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HOSPITAL COST CONTAINMENT (S.570, H.R.2626)

INTRODUCTION

The Hospital Cost Containment Bill of 1979 (S. 570, H.R. 2626) was introduced in the Senate on March 7, 1979, by Senator Gaylord Nelson (D-Wis.) and supported by eight cosponsors. In the House of Representatives, the bill was introduced on March 6, 1979, by Congressmen Charles B. Rangel (D-N.Y.) and Henry A. Waxman (D-Calif.). The Senate bill was referred to the Committees on Finance and Human Resources, and the House bill was referred to the Ways and Means and Interstate and Foreign Commerce Committees. The Health and Science Subcommittee of the Senate Human Resources Committee held hearings for S. 570 on March 9 and 15 and scheduled mark-up in subcommittee for March 27. The Health Subcommittee of the Senate Finance Committee held hearings on March 13 and 14 and the full Committee scheduled mark-up for April 10. In the House, the Health and Environment Subcommittee of the Interstate and Foreign Commerce Committee and the Health Subcommittee of the Ways and Means Committee held joint hearings on March 12. The Health and Environment Subcommittee also held separate hearings on April 2 and scheduled hearings for April 9, 10, and 23; and the Health Subcommittee of Ways and Means held separate hearings on March 23, 26, and 29.

BACKGROUND

Both S. 570 and H.R. 2626 have the support of the Carter Administration, which sponsored similar bills in the 95th Congress

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(H.R. 6575 and S. 1391).[1] Both of these earlier bills encountered strong opposition from Congress and from the hospital industry, and neither was expected to pass. However, in the last days of the 95th Congress, the Senate passed by voice vote a compromise Cost Containment Bill (H.R. 5285) on October 12, 1978, after refusing to table the bill by a vote of 42-47. Despite last-minute efforts by the Administration and the supporters of the bill in the House, the compromise Cost Containment proposal died when the House adjourned on October 15, 1978.

Despite this setback, the bill's supporters resolved to revise the legislation in the present Congress. The supporters in this Congress include the Department of Health, Education, and Welfare (HEW) as well as the White House and the staff of Vice President Mondale. President Carter, viewing the measure as part of his anti-inflation plans, stated in a White House briefing on March 6, that the bill was "of equal importance" with his search for peace in the Middle East. The Hospital Cost Containment Bill is particularly important for the future prospects of National Health Insurance (NHI). Since NHI would make health care available to a wider range of consumers, it would stimulate demand and result in higher prices for health care. Therefore, even the advocates of NHI are concerned to "place a lid" on hospital costs before NHI is implemented, lest the costs of health care skyrocket. If the Hospital Cost Containment proposal dies, therefore, it is doubtful that NHI would obtain a very sympathetic reception in Congress; but if it passes, the movement for NHI would be encouraged.

However, considerable opposition to the bill is expected. In the Senate, neither Senator Russell Long (D-La.), Chairman of the Finance Committee, nor Senator Herman Talmadge (D-Ga.), Chairman of the Health Subcommittee of the Senate Finance Committee, was willing to cosponsor the Administration's bill. Senator Talmadge, in fact, introduced his own Cost Containment bill (S. 505) on March 1. Senator Edward Kennedy (D-Mass.), who did cosponsor the bill, has come to have considerable reservations about some of its provisions and has supported heavy amendments in the mark-up in the Senate Human Resources Committee. In the House, the Carter proposal also faced strong opposition, particularly in the Health Subcommittee of the Foreign and Interstate Commerce Committee. To avoid opposition in subcommittee, the bill's supporters agreed to hold joint hearings on H.R. 2626 by the Health Subcommittee and the full Ways and Means Committee, which was expected to be much more favorable to the bill.

PROVISIONS OF THE BILL

The principal purpose of the Hospital Cost Containment Bill is to reduce the rate of increase in the price of goods and services

1. For a discussion, see Heritage Issue Bulletin No. 9, "Hospital Cost Containment (H.R. 6575, S. 1391)," May 24, 1977.

provided by hospitals. It is generally acknowledged that hospital costs are among the most inflated in the U.S. economy and that their rise affects not only other health care costs but also the general increase in prices. In 1978 the United States spent $183 billion on health care, and over 40 percent of this was due to hospital costs. In the past 20 years, the cost of an average hospital stay has risen by 1,000 percent to $1300, although, due to progress in the quality of health care services, the length of stay in hospitals has declined. The present bill seeks to contain hospital costs through a mix of federally-imposed and enforced voluntary and mandatory controls. Specifically, the bill's provisions are as follows:

(1) Determination of Voluntary Price Limits (VPL): The Secretary of HEW (hereafter referred to as "the Secretary") would be authorized by section 2 of the bill to determine and establish normal voluntary price limits for the increases in the prices of hospital goods and services. These limits would be established for the nation, for each state, and for each hospital. The national VPL would be determined by the sum of three components: the annual percentage increases in the costs of goods and services purchased by hospitals, the annual percentage increases in the U.S. population, and 1 percent to allow for increase in the intensity of usage of hospital care. The state VPL would be determined by the national VPL modified by state increases in the wages of non-supervisory hospital employees and by the fluctuations in the state population. The VPL for each hospital would be determined by the state VPL modified by the hospital's increases in the wages of its employees during the year.

(2) Mandatory Price Limits (MPL): The Secretary would be authorized to determine whether hospitals have met the VPL and, if not, to apply the MPL's. He would also be authorized to exempt certain categories from the MPL's altogether (see below). A hospital would be subject to MPL's if its expenses exceeded the VPL's for the U.S., for the state in which the hospital was located, and for the hospital itself. The MPL would be applied to the hospital's inpatient charges and reimbursement by insurers.

(3) Determination and Application of MPL: To determine the MPL, the Secretary would (a) determine the market basket costs of the hospital; (b) establish categories for measuring the efficiency of hospitals based on characteristics of the hospital's size, location, and patient case mix; (c) evaluate the efficiency of each hospital in terms of these categories (hospitals with positive efficiency ratings would be allowed percentage cost increase bonuses and those with negative ratings would be sanctioned by percentage cost penalties); (d) impose penalties for exceeding MPL's thus determined in the form of (1) refusal of medicare and medicaid funds to pay for the

excess costs and (2) imposition of a 150 percent tax on excessive revenues collected by hospitals from reimbursement payors.

(4) Exemptions: A considerable number of hospitals would be automatically exempt from the MPL's and the penalties, and others could be exempted by special direction of the Secretary. The categories of hospitals exempted would include (a) all the hospitals in a state in which the hospitals, in the aggregate, met the national VPL, and any hospital in any state that meets the national VPL, (b) hospitals with less than 4000 annual admissions, new hospitals, and HMO hospitals; and (c) hospitals in states that have mandatory cost containment programs meeting the standards of the Secretary (nine states already have such programs). Also exempted are those hospitals engaged in certain experiments and demonstrations authorized by previous federal legislation if the Secretary judges these activities to be consistent with the present act.

(5) National Commission on Hospital Cost Containment: The bill establishes a fifteen-member commission to assist the Secretary in the implementation of the Act and advises him on all matters relative to hospital expenses or revenues. The commission is to be appointed by the Secreatry and its members are to represent hospitals, hospital reimbursement entities, and to include five members not representative of either.

(6) Mandatory "Pass-Through" for Wages: Although it is not a separate provision, the bill includes a "pass-through" system for the wage increases of non-supervisory hospital employees in determining the VPL and the MPL for cost increases. The permissible limits in price increases are established after adding in the percentage wage increases in the preceding year. This provision thus allows wage increases for hospital labor and does not count such increases in determining excessive price rises. This "pass-through" allowance is the result of the demands of organized labor, which would not support the bill otherwise.

ARGUMENTS IN FAVOR OF THE BILL

Proponents of the bill argue that its stringent measures are necessary to hold down the rising costs of hospital care and to control inflation. They point to the fact that in 1975-77 total hospital costs rose between 14 percent and 20 percent, and increased more rapidly than the cost of food, housing and fuel. They regard hospital costs as a significant contributor to general inflation. Furthermore, the rise in hospital costs affects most seriously the incomes and savings of the poor, the middle income groups, and the elderly. President Carter has stated that the bill would save $3.7 billion in FY 1980 and about $53 billion in the next five years. The

Administration predicts that the price limit mechanism of the bill will result in a 9.7 percent cap on hospital prices in 1979.

Advocates of the bill point to a need for federal legislation because only nine states have established their own mandatory programs. Last year the hospital industry, recognizing the need to contain costs, undertook a voluntary program of self-restraint. Statistics provided by the Department of Labor, according to the bill's supporters, show that hospital costs rose after initial industry efforts to hold them down. The Congressional Budget Office (CBO) has stated that the voluntary cost control effort will not succeed this year. The Carter Administration claims that the decrease in the costs of hospitals last year was due only to the mandatory programs of the nine states that have them.

Supporters of the bill also argue that the present bill, unlike its predecessors, allows for variations in the location and type of hospitals and that it fixes control measures to the fluctuating population and to the costs of the hospitals, thus allowing for a more flexible system than the flat nation-wide 9 percent cost increase cap proposed in earlier legislation. Finally, proponents of the bill point to the voluntary aspects of the program, the provisions for exemption, and the authority of the Secretary to use his discretion in some circumstances as leading to a more flexible program that would allow local and institutional peculiarities to be considered before imposing MPL's.

ARGUMENTS AGAINST THE BILL

Two kinds of arguments have been used by critics of the bill. First, they challenge the whole concept of governmentally-mandated cost controls as a fair or effective way to contain inflation. Secondly, they challenge the specific arrangements and provisions of the program put forward in the bill.

A. The Efficacy of Cost Control: Critics point out that the increase in hospital costs is due to government intervention in the health care market,[2] to the third-party reimbursement system, to spiralling labor and energy costs (hospitals are intensive consumers of both), and to the vastly increased burden of malpractice insurance which must be passed on to the consumers in higher prices. Two ways in which governmental intervention in health care matters has served to increase prices may be remarked. First, by seeking to make health care more available to low income groups through programs such as Medicare and Medicaid, the government has already stimulated demand and, hence, consumption of health care goods and services.

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2. See "Health Care Costs and the Free Market" Heritage Backgrounder, No. 11, May 31, 1977.

Secondly, as government programs and regulations increase, the costs of regulation also increase. The Social Security Administration has calculated that in FY 1975, federal and state costs for administration of Medicare and Medicaid were $1.1 billion. At the present time, the Crouse Irving Memorial Hospital of Syracuse, N.Y. finds that there are 164 different government agencies that supervise almost every aspect of its operations. One state agency required the hospital to spend $1 million on the installation of fire stair towers at the ends of its building, when the safety regulations were suddenly changed. The Hospital Association of New York found that 25 percent of New York hospital costs were due solely to government regulation -- more than $1.1 billion. This figure works out to $38.85 per day for every patient in a New York hospital, and to the equivalent of 56,000 hospital employees working full time on regulation, or 115 million worker-hours a year. New York, it should be noted, is one of the nine states exempted from the Administration's Cost Containment Bill because it already has a mandatory state program.

In terms of any cost control program, anticipatory price increases very often offset any savings calculated to be realized once the program goes into effect. Furthermore, many hospitals would make use of avoidance measures. In Connecticut, for example, when a mandatory cost control program is in effect, hospitals practice what is known as "unbundling" -- e.g., transferring costs of diagnostic radiology in the hospital budget by using independent computer services -- and this practice is applicable to a variety of hospital services.

B. Specific Objections: In addition to the general reservations about the concept of mandatory controls, the critics of the bill have pointed to certain provisions and aspects of the legislation that render its efficacy or desirability dubious, even if the mandatory policy is enacted.

(1) The Wage Pass-Through Provisions of the VPL and MPL have been criticized because they allow cost increases in hospitals due to wage inflation. Since over 60 percent of a hospital's budget is due to non-supervisory labor costs, this much of its cost increases would be exempted from control. Thus, while hospitals are expected to cut back or hold down increases due to improved goods and services, to salary increases for supervisory personnel, and for other aspects of their budgets that affect the quality of American health care, they are permitted increases in labor costs that would add little to the quality of health care.

(2) The Regulatory Mechanisms of the legislation have also been criticized. Every hospital in the United States will be subject to supervision in budgetary matters by the Secretary of HEW and the

fifteen member commission appointed by him. Senator Richard Schweiker (R-Pa.) has identified seventeen new sources of discretionary authority for the Secretary; this would not only increase the burden on the federal government (and thereby limit its effectiveness) but also would extend the centralized power of the federal government enormously and curtail the autonomy of American hospitals. In addition, the extraordinary complexity of the methods of determining the VPL and the MPL authorized by section 2 and 7 of the bill means that the necessary administrative and regulation will result in increased costs for hospitals and further diversion of their funds and energies for coping with government paperwork.

(3) The Exemptions discussed above, would exclude about 57 percent of the nation's hospitals, according to Secretary Califano. Given this number of exemptions it is doubtful that the measure would be effective, even if it were granted that mandated controls could be effective.

(4) Although the legislation claims to be based on careful statistical evidence with adjustments for peculiar circumstances, in fact there is considerable disagreement as to the validity of its statistical bases. The Congressional Budget Office and the hospital industry have arrived at different conclusions, and, until these differences are resolved, any implementation of the present bill will lead to acrimony and inefficiency.

(5) The critics of the bill also argue that the hospital industry's voluntary cost control program is working and that mandatory controls are unnecessary. Again, there is a statistical discrepancy between the Department of Labor's figures on the estimate of the efficiency of the voluntary program and the figures of the industry. As of November 1978, the industry's own estimates showed that the voluntary program had realized its cost control goals for that year, but Department of Labor figures on the cost of living showed a rise in hospital costs after the fall of the rate of incease. In any case, the critics of the bill also point out that the "Voluntary" Price Limits -- urged as a selling point of the bill by its supporters -- are in fact a euphemism, for, if the "voluntary" limits (designed by HEW) are not met, mandatory limits and penalties will then be imposed. The critics argue that the present bill is in effect a rationing measure that will, in so far as it is effective, limit access to hospital care for Americans and force hospitals to abandon progress in their services.

CONCLUSION

The Hospital Cost Containment bill has already encountered strong opposition, not only from the hospital industry, but also from legislators usually more open to government intervention in health care. It appears likely that the bill will be heavily amended in both the House and Senate before it reaches the floor, but the basic concepts of the legislation -- federal intervention in hospital care and the attempt to legislate prices -- will assure a long and bitter debate over this kind of approach to the rising costs of health care.

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