulations, regardless of whether advertising or negotiation procedure is followed in letting the contract."

We recognize there is considerable doubt that the services being paid for under the medicare program are being procured pursuant to the provisions of the Federal Property and Administrative Services Act of 1949 and that the authority provided by that act can be relied upon as specific authority for making advance payments. However, we believe it is significant that in the ordinary procurement situation the Congress has seen fit to recognize the desirability of advance payment procedures. See in this connection our decision of April 14, 1966, B-158487, to the Administrator of General Services in which we concluded that we would not object to the procedure of paying direct delivery vouchers prior to the receipt of receiving reports provided he determined that contract provisions furnished adequate security to safeguard the interests of the United States and that the advance payment procedure considered in the decision would be in the public interest.

The medicare program is unique in the sense that insofar as the procurement of provider services is concerned, the services are being procured only indirectly for the benefit of the United States. The essential purpose of the program is, of course, to secure medical services for a specific group in the society. To achieve this purpose, the Federal Government and various medical institutions are in effect engaging in a long-term cooperative arrangement whereby the institutions will provide service to the group and receive payment therefor from the Government rather than directly from the group served. The payment provisions contained in section 1815 of the act do speak in terms of periodically making payment for services which have been furnished, but they also recognize the fundamental difference between the program and the ordinary procurement situation in specifically providing for continual adjustment of overpayments and underpayments. We seriously question that the concept underlying the prohibition against advance payments is properly applicable to such a massive undertaking as this is in light of the cooperative concepts upon which it is based.

In any event, in light of our conclusion that some portion of the payment under the principle in question does not, in fact, constitute a true advance and recognizing the continuing aspect of the program, the types of institutions involved, and the fact that over-all the risks associated with such payments would appear to be minimal, we would not feel compelled to conclude that payments under the principle are unauthorized if it is determined that such payments are necessary or desirable and in the best interests of the United States to make. We have some question whether as a practical matter the principle in question is either necessary or desirable or in the best interests of the Government. However,

from a purely legal standpoint we would have to abide by such determinations as made by the Secretary unless we could establish that they were wholly arbitrary and capricious.

Other considerations

Although we do not conclude that we are required to object on legal grounds to the making of advance payments as provided for by this principle and in the context of this program, we believe that the merits of providing advance payments are deserving of careful consideration from the standpoint of policy and administration not only from the standpoint of the health insurance benefits program, but also from the precedent that would be established for other Government programs that may be established in the future.

The advance payments would be made available to all providers of services without regard to their individual need for additional funds in the light of their responsibilities under the health insurance benefits program. In these circumstances, there would be no assurance that the full benefit which would result from improvement of the provider's financial position would accrue to the program. As we will discuss separately with regard to the principle relating to interest expense, (see p. 36) this situation could be mitigated to some extent by not allowing interest on current borrowings to be charged to the cost of the program. However, to the extent that the advance payment not only eliminates the need for current borrowing to finance the providing of covered services, but also reduces or eliminates the need to borrow funds to finance other services, the cost of the other services will benefit. Similarly, advantages gained by the provider through improvement of its ability to earn suppliers' discounts, reduce accounts payable and achieve more advantageous purchasing, and refinance indebtedness to obtain more advantageous terms, which are cited in the

comments on the principle as factors tending to justify advance payments, would accrue to the general benefit of all services provided and would not be unique to covered services.

In addition, advances would be based on the projected costs of covered services for one month, which we believe can be expected to at least cover the delay between the rendition of services and payment on a reimbursement basis. In this connection, we believe consideration should be given to the fact that the provider itself does not pay for all its costs at or before the time services are provided. On the contrary, it pays for a large portion of its costs on an after the fact basis. For example, according to statistics compiled by the American Hospital Association, payroll represents about two-thirds of total hospital expense.

The probability that the total amount of the advance may not be needed by individual providers is recognized in the comments on the principle as follows:

> "The use to be made of funds received as advance payments is solely within the discretion of the provider. However, to the extent that funds advanced are not used interest expense on borrowed funds up to the amount of the unused advance payments will not be allowed for reimbursement purposes. Moreover, interest expense incurred by the provider will be reduced by income earned on invested advance payments in the determination of allowable costs."

Since the advance payments will undoubtedly be merged with the provider's general funds, the administration of these provisions will be very difficult.

In summary, because of the factors discussed, we believe there is considerable doubt that the financial benefits to the program which will result from the making of advance payments as presently

contemplated will be commensurate with the corresponding loss of earnings to the trust fund, which will amount to about $10 million annually. Perhaps a smaller advance in the area of 1/24th of the estimated annual billings would be more equitable from the Government's standpoint. Or as an alternative, the principle might be modified to establish a limitation on the amount which could be made available to an individual provider depending upon its actual need for an advance.

OTHER PRINCIPLES INVOLVING SUBSTANTIVE QUESTIONS AND PROBLEM AREAS

On the basis of our review, we believe that several of the proposed principles to govern the determination of the reasonable costs of providing services covered by the health insurance benefits program, in addition to those discussed in the preceding section of this report, involve, from the standpoint of both policy and administration, substantive questions and problem areas which should be given careful consideration before the principles are promulgated. These questions and problem areas are discussed in the succeeding sections of this report.

Principle 1-1 Depreciation

With the exception of principle 1-1D, which has been discussed separately in a preceding section of this report (see pp. 17 through 20), the principles relating to depreciation as an allowable cost may be summarized as follows:

Principle 1-1A Allowance for Depreciation Based on Asset Costs

Provides for an allowance for depreciation on buildings and equipment based on the historical cost of the asset or fair market value at the time of donation in the case of donated assets, prorated over the estimated useful life of the asset using the straight-line method or accelerated depreciation under the declining balance or sum-of-the years' digits methods.

Principle 1-1B Optional Allowance for Depreciation Based on a Percentage of Operating Costs

Allows the provider an allowance of 5 percent of 1965 operating costs or current year's allowable costs with such percentage being uniformly reduced by 1/2 percent each succeeding year for all assets acquired before 1966. This allowance is in addition to regular depreciation on assets acquired after 1965.

Principle 1-1C Allowance for Depreciation on Fully Depreciated or Partially Depreciated Assets

Provides for depreciation on fully or partially depreciated assets being used by a provider at the time it enters into the program.

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We believe that the principles relating to the treatment of depreciation as a cost raise several questions and problems both from the standpoint of the appropriate measurement of reasonable cost and from the standpoint of administration. We have discussed the pertinent aspects of these principles with officials of the Social Security Administration who have indicated their intent to give our views careful consideration. Briefly, the questions and problems which we have noted are the following:

1. There appears to be a need to provide in the principles some guidance as to acceptable estimated useful lives of various classes of assets for the purposes of computing depreciation. We have suggested that consideration be given to issuing separately a schedule of acceptable useful lives, similar to the one which has been developed by the American Hospital Association or the one developed by the Internal Revenue Service, and modifying the principles to require the use of the lives shown by the schedule unless a deviation therefrom can be justified under the circumstances of an individual case.

2. We believe the principles should provide for the treatment for allowable cost purposes of gains or losses on the sale or other disposition of depreciable assets by the provider. Since such gains or losses can be viewed as resulting from inaccuracies in the allocation, through depreciation, of the cost of assets to the periods

of their use--although, admittedly there are other contributing factors such as changes in price levels--, the principles might require that gains or losses on depreciable assets disposed of in the ordinary course of business be taken into account in determining allowable costs for the accounting period in which the disposal occurred.

We believe special consideration should be given in the principles to the case where all or a major part of a medical care facility is sold, particularly where the facility is suitable for and will continue in use as a medical care facility and where an accelerated method of depreciation has been used by the transferring provider for determining costs of providing covered services. Unless some provision is made to require some adjustment to past reimbursements in appropriate circumstances, abuses of the program through the transfer of ownership for the primary purpose of realizing a gain, which would result in increased program costs, would be invited. We have discussed this matter briefly with Administration officials but have not reached a conclusion as to how such a provision should be framed.

3. In our view, the application of the accelerated depreciation methods as would be permitted by the principles is inappropriate in that (1) providers would be permitted to initiate accelerated depreciation methods with respect to used assets, and (2) providers would be permitted to change from the straight-line method to an accelerated method.

The generally accepted definition of depreciation accounting is a system which aims to distribute the cost of an asset, less salvage, if any, over the estimated useful life of the asset in a systematic and rational manner. The accelerated depreciation methods provided for by principles have been generally recognized as

meeting the test of being systematic and rational and have been accepted for use, subject to certain limitations and conditions, for Federal income tax purposes and for cost determinations under Federal procurement contracts. However, the conditions set out in the Federal income tax law (26 U.S.C. 167) and implementing regulations, which have also been incorporated by reference in the Federal Procurement Regulations and the Armed Services Procurement Regulations, generally limit the use of accelerated depreciation methods to new assets. Also, changes with respect to given assets from the straight-line method to an accelerated method of depreciation are not permitted.

These limitations are consistent with the basic rationale underlying the use of accelerated depreciation methods which, although variously stated by different authorities, is to the effect that the economic utility of an asset is relatively greater during the early years of its useful life, and accordingly relatively larger portions of the asset's cost should be assigned to the early periods of its use.

The proposed principles would permit the initiation of accelerated depreciation methods with respect to used assets, which in substance would be a change from the straight-line method to an accelerated method. The changing from the straight-line to an accelerated method during the course of the program would also be permitted. In our view, their application under these circumstances is not appropriate. Further, through the judicious use of the authority to change methods, the provider could, even with respect to a new asset, receive a significantly faster recovery of asset cost than would be possible through the consistent application of any one of the permitted methods.

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We note that in the introduction to the proposed principles, it is stated that "In general, the options for accelerated depreciation permitted by the income tax laws will be permitted." In our discussions with administration officials we have suggested that consideration be given to revising the principles to permit the use of these methods only under the conditions permitted by the income tax laws.

4. We believe that the optional allowance in lieu of depreciation provided for by principle 1-1B raises some questions and problems from the standpoint of an appropriate and administratively desirable measurement of reasonable cost. This allowance would apply only to assets acquired before 1966 and would be based on fixed percentages of the lower of 1965 operating costs or current year operating costs. The percentage would be 5 percent for the first year of the program and would decrease by 1/2 of one percent each year and be eliminated entirely at the end of the tenth year. The provider electing to receive the allowance at the beginning of the program would have the option of changing, at any time before 1976, to one of the specified methods of computing depreciation based on historical cost.

Although the principle is designed primarily for providers which do not, at the beginning of the program, have the historical cost records requisite to computing depreciation by one of the specified methods, the principle permits its use also by providers which do have such records. We note also that providers which do not have the requisite records but which desire to apply one of the specified depreciation methods would be permitted to establish the historical cost of assets by expert opinion.

Although it is difficult to assess the financial significance of this principle, we believe it can be assumed that most providers will elect to receive the optional allowance only if and for so long as it results in receiving a greater amount than could otherwise be received. This raises a question as to whether the excess could reasonably be considered as a cost. In addition, some difficulty would arise in giving effect to allowances which have been given in establishing, at the time a provider exercises its option to change to actual depreciation, the amount which should be charged as depreciation over the asset's remaining useful life.

In view of these considerations, we have suggested to Administration officials that consideration be given to eliminating the optional allowance provision and requiring that where historical cost records do not exist, a historical cost basis for depreciation be established through expert opinion and that depreciation be charged to the program on the basis of one of the specified depreciation methods. In making this suggestion we recognized that providers may not be able to establish the historical cost basis through expert opinion before the commencement of the program, but pointed out that retroactive adjustment of payments is permissible under the program and providers could be given at least a year to establish the necessary basis.

Principle 1-2 Interest expense

Principle 1-2 would provide:

"Necessary and proper interest on both current and capital indebtedness is an allowable cost."

The definitions and comments prepared by the Social Security Administration in connection with this principle provide that in general, in order to limit allowable interest to that which is necessary, actual interest expense would be reduced by investment income. However, as an incentive for funding depreciation, the reduction of interest expense by investment income to the depreciation fund would not be required. Also, interest paid on borrowings from the depreciation fund or from donor-restricted funds would be includable in allowable cost.

We have two questions concerning this principle, both of which we have discussed with officials of the Social Security Administration who have indicated that our views will be considered.

First, if advances of funds for working capital needs are to be made to providers, as now provided for in principle 2-4, it appears to us that for the most part the need for short-term borrowing by providers will not be attributable to the providing of covered services. Accordingly, we believe if the advance provision is retained, the principle relating to interest expense should be revised to exclude from allowable cost interest on current borrowings, whether from unrelated parties or from depreciation or donor-restricted funds.

Second, we question the desirability of providing, through the interest principle, a financial incentive to fund depreciation unless some contractual commitment or guarantee that the funds will ultimately be used for the purpose for which set aside is secured

from the provider. This consideration is particularly relevant in the absence of a requirement that funds received on account of depreciation be first applied to the reduction of long-term interest bearing debt, the interest on which is includable in allowable cost.

Without such a contractual commitment or guarantee, the situation might well arise in which the assets of the depreciation fund are diverted to purposes other than the improvement, expansion, or replacement of patient care facilities. In this case, the benefit expected to result from and considered to be the justification for providing the financial incentive will have been lost.

Principle 1-7 Value of Voluntary Services

Principle 1-7 would provide:

> "The value of voluntary services provided by sisters or other members of religious orders is allowable as an operating expense for the determination of allowable cost. The amounts included are not to exceed those paid other employees for similar work. Such amounts must be identifiable in the records of the institution as operating expenses."

As we understand this principle and the related comments prepared by the Social Security Administration, the value of the services would not have to be actually paid by the provider to the religious order; rather the services would be treated as a donation and would be recorded in the provider's books at their fair market value.

We have discussed with Administration officials the question of whether the value of the services rendered by members of religious orders represents a cost to the provider unless payment is made therefor. In our view, to the extent that the services are donated they are donated for a specific purpose. As such, in accordance with the same reasoning by which gifts or grants to a provider for the payment of specific operating costs are excluded from allowable costs under principle 1-6, the value of the donated services would not be a cost to the provider.

We have suggested that consideration be given to modifying the principle to permit the inclusion of the value of the services in allowable costs only to the extent that the provider, under an agreement with the religious order, is obligated to make payment for such value. The religious order could, of course, if it desired to do so, donate any payment to which it is entitled under the agreement back to the provider without restrictions as to its

use. This treatment would be similar to that now given to the value of services by members of religious orders by several Government agencies which reimburse hospitals for patient care on the basis of costs.

Principle 1-10 Cost to Related Organizations

Principle 1-10 would provide:

> "Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. However, such cost must not exceed the cost of comparable services, facilities, or supplies that could be purchased elsewhere."

We endorse the objective of this principle but believe that the language used in the principle itself and in the related comments prepared by the Social Security Administration, contains certain ambiguities and leaves some doubt as to the relationship which must exist to bring an organization within the purview of the principle. We have suggested to administration officials the need to clarify the principle in this respect.

Principle 2-3 Cost of Services to Beneficiaries

Principle 2-3 would provide:

> "Total allowable costs of a provider shall be apportioned between program beneficiaries and other patients so that the share borne by the program is based upon actual services received by program beneficiaries. The law provides that the costs with respect to individuals covered by the insurance program will not be borne by individuals not so covered, and, conversely, that costs with respect to individuals who are not under the program will not be borne by the program. To accomplish this apportionment, the provider shall have the option of either of the two following methods: (1) Departmental Method - The ratio of beneficiary charges to total patient charges for the services of each department is applied to the cost of the department. (2) Combination Method - The cost of 'routine services' for program beneficiaries is determined on the basis of average cost per diem of these services for all patients; to this is added the cost of ancillary services used by beneficiaries, apportioned on the basis of

the ratio of beneficiary charges for ancillary services to total patient charges for ancillary services."

Each of the two methods of apportionment outlined in the principle involve a technique in which costs are apportioned on the basis of the ratio between charges entered in the provider records for covered services and total patient charges. The principle as now stated, however, does not make clear that this technique can be expected to result in a reasonable apportionment of costs only where charges for services are reasonably related to the cost of providing the services. We have suggested to administration officials the need to incorporate this condition in the principle.

APPENDIX B

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May 24, 1966

Honorable Russell B. Long
Chairman, Finance Committee
United States Senate
Washington, D.C. 20025

Dear Senator Long

We were concerned to read your recent press release with respect to the reimbursement formula developed for the reimbursement of hospitals under Title XVIII, Public Law 89-97. We now understand that you intend to discuss this matter in detail in an executive session of the Senate Finance Committee this week.

The Principles of Reimbursement for Hospitals resulted from countless hours of thoughtful discussion involving representatives of the federal government and a number of the most knowledgeable individuals in the field of health economics. The principles were also reviewed at great length by the Health Insurance Benefits Advisory Council established by the Congress, prior to their approval. The council is chaired as you know by an individual who is recognized as an astute economist and who recently served as Director of the Budget. We believe that he and the other distinguished members of the council certainly exercised their best judgment in the interest of the public as a whole and not just for the benefit of hospitals. We, therefore, were quite surprised at your expression of dissatisfaction with the principles that were agreed upon.

Throughout the Congressional hearings in both the House and Senate, and as the discussion appeared in the committee reports, it was apparent to us that the government intended to reimburse hospitals in a manner which would insure their continued growth and development. We believe

it was fully recognized that it is not sufficient simply to reimburse hospitals for their out-of-pocket costs. To have done so would have seriously hampered the acquisition or replacement of equipment in an ever-rising cost market; it would seriously curtail the expansion of existing services; it would largely frustrate the creation of new and improved services and make most difficult the retirement of debt.

*Economic studies of the hospital field indicate wide variance from the experience of the economy as a whole. In 1946 the ratio of labor costs in hospitals to total expense was 51% and the ratio for the economy as a whole was 53%. In 1964, while this ratio for the economy as a whole remained at 53%, in the non-profit voluntary community hospitals the ratio of labor to total expense had increased to 61%.

It is obvious that the general economy has been able to substitute capital for a significant amount of labor costs. This has not been generally true in the hospital field. The relative importance of labor in the hospital economy increased 18% during the period 1946 to 1964, while in the economy as a whole it did not change. In comparison with industry generally, it is unlikely that hospitals can substitute mechanization for labor to an equal extent. Though there are developing areas for mechanization in hospitals, they are in no way comparable to that of industry since much of the area of patient care is directly related to personal service and is subject only to limited mechanization. However, to the extent that hospitals can increase the extent of mechanization and take steps to reduce their labor needs, hospitals' efforts have suffered from lack of recognition of their capital needs. It is unlikely that hospitals will be enabled to reduce the percentage of their costs attributable to labor unless there is much greater support of their capital needs.

The gradual growth of the involvement of third party payers in the hospital field has resulted in a continued decrease in community involvement. Hospitals must look to their third party payers for more and more of their capital. We have often stated our belief that the private non-profit hospital represents an endeavor and a community investment that would otherwise have to be supplied by

* Studies in process by David F. Drake, Ph.D., C.P.A. University of Chicago Graduate School of Business.

government. We believe, therefore, it makes good sense for government to make possible in every way the continued growth and viability of the voluntary hospital system. The tremendous investment on the part of the community, not only in dollars but in contributed personal service, is an asset which benefits the government and can only continue if the voluntary system is encouraged and nurtured. Thus, support of the voluntary system is in the interest of the taxpayers of the country.

A failure on the part of the federal government to provide a factor for capital growth and development would freeze the voluntary hospitals at their present size and physical condition and make it difficult or impossible for them to modernize their facilities and equipment and keep pace with rapid changes in medical care.

We understand that your questions with respect to reimbursement, in the main, refer to the one-month advance to be paid to hospitals, the non-funding of depreciation paid, and the two percent capital improvement allowance.

Advance Payment of Operating Funds

This procedure is intended to provide pre-payment of the anticipated cost of caring for medicare patients for one month. The principle involved here has been widely applied by third party payers. As the program gets under way, hospitals will have substantial funds tied up in expenditures for the care of medicare patients and for which payment will be recovered only after the discharge of the patients and within a subsequent thirty-day period as required under the law. Since about two-thirds of the cost of operating a hospital is in salaries, hospitals will be paying out cash funds in behalf of medicare patients before any reimbursement is received. In a great many instances, hospitals would be forced to borrow funds from commercial sources to meet their day-to-day operating needs. The provision of advance payment is a wise economy on the part of the government because it would otherwise be paying the interest costs on the money borrowed which would be chargeable to the medicare program. This advance payment procedure, we believe, recognizes the practical needs of institutions rendering care to medicare beneficiaries.

Funding of Depreciation

Public Law 89-97 does not require the funding of depreciation. The Principles of Reimbursement indicate to hospitals that it would be desirable for them to fund depreciation payments. Depreciation, in modern accounting practice, is looked upon as an operating cost. We understand the Health Insurance Benefits Advisory Council concluded that there is no basis for the federal government imposing restrictions on the use of operating funds. Also, there is no general practice in the hospital field at present of funding depreciation.

It is our belief that any consideration of an amendment to Public Law 89-97 requiring the funding of depreciation would be premature at this time. We further believe that this, and other aspects of the program, should be carefully studied and evaluated after an appropriate period of experience, as is contemplated by the Secretary of Health, Education and Welfare.

Capital Improvement Payment

The factor of two percent for working capital presently included in the reimbursement provision is minimal. In fact, large segments of the hospital field were extremely disappointed in the limited recognition by the federal government of the need for growth and development funds. We wish to state unequivocally that this factor is in no sense a "bonus" as it has been erroneously characterized. Without this factor as a recognized cost of hospital operation, hospital plants in this country will either be allowed to stagnate or the costs of care for all non-medicare patients will have to be increased. The Congress stated its intent that the medicare program should not result in increased financial burdens to non-medicare patients. Without the recognition of the essentiality of capital funds in the reimbursement formula under medicare, this Congressionally established principle will, without doubt, be violated. Furthermore, there is little reason to expect other third party payers of hospital care to continue the practice of paying hospitals for their capital needs if the federal government fails to do so.

Though recognition is given to obsolete physical plants and facilities, it is equally essential that recognition be given to the factor of obsolescence of services. The federal government is investing vast sums of money in medical research programs. This expenditure of money and effort is of little value unless it is to be translated into improved procedures and practices for patient care. There is no source of money to accomplish this in hospitals without the payment of capital improvement funds.

We wish to point to some relevant experience in other countries. The failure to recognize capital financing needs in certain other systems of payment for hospital care has been a major deterrent to the growth and development of their hospitals.

We, therefore, urge strongly against the acceptance of any philosophy which fails to recognize the essential needs of hospitals for adequate capital improvement financing and the inclusion of such a factor in the cost reimbursement formula adopted for medicare patients.

The attached resolution adopted on May 21, 1966, by the House of Delegates, the policy-making body of the American Hospital Association, represents the views of hospitals in every state on these matters.

Sincerely yours

Kenneth Williamson
Associate Director
American Hospital Association

kmb

enclosure

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May 21, 1966

RESOLUTION

The House of Delegates of the American Hospital Association, in special meeting in Chicago, Illinois, urges all hospitals to participate in the implementation of Public Law 89-97 (Social Security Amendments of 1965).

It wishes also to record its approval of the actions taken by the Board of Trustees and the officers of the Association in behalf of hospitals in preparation for the inauguration of the Medicare program.

It notes specifically its vigorous support of the statement by Philip D. Bonnet, M.D., president of the Association, in a letter of April 20, 1966, to John W. Gardner, Ph.D., Secretary of Health, Education, and Welfare, "that it is our responsibility and intent to make sure insofar as it is within our power to do so, that in taking care of the Medicare beneficiaries, there is no damage done to the viability, to the strength and to the continued improvement of the voluntary health and hospital system."

This House of Delegates also endorses the resolution of the Board of Trustees, voted on February 3-4, 1966, "to reaffirm the position of the American Hospital Association that the average per diem method

of reimbursement for payment for services rendered to beneficiaries of Public Law 89-97, as well as for other patients, is the most satisfactory for most hospitals."

It concurs with the concern expressed by President Bonnet to Secretary Gardner that the proposed method of apportionment of provider costs under Public Law 89-97 is "novel and untried" with respect to the overwhelming majority and with his further statement that "we have, however, agreed that it is desirable and necessary to work out within a reasonable number of years a new and fair and definitive distribution of hospital costs, in spite of the well-known difficulties of developing partial costs in complex enterprises."

We believe that the inclusion in the proposed principles of an element of total allowable costs to meet the continuing need for capital funds to preserve and improve the capability of rendering service and to bring to patients the benefits of improvements in medical science is essential to the provision of high quality health care and the preservation of the voluntary health system.

The House of Delegates requests the Board of Trustees to undertake, at the very beginning of the Medicare program on July 1, an objective evaluation of the effect on our hospital and health system of all aspects of Public Law 89-97: the method of apportionment, the

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adequacy of the two per cent allowance, the provisions for capital financing and working capital, and of the arrangements with the hospital-based physician specialists. It requests the Board to make the results of this evaluation known to hospitals, to representatives of government and to the general public as quickly as possible.

APPENDIX C

[From the Modern Hospital, May 1966]

Hospitals Gain Last Minute Concessions in Medicare Reimbursement Principles Announced in Los Angeles

LOS ANGELES.—For a few hours on April 28, the 36th annual Convention of Western Hospitals became the focus of the hospital universe: Social Security Commissioner Robert M. Ball chose this time and place to announce the principles for Medicare reimbursement of hospitals.

The setting was appropriate. It had been California hospital leaders who pushed hardest to obtain some of the last minute concessions which S.S.A. made to the American Hospital Association.

The most noteworthy change in the S.S.A.'s original proposal was, however, a disappointment to California hospitals. They had insisted on payment for a "growth and development factor" and had asked for 6 percent. Hospitals were granted the factor, but it was 2 percent, as first proposed by the A.H.A.

Significantly, the California Hospital Association includes some 180 proprietary hospitals. To proprietary hospitals and nursing homes, "growth and development" can be translated as "return on investment" or, more simply, as profit.

The California case had been buttressed by statistics. From 1950 to 1963, hospital beds in the state increased by 7,000 at a cost of $1.35 billion of which barely 10 percent came from federal and state grants. Most of the rest was borrowed money.

The 2 percent will be paid on each hospital's "allowable cost"—the determination of what share of its costs are attributable to Medicare beneficiaries.

Here—as predicted—Social Security is committed to the use of hospital charges as the basis for determining Medicare payments to hospitals, in spite of dire warnings from many. Walter M. McNerney, president of the Blue Cross Association, for example, had written Commissioner Ball in February to urge use of hospitals' average per diem costs instead of the ratio-of-charges system.

At the press conference held here for Commissioner Ball, however, Mr. McNerney said, "The American Hospital Association has bargained well and has gained about the best formula possible under the law. I cannot see any stone that has been left unturned."

He added that "the next step" would be evaluation of the effects of the reimbursement plan and, if necessary, legislation to amend the law after experience is gained.

This was seconded by Commissioner Ball, who said, "The Secretary of the Department of Health, Education and Welfare has assured the officers of the American Hospital Association that, after the first full year of experience under these principles, we will evaluate the results and move quickly to any changes which seem called for."

The H.E.W. Secretary's promise was made in a letter to Philip D. Bonnet, M.D., A.H.A. president, in correspondence initiated by the A.H.A. after a stormy meeting at its headquarters in mid-April. With Arthur E. Hess, director of S.S.A.'s Bureau, Health Insurance, present, state association leaders—particularly those from California—obtained assurance that A.H.A. would make a last ditch fight with the government about the reimbursement proposals.

Following that meeting, Avery M. Millard, executive director of the California Hospital Association, commented, "We are very glad that A.H.A. is taking the initiative at this point, because our feeling was one of strong disappointment as to how our hospitals would fare. It was going to be necessary to do something within the democratic process to provide some relief."

Reportedly, the Chicago meeting was followed by immediate overtures by a number of state delegations with their congressmen, and this in turn was reported as materially influencing the concessions granted in the week following the A.H.A. conference.

Among these changes was one that is unprecedented in the history of third-party payment: Hospitals will, in effect, be paid before, not after, they provide care to Medicare beneficiaries.

As of July 1, Commissioner Ball indicated, intermediaries can pay hospitals for the estimated cost of service to beneficiaries for the month ahead.

He explained this as follows: "We believe that unless we make such advances, the hospital is actually put in a position of losing the equivalent of interest on its money when it makes purchases from its own funds. We would, of course, share in the interest if the hospital does borrow for working capital and, in a sense, the advance is in lieu of such payment."

The principles give hospitals three alternative methods of determining reimbursable Medicare costs, two of them "approved" and the third permissible only for the first 18 months of the program for those hospitals unprepared for cost-finding procedures.

The provision for 18 months represented another late change: The original draft had limited this to one accounting period.

In his address to the convention Commissioner Ball said the principles "have come out of a long process of conferences and technical consultation and, on occasion, bargaining." He paid tribute to "the vigorous presentation of the hospital case by the A.H.A."

Speaking from the same platform, Dr. Edwin L. Crosby, A.H.A. executive vice-president, in turn praised the "understanding, cooperation and patience" of the commissioner and his staff. Emphasizing the importance of the growth factor which had been allowed, he commented, "Hospitals' ratio of assets to expense has been steadily decreasing in contrast to other segments of our economy."

Mr. McNerney, also on the same program, described the probable roles of intermediaries. Still under negotiation is the prime contract between the Blue Cross Association and Social Security. At issue, he said, is B.C.A.'s desire "to get as much written into the contract as possible" and S.S.A.'s desire "to stay close to everything going on."

Medicare itself, he said, represents "creative federalism" with the government "reaching out to strengthen private institutions."

The only real cloud on the horizon, he added, is "the danger of the wrong kind of competition among intermediaries." This would occur if some intermediaries (presumably a reference to commercial companies) were to "promise less stringent application of principles" in an effort to obtain hospital designation.

"The test will be not how weakly but how well the intermediaries have performed," he commented.

The final speaker of the convention was John D. Porterfield, M.D., director of the Joint Commission on Accreditation of Hospitals, who predicted that, with state agencies taking over the role of certifying hospitals for Medicare, the J.C.A.H. would move from "minimum essential" to "optimum achievable" standard setting.

He said the J.C.A.H. has approved "1,800 grandfathers" in its accreditation program for nursing homes, a legacy from two previously existing programs. While accreditation is not now required as a condition of participation in Medicare for nursing homes, this could be established by executive order, Dr. Porterfield said.

How Hospitals Will be Paid in Medicare

WASHINGTON, D.C.—A final draft of the Medicare principles of hospital reimbursement as agreed on by the Social Security Administration and American Hospital Association (see accompanying story) was released at a press conference here May 2. Following are some highlights of the reimbursement plan:

1. *Interim Payment:* Funded from Social Security, intermediaries will pay hospitals not less often than monthly on an estimated cost basis to be determined between hospitals and intermediaries.

2. *Retroactive Adjustment:* At the end of either the 1966 or 1967 fiscal years, hospitals will submit a cost report to the intermediary, which will then adjust the difference between what the hospital has received in interim payments and what its actual allowable cost may be.

3. *Depreciation Allowance:* Hospitals may include a depreciation factor in determining allowable costs. The depreciation is "historical"—based on fair value at time of acquisition of the building or equipment—and prorated over the useful life of the item.

4. *Depreciation Option:* Assets acquired prior to 1966 need not be depreciated on an item-by-item basis. Instead, the hospital may take a flat 5 percent of the lower of either its 1965 or 1966 costs for fiscal 1966–67, reducing the precentage allowance by half a percent in succeeding years.

5. *Fully Depreciated Assets:* Although fully depreciated (*e.g.* a 51 year old building), assets may be depreciated further as an allowable cost by prorating value over the total estimated years of utility.

6. *Interest:* If loans were "necessary and proper," interest on both borrowed capital funds and borrowed operating money is an allowable cost. "Proper" interest includes loans from the hospital's funded depreciation and restricted fund accounts and, in the case of church hospitals, from the controlling body.

7. *Medicare Bad Debts:* Uncollectible accounts due solely to the deductible and coinsurance factors of Medicare are considered allowable costs.

8. *Charity and Courtesy Allowances:* Charity allowances are not allowable cost factors, but the Medicare share of courtesy allowances to employees (only) is an allowable cost.

9. *Medical Research and Education:* Medicare's shares of the net cost of educational programs, and of research cost if closely related to patient care and not otherwise reimbursed are allowable costs.

10. *Unrestricted Income:* Money from unrestricted grants, gifts and endowments need not be deducted from operating cost in determining allowable cost.

11. *Service by Members of Religious Orders:* The value of these workers' services (less value of perquisites) is allowable cost.

12. *Compensation of Owners:* When an owner renders "necessary" service, a "reasonable" salary is allowable cost.

13. *Cost to Related Organizations:* Services provided by a related organization (*e.g.* laundry cooperative) are allowable as costs, provided charges to do not exceed cost of such services from non-owned sources.

14. *Financial and Statistical Data:* Provider must maintain such statistical and financial data as needed to support claims to Medicare. Cost data must be based on accrual basis of accounting (except in certain municipal and state institutions).

15. *Cost Finding:* Hospitals must use step-down or double-apportionment technics of allocating expense to revenue-producing departments (cost centers) in determination of allowable cost.

16. *Apportionment:* The ratio of charges for beneficiaries to charges for all patients determines Medicare share of allowable cost. Hospitals may calculate this for routine service and total of *all* ancillary services or on a department by department basis. Where hospital is not prepared for such data finding, intermediaries may approve some simpler method for not more than 18 months.

The federal document gives detailed explanations of these various rules, a number of limitations and exceptions, and examples of typical applications. One basic principle underlies the entire system: Payment for Medicare beneficiaries should in no way subsidize other patients nor shall other patients be required to subsidize care given to beneficiaries.

APPENDIX D

[From Hospitals, J.A.H.A., May 16, 1966]

Reimbursement Under Medicare

The long-awaited principles of reimbursement under Medicare (P.L. 89–97) have been released by the Social Security Administration and are now being finally edited for distribution. They apply both to hospitals and extended care facilities.

The principles as released commit the Social Security Administration to an RCC (ratio of charges to cost) method of apportionment but do make a concession to hospital arguments that the earlier drafts of the principles did not make the necessary provisions for working capital and for growth and development of hospitals.

These two points were the subject of intensive negotiations between the American Hospital Association and the Department of Health, Education, and Welfare, culminating in a conference with John W. Gardner, Ph.D., secretary of Health, Education, and Welfare, on April 21. In his correspondence with the secretary, Philip D. Bonnet, M.D., president of the American Hospital Association, said that major revisions in the principles were necessary and that if such revisions were not made the principles could pose a "major threat to the future of the voluntary hospital system and its ability to furnish quality care to all citizens of this country * * *." The American Hospital Association had taken the position that the average per diem method of apportioning costs was the most satisfactory way for Medicare patients, at least at the outset of the program and until further data were collected, and that provisions for working capital ought to be made.

The principles, as proposed by the secretary, reject the average per diem method of apportionment but do make concessions to the AHA position on working capital, providing for a continuing 30-day advance payment of projected costs of caring for Medicare beneficiaries and also providing for a two per cent growth and development factor, described by the government as service-rendering capabilities.

In response to the opinions expressed by the Association at the conference and in Dr. Bonnet's letter, Secretary Gardner promised "prompt evaluation of the fairness of the results of the application of these principles to the first year cost settlements." Dr. Bonnet responded that the proposed principles were "now in satisfactory form" and that there was no need to delay their publication any longer. He restated the belief of the Association that "experience will demonstrate the need to give further consideration to the problems of capital financing and of debt retirement in nonprofit institutions and to problems relating to the method of apportionment."

The letter written by Dr. Bonnet to Secretary Gardner espousing average per diem and provision of working capital and his subsequent letter restating these points but accepting the necessity for publication were approved and endorsed by the Board of Trustees of the American Hospital Association at its meeting of May 2–4.

Recognizing the interest of the hospital field in the principles of reimbursement, Robert M. Ball, commissioner of social security, discussed the principles in detail at the annual meeting of the Association of Western Hospitals on April 26 in Los Angeles and at the Upper Midwest Hospital Conference in Minneapolis on May 5.

Commissioner Ball said that "in very considerable part, the principles of reimbursement are based on the 'Principles of Payment for Hospital Care' adopted by the American Hospital Association but since, in many instances, these [AHA] principles are quite general, it has, of course, been necessary to elaborate and expand on many of them."

Commissioner Ball said that the HEW principles had been evolved after long meetings with representatives of the AHA and other organizations.

"In the end, of course," Commissioner Ball said, "it is the government's responsibility to establish the principles based upon the legislative intent and taking into account fully the interests of all concerned. The principles should

be ones that support the maintenance and improvement of quality care, paying the full reasonable costs of services rendered to the beneficiaries of the program."

The commissioner recognized that differences over the principles were inevitable. As he put it, the purchaser of services wanted the most for his money and the provider of services wanted to be sure that he was paid fully for the services he provided.

PRINCIPLES OF REIMBURSEMENT MUST MEET TESTS

The commissioner said that in general terms the tests for the principles of reimbursement and for the goals "which they should be designed to accomplish" were as follows:

"1. That the methods of reimbursement should result in current payment so that hospitals would not be disadvantaged, as they sometimes are under other arrangements, by having to put up money for the purchase of goods and services well before they receive reimbursement.

"2. That in addition to current payment there should be retroactive adjustment so that increases in costs or other factors are taken fully into account as they actually occurred, not just prospectively.

"3. That there be a division of the allowable costs between the beneficiaries of this program and the other patients of the hospital that takes account of the actual use of services by the beneficiaries of this program and is fair to each hospital individually.

"4. That there be sufficient flexibility in the methods of reimbursement to be used, particularly at the beginning of the program, to take fully into account the great differences in the present state of the art of recordkeeping.

"5. That the principles should result in equitable treatment as between the nonprofit organizations and the profit-making organizations.

"6. That there should be a recognition of the need of hospitals to grow and to improve."

Commissioner Ball said that certain aspects of allowable costs were fairly easy to determine. These included the appropriate part of the net cost of approved educational activities and certain research costs, and the value of voluntary services provided by sisters or other members of religious orders.

He also said that items such as necessary and proper interest on both current and capital indebtedness were stickier matters. He said that such items would be allowed, although this departs from governmental custom. Also allowed, he said, would be interest on loans which a religious order makes to an institution. Further, Commissioner Ball said, if there are bad debts resulting from the deductibles and coinsurance features of the law, these would be allowable costs.

On depreciation, Commissioner Bass said, "The decision has been made to base depreciation essentially on historical cost. We have at the same time decided to allow for accelerated depreciation; to provide an optional allowance for certain assets based on a percentage of operating costs; and to permit the establishment of a new useful life for assets in use at the beginning of the program, whether or not partially or fully depreciated for other purposes. With these modifications, historical depreciation becomes responsive to current needs and meets many of the objections that have been voiced to a conventional approach."

Depreciation will be allowed on assets regardless of the source from which the assets were originally financed.

The American Hospital Association had argued that pure cost reimbursement would not permit hospitals to stay alive. In the final principles, the Association won its point. Commissioner Ball said, "We are also including an allowance in recognition of the continuing need for capital funds to secure, preserve and improve service-rendering capability. In part, this allowance is in lieu of a direct return on net capital investment and in part is a recognition of various uncertainties that are inherent in the application of any cost formula at this stage of our cost-finding capability. The allowance will apply to both non-profit and profit-making organizations alike. Thus we will avoid the anomalous result that would arise from reimbursing a profit-making organization more than a nonprofit organization for rendering exactly the same service solely by reason of allowing a return on investment in one case but not the other. The allowance will be computed by taking two per cent of total allowable cost (for purposes of determining this base interest expense will be subtracted). The amount computed will be subject to the limitation that the total allowance not exceed a reasonable long-term interest rate on net capital investment."

AHA'S AVERAGE PER DIEM POSITION REJECTED

Commissioner Ball confirmed that the average per diem position of the American Hospital Association had been rejected and, he said, "The matter of apportionment of allowable costs between the Medicare beneficiaries and the other patients in the hospital * * * has been one of considerable controversy. We have been urged by many groups to go along with the common practice of arriving at the apportionment of costs by the device of multiplying the average per diem cost for all patients by the number of patient days used by our beneficiaries. The difficulty that we have had with this approach is that the preponderamce of presently available evidence points strongly in the direction of indicating that the over-65 patient is not typical from the standpoint of average per diem cost. On the average he stays in the hospital twice as long, and therefore the ancillary services that he uses are averaged over the longer period of time, resulting in an average per diem cost if we looked at the age alone, significantly below the average per diem for *all* patients.

"The law specifically directs us, while paying the full cost of services for people covered by the program, not to do more than that and not to pick up cost for other patients. 'The Principles of Payment for Hospital Care' of the American Hospital Association are also applicable on this point, stating that, 'An average per diem cost, computed under a reimbursable cost formula, should be used to establish a rate of payment under contractual agreements with third-party agencies *when the patient for whom a contracting agency is responsible are average for the hospital concerned.*'

"Moreover, the use of the average per diem method of allocation is extremely unfair as between one hospital and another. If a hospital has aged patients who by reason of selection are a particularly high-cost group, this should be recognized in reimbursement to that hospital even though it is not typical of the picture nationwide. Admittedly, no method of allocation is perfect, but certainly we must come closer to the objective of the law than a method which in effect divides laboratory services, for example, by the average number of days *all* patients stay in the hospital and then assumes that this is the right cost for the aged even though they stay in twice as long.

"What we are proposing in the way of cost allocation is, basically, to divide allowable costs between Medicare patients and other patients by measuring services actually used by the two groups. Two alternatives are proposed and modifications in the alternatives are allowed in order to avoid difficult recordkeeping problems in the early stages of the program. The first alternative is to use the average per diem method for the roughly two-thirds of allowable costs that, on the average, are connected with room, board and nursing services and then to allocate the cost for ancillary services according to the ratio that charges made to Medicare beneficiaries bears to the charges made to all patients. Although charges are sometimes not a precise measure of services rendered, they come much closer to being such a measure than anything else that is now available. Over time, as indicated in the American Hospital Association Principles, it is hoped that charges for individual items will be brought more closely in line with the cost of services and therefore become a more precise measurement of the services rendered.

"The other alternative is to apply, on a departmental basis, the ratio of charges made to Medicare beneficiaries to charges made to all patients. Because many hospitals are not now equipped with the cost-finding methods necessary to follow this approach, department-by-department, and in some instances may not be able readily to support a cost division between the production of room and board on the one hand and ancillary services on the other, we intend to allow for the first 18 months of operations such a division to be made on the basis of estimates using the experience of other organizations of like size and character and with the help of the fiscal intermediary and the help that can be furnished from the hospital associations. Under such a procedure anyone who has a charge structure can apply the method described very readily and little in the way of advance planning would be required.

"There are several matters in the area of reimbursement which are related to the process of payment which are of great importance to hospitals. I indicated earlier that two of our objectives were to keep the payments current and to avoid the burden on hospitals that comes from having to put up money for expenditures prior to reimbursement. Basically, of course, payments will be made for services throughout the year and final settlement on a retroactive basis will be made at the end of the accounting period. Continuing payments will be made as often

as possible and in no event less frequently than once a month. The retroactive payments will take fully into account costs as they were actually incurred and settle on an incurred, rather than on an estimated basis. Most importantly, we have decided to make interest-free advance payments so that hospitals will have money from us on the average about 30 days ahead of when we would normally be making payment after the rendition of services. We believe that unless we make such advances, the hospital is actually put in a position of losing the equivalent of interest on its money when it makes purchases from its own funds. We would, of course, share in the interest if the hospital does borrow for working capital and in a sense the advance is in lieu of such a payment.

"Many hospitals have had no quarrel with the long-range objectives of improved cost finding as a basis for cost reimbursement but have been very uneasy about being ready at the start—on even in the first year of the program. True, the determination of reimbursable cost does require the acceptance and use of uniform definitions, accounting, statistics, and reporting. But these can be done entirely according to the American Hospital Association's recommended policies. Any systematic payment program requires orderly procedures of reporting and an agreement by providers to submit basic information necessary for cost comparison and analysis, so that there may be a final equitable distribution of payments for third-party purchasers at the end of each period.

"This is, in substance, all that will be asked of providers in furnishing reports at the end of an accounting period for purposes of reimbursement for services rendered under the health insurance program. The requirement that providers be able to carry out cost-finding procedures is not a new development. It has been strongly advocated by national organizations for hospitals and nursing homes for several years past.

"To get started, an interim rate must be established. This may be done by one of several methods. Where an intermediary is already paying the provider on a cost basis, the intermediary can adjust its rate of payment to an estimate of the result to be attained under the program's principles of reimbursement. Where no organization is paying the provider on cost, the intermediary can obtain the previous year's financial statement from the provider and, by applying the principles of reimbursement, compute or approximate an appropriate rate of payment. Or the interim payment may be related to last year's average per diem, or to charges, or to any other ready basis of approximating costs.

"I know the American Hospital Association is prepared to give guidance and assistance to hospital providers through its Hospital Administrative Services and its Cost Allocation Program. Providers may also look to their state and metropolitan associations, to local chapters of the American Association of Hospital Accountants, and to their own certified public accountants for assistance. Most especially, the fiscal intermediary will provide consultative service and assistance."

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