The Heritage Foundation Issue Bulletin

No. 9 | The Heritage Foundation • 214 Massachusetts Avenue • N.E. • Washington, D.C. • (202) 546-4400

May 24, 1977

HOSPITAL COST CONTAINMENT

H.R. 6575, S. 1391

THE ISSUE:

On April 25, 1977, President Carter submitted to Congress a bill entitled the "Hospital Cost Containment Act of 1977." The legislation, introduced in the House the same day by Congressmen Dan Rostenkowski and Paul G. Rogers as H. R. 6575 and in the Senate by Senator Edward Kennedy as S. 1391, was the opening shot in the President's campaign for a full-scale National Health Care Plan. During the 1976 campaign, Jimmy Carter promised to submit and support such a plan; at the present time the Administration is considering a variety of measures intended to control the rising costs of health care and to improve the distribution of health care services among the general population. The President expects to submit such general measures to Congress by March, 1978.

S. 1391, therefore, is the beginning of another battle in the controversy surrounding health care in the United States.

PROVISIONS OF S. 1391/H.R. 6575:

The announced purpose of the bill is to reduce the rising cost of health care as provided by approximately 6,000 acute care (i.e., short term) community hospitals. Long-term care hospitals, HMOs, and new hospitals two years old or less would be exempted from the plan, as would all VA and other federal hospitals. The Secretary of HEW, Joseph Califano, has argued that the basis for such exemptions is that cost increases in such types of hospitals are not high enough to warrant special action and that the provisions of the bill would be applied to federal hospitals by executive action. In order to achieve its purpose the bill makes two major proposals:

1. The bill places restrictions on the increase in hospital revenues from all sources. In the first year of its operation, the plan would allow for a 9% increase in hospital revenues but penalize higher increases. In subsequent years revenue increases of hospitals would be reduced even further. The formula by which these reductions are figured out is based on the trends of prices in the economy with an additional allowance for some increase in patient load. As Secretary

Califano explains it,

> ...the allowable increase will equal the increase in the GNP deflator for the most recently published 12-month period, plus one-third of the difference between the average annual increase in hospital costs in the preceding two years, and the increase in the GNP deflator for the same period. (New Republic, 5/10/77, p. 10)

2. The bill would also limit capital expenditures by hospitals for new equipment. At present it is estimated that hospitals spend about $5 billion annually in new capital expenditures. The President's bill would halve this amount to $2.5 billion for the first year. The purpose here is partly to control the increasing costs of "empty beds" provided by federal assistance under the Hill-Burton Act; also, this provision reflects the beliefs of some of the bill's supporters that a principal cause of the increase in costs has been the irresponsible and unnecessary purchase of highly sophisticated and expensive equipment of the most advanced technological kind (such as, for example, the CAT scanner). Critics of American hospitals charge that such equipment is seldom used, is not applicable to the most pressing needs of American patients, and is soon outmoded by other technological advances.

3. Exceptions: The bill allows for several categories which will be exempted from the two major provisions of the legislation:

a. Those hospitals with unusual changes in patient load, capacity, renovation, or services offered can be exempted from the revenue ceiling if they satisfy local, state, and federal agencies, or if their states already had adequate cost containment programs.

b. Exemptions from the capital expenditure ceiling could be obtained if the hospitals applying were not in areas where the number of hospital beds exceed 4 per 1,000 inhabitants or the average hospital occupancy rate was less than 80%.

c. The "Pass Through" for Labor: Increases in the wages of non-supervisory labor beyond the 9% cap would be allowed and not counted against the cap for other costs.

4. Penalties: Hospitals failing to meet the 9% cap would be required to put the excess in escrow and reduce increases the following year by the same amount. Failure to comply would result in the levy of a 150% tax on the excess revenue. Local agencies which fail to comply would be deprived of their certification and funding by the federal government.

ARGUMENTS FOR THE BILL:

President Carter and his supporters have pointed out that the United States spent $55 billion on hospital care last year, or $1,000 per family. Hospital expenses accounted for 40% of U.S spending on health care, and the average cost per day of hospital care has increased from $15 to $176 between 1950 and 1976. These increases and the prospect of even more dramatic increases in the near future, they argue, justify drastic action to curb hospital costs. The present plan, they say, has several attractions.

1. The current plan calls for no new bureaucracy or record keeping. Existing agencies at local, state, and federal levels can enforce its provisions.

2. It avoids wage-price controls through the pass through system, through limiting expenditures and revenues rather than regulating prices, and by allowing some exceptions in necessary cases.

3. The plan encourages hospitals to reduce unnecessary expenses and to conserve on such high-cost goods and services as energy and food and to reduce excess beds.

4. The plan would reduce costs of hospital care significantly. In the first year, Mr. Califano estimates $1.9 billion savings, and by 1980, $6 billion.

5. The plan is fair to hospitals and will not reduce the quality of hospital care in the United States.

ARGUMENTS AGAINST THE BILL:

Opponents of the bill have made several points against its enactment. In general, they charge that the bill allows too many exceptions to be an effective curb on hospital expenses in the most critical areas of increase, and that where it would be effective it would impair the quality of health services.

1. 9% Revenue Cap: Opponents argue that this provision would not allow hospitals to continue various services that increase the comfort and health of their patients. Costs affecting the quantity or quality of food, energy, and labor services that add to the ease and amusement of an otherwise tedious and anxious experience would have to be curtailed or reduced. Educational and research activities that promote the quality of health care by improving personnel and services would also have to be decreased. Operating rooms and X-ray and other technological services would be reduced in their hours of operation, as well as special diagnostic and therapeutic services. Furthermore, critics point out that half the nation's hospitals already contain their expenses to less than 9% increase. The excess comes from hospitals in large

cities which provide Medicaid outpatient services. Enactment of the bill would affect these hospitals by forcing curtailment of these programs.

2. Capital Expenditure Limitation: Critics charge that the $2.5 billion limit would retard the extent to which hospitals could improve their health services by the purchases of new and progressive equipment. Such purchases aid in diagnosing and treating serious illnesses such as cancer, kidney disease, cardiac disease, and neonatal problems, and are also necessary to provide more careful diagnoses to protect against the increasing threat of malpractice litigation.

3. Cost Transferrals: Critics charge that hospitals could avoid the limitation and still increase costs to the patients by transferring increases from their own budgets to those of other health providers. In Connecticut, for example, where state procedures require similar limitations, hospitals make use of independent computer services to transfer costs of diagnostic radiology in the hospital budget. This practice is known as "unbundling" and is easily applicable to a variety of hospital services.

4. Exceptions: Critics charge that the exceptions contained in the bill will not allow the program to be effective or will harm hospital care.

a. The bill applies only to the 6,000 acute care community hospitals and not to the federal, HMO, or new ones. Though the Administration promises to apply the same standards to federal hospitals, there is no legal provision for this. Inequitable administration would result in a disincentive to competition among hospitals and give an advantage to those that are legally excepted.

b. The many exceptions for special, changed situations in the bill would undermine any effect the bill might have in reducing costs.

c. The "pass through" for non-supervisory labor is discriminatory against supervisory labor and would lead to a decreased percentage of the hospital budget going to health costs. The increases in labor costs would result in cutbacks on hospital labor and therefore in the services they perform and would impair the quality of health care.

5. Arbitrariness: Critics have charged that the bill imposes an arbitrary limit on hospital revenue and capital expenses. It does not sufficiently allow for regional variations and for the special needs of hospitals. Other than the penalization provisions, the bill contain no incentives for reducing or holding down costs.

6. Interim Aspects: The President and other supporters of the bill have said that the bill is only an interim measure that will be replaced and/or supplemented by more comprehensive reforms for health

care to be introduced in the near future. Critics reply (a) there is no termination date in the bill and therefore no assurance that it will be temporary; and (b) how can the Congress and the hospital sector evaluate the proposals properly unless they know how they will relate to future proposals?

7. Administrative Burdens: Despite the assurances of the Administration, the reviewing and enforcement procedures of the bill would increase the burden on federal and state agencies in the form of new personnel, paperwork, costs, and responsibilities. Either these agencies would have to be considerably expanded or new agencies would have to be created. In any case, the bill would require further involvement by hospitals themselves in complying with government regulations. This would increase the costs of regulation to hospitals and would further deflect from their primary duty of promoting health care.

8. The penalization provisions would punish the patient, not the "hospital," by depriving the consumers of health care of services provided by expenditures. The hospital services--not the individuals who make up the hospitals--would be punished, and therefore their consumers.

9. Inefficiency: All hospitals affected would be permitted the same increases regardless of their efficiency or inefficiency. There would be no incentive for inefficient hospitals to improve their quality, as their competitors would be liable to the same expenditure limits. Hence, the bill perpetuates and encourages inefficiency.

10. The bill contradicts former government policy in health care, which increased demand for health services; while the bill does nothing to reverse the increased demand or to increase supply, it attempts to limit supply of health services by limiting revenues and expenditures. It thus upsets previous hospital planning, administration, and budgeting and will increase further the cost of health care.

11. The bill does nothing to address the real costs of health care and their real causes: general inflation (particularly severe on hospitals as they are intensive consumers of goods specially affected by inflation: energy, food, construction); labor (hospitals are labor intensive); malpractice claims (it renders them more vulnerable to these by limiting capital expenditure which protect against them); or the increased demand for health care stimulated by such governmentally related forces as Medicare and Medicaid, and the reimbursement system.

SUMMARY:

The Carter plan contained in S. 1391 has met with strong opposition from hospital industry, but has received only tepid support from such conventional supporters of governmentally planned health care programs as organized labor. One labor official was quoted in the National

Journal (April 30, 1977, p. 685) as saying, "We told the Administration that basically /the pass through/ was the price of labor support for the bill." The gist of most opposition, as outlined above, is, first, that the bill does not address the real causes of hospital (and health) care cost increases, and that it will not affect such costs in many instances. Secondly, where the bill will have an effect, is in metropolitan hospitals, or in high labor cost hospitals, the effect will impair the quality of health services and may well raise its costs. Sen. Kennedy himself, introducing the bill to the Senate, admitted that it left "several unresolved issues" and that he had some reservations in supporting it. He stated that he did so in the expectation that the Administration would submit "more permanent reforms" next year, and both the President and Secretary Califano have promised to do so. Regardless of whether Congress passes or rejects the measure, therefore, this will not resolve the controversies surrounding health care in the United States or the role the federal government should play in it. These controversies promise to become even more intense as the costs of health care continue to rise, and this in turn stimulates new and more intense demands for National Health Care plans.

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