HOSPITAL COST CONTAINMENT

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ISSUE DEFINITION

Expenditures for hospital care have been increasing at double-digit rates for years. The Health Care Financing Administration (HCFA), Department of Health and Human Resources, estimates that the 1981 national hospital expenditure level ($118.0 billion) was 17.5% above that for 1980. According to the American Hospital Association, community hospital expenses rose 17.0% in 1980 and 18.7% in 1981. The rising cost of hospital care has focused attention in recent years on various ways of controlling or at least slowing the growth of hospital expenditures.

This issue brief provides an overview of the dimensions of the problem of rising expenditures for hospital care, the reasons for rising hospital costs, general information on methods of controlling hospital costs and specific programs which have been developed, and some of the issues involved.

BACKGROUND AND POLICY ANALYSIS

1. Dimensions of the Problem. Expenditures for hospital care have been increasing at double-digit rates for many years. The estimate of the 1981 national hospital expenditure level, $118.0 billion, is 17.5% above that for 1980 (see CRS IB77066, Health Care Expenditures and Prices). Hospital expenditures in 1981 represented 4.0% of the Gross National Product and $504 per capita.

Hospital expenditures are not only the most rapidly increasing component of total health care expenditures but are also the largest component, comprising 41.2% of total national health care expenditures in 1981. In addition, hospital costs have generally risen more rapidly than consumer prices in the economy as a whole. In 1981, for example, the annual average increase in the Consumer Price Index (CPI) was 10.4% while the increase in the Hospital Room component of the CPI was 14.8%.

Three basic factors contribute to the level of hospital expenditures: the price of hospital care, which is affected by general inflation in the economy as a whole; the utilization of hospital care, which is affected by changes in population, including changes in size and the aging of the U.S. population; and intensity, which reflects the nature and quantity of services and supplies provided to patients in the hospital, as well as advancements in medical technology. Of the approximate 19% increase in hospital expenses in 1981 over 1980, approximately 14% could be attributed to the increase in the price of hospital care, 1% to an increase in admissions (a measure of utilization), and 4% to an increase in intensity.

Increasing expenditures for hospital care also have implications for the Federal budget. In 1981, Federal expenditures for hospital care, under such programs as Medicare, Medicaid, the Veterans Administration and the Defense Department, were $48.7 billion, an increase of 17.9% over the 1980 expenditure level of $41.3 billion. Although the proportion of Federal health care dollars devoted to hospital care has remained the same over the last ten years (approximately 65%), the proportion of national expenditures for hospital services which are paid for with Federal dollars has risen from 34.3% in 1970 to 41.3% in 1981.

2. Theories Explaining Hospital Cost Increases. Several different theories have been suggested to explain the rapid increases in hospital costs over the years. Although no single overall theory totally explains the reasons for hospital cost increases, each of the theories mentioned below contribute to a partial understanding of the cost escalation problem. No attempt is made to assess the validity of the theories presented. Each has its proponents, as well as opponents.

For example, some have argued that rising costs are attributable to increases in the demand for hospital care and to the response by hospitals to this demand. Supporters of this view note that third-party payers (i.e., organizations that pay for health expenses, such as private insurers, Blue Cross/Blue Shield, Medicare, or Medicaid) finance the overwhelming proportion of the care rendered in community hospitals. As a result, the actual out-of-pocket or net costs of hospital care for most patients are very small. The patient and his agent, the physician, can therefore elect the most expensive care available -- more expensive than they might elect if the third-party payment programs did not exist.

Comprehensive insurance enables hospitals to provide more amenities, more technology and more staff which drive up the costs of hospital care. The costs of care can thus greatly increase without significantly increasing the direct financial burden on patients. This process may even be self-reinforcing: the high cost of care creates pressures for even more comprehensive third-party protection, and the expanded coverage, in turn, enables hospitals to provide even more costly care.

A second theory of hospital inflation focuses attention on the methods currently used by third-party payers to reimburse hospitals for care rendered to patients. Third-party reimbursement to hospitals is generally made either on the basis of costs (what the hospital spends to provide goods and services) or charges (the amount a hospital bills for the goods and services it provides). If a third-party payer establishes no controls on the amounts of costs or charges for which it will reimburse, the hospital will have no incentive to contain its costs, since any increases are simply passed along to the third-party payer. If a third-party payer does establish limits on the amounts it will reimburse, costs may still not be contained because the hospital may pass the unreimbursed costs on to other third-party payers that reimburse without limits or to uninsured patients who must pay whatever the hospital charges.

Another issue concerns retrospective reimbursements. Generally, payments are made to hospitals for costs incurred, or charges billed, for services that have already been provided. Observers have questioned whether costs can be adequately contained without establishing in advance the amounts or rate of reimbursement the hospital will receive (prospective reimbursement) rather than paying the costs of care after the services have been provided.

A third theory of hospital inflation blames wasteful capital expenditures and certain advances in medical technology for escalating costs. Advances in medical technology have made it possible to treat patients with an array of high-cost therapies (e.g., cobalt therapy, computerized tomography scanners) not previously available. These advances are costly for a variety of reasons. The capital acquisitions, such as new equipment and services, are themselves costly and require specialized personnel to staff them. In addition, hospitals in a single community often duplicate these highly specialized and expensive services and equipment, driving costs up if they

are underutilized.

A fourth theory singles out labor costs as a principal pressure inflating hospital costs, although labor expenses as a proportion of total community hospital expenses have remained relatively constant in recent years (approximately 60%). Supporters of this view note that hospitals are employing greater numbers of personnel to produce services for patients and that wages for such personnel have increased at rates above those received by other workers in the economy as whole. Advocates of this theory also note that there appear to be few opportunities for improved productivity in a highly labor-intensive industry such as the hospital industry. They point out that new capital investment frequently does not lead to a reduction in the hospital labor force. On the contrary, such investment often requires the hiring of even more hospital employees.

3. General Information on Methods of Hospital Cost Containment=. In large part, the debate concerning the control of hospital costs has focused on ways of reducing hospital operating costs by changing the way hospitals are reimbursed or by limiting such reimbursement. There are a number of different methods which separately or in combination could be and are used to restrain hospital operating costs. Generally, such methods are known as hospital rate-setting or rate review programs. Under such programs, an external authority (such as a State commission, a Blue Cross board, or a hospital association) reviews or determines hospital rates, costs, revenues or charges. Usually the rate is determined in advance, and the hospital is then reimbursed on the basis of this prospective rate rather than on the basis of the costs actually incurred. Under this method, known as prospective payment, the hospital is then at risk for any difference between the rate set and its actual costs.

The prospective payment level may be determined by a budget review method, whereby the hospital's budget is reviewed and approved in advance using, for example, a past year's costs, costs of groupings of similar hospitals, or some normative cost standard in the review. Or the prospective rate could be established using a formula approach, in which a prescribed set of rules is applied to each hospital's costs to arrive at an allowable rate. The formula could include, for example, a limit on hospital expenditures (using adjustments for increases in inflation, in volume of patients, or other factors), or a limit based on the average costs of groupings of similar hospitals. Another prospective payment method could be a maxi-cap approach whereby a hospital's limit is determined by an allocation from the total resources available for all hospitals within a defined geographic area. Another prospective method is based on case mix measures, such as diagnostic related groups (DRGs), under which hospital reimbursement is based on the average cost of providing hospital services and supplies to patients with a specific diagnosis.

In addition to the various general approaches to controlling hospital operating costs through reimbursement changes or limits as described above, other methods of controlling hospital costs have been suggested and tried, including:

-- health planning and certificate-of-need programs, designed to control capital expenditures and prevent duplication of costly health procedures and facilities (see CRS IB82023, Health Planning: Issues for the

Future)

-- utilization review programs and Professional Standard Review Organizations, designed to review the appropriateness of care in health care institutions

-- structural reform of the medical care system to encourage system-wide competition (see CRS IB81046, Health Insurance: The Pro-Competition Proposals).

4. Efforts to Moderate Hospital Costs. A number of programs have been established or proposed with the goal of limiting hospital costs. These programs include:

a. The Economic Stabilization Program. The Economic Stabilization Program (ESP) was a four-phase series of economy-wide wage and price controls which was designed to reduce inflation by about one-half in the economy as a whole. The program began with a freeze on wages and prices in August 1971 (Phase I). The freeze was replaced in December 1971 with control programs for each major sector of the economy (Phase II). For the hospital sector, Phase II placed a general ceiling on increases in prices and revenues per inpatient day as well as limits on increased expenditures for new technology, non-wage related expenses, and wage-related expenses. Other health care institutions and practitioners were also subject to controls. Phase III, lasting from January through June of 1973, was essentially an extension of Phase II controls. Phase IV controls, however, placed emphasis on the total cost of a hospital stay rather than the price per day. In addition, Phase IV treated increased operating costs due to capital expenditures separately and placed controls on hospital outpatient services. Phase IV lasted from July 1973 to April 1974, when ESP authority expired, and the program ended.

Before ESP went into effect, the annualized rates of increase in prices of medical care and hospital charges (semi-private room) exceeded those of prices in the economy as a whole. During the various phases of ESP, not only were the rates of increase of medical care and hospital charges reduced, but the rates of increase dropped below price increases in the economy as a whole. In the post-ESP period, after the controls were lifted, the rates of increase for medical care and hospital charges rose significantly and once again exceeded price increases in the economy as a whole.

b. Hospital Reimbursement Limits Under Medicare. Section 223 of the 1972 amendments to the Social Security Act authorized the Secretary of Health, Education and Welfare (now Health and Human Services, HHS) to set prospective limits on costs that are reimbursed under the Medicare program. The Secretary was given broad discretion in the selection of the institutions and kinds of costs to which the limits would be applied and in the method of setting the limits. Under this authority, HHS has established limits for the Medicare program on general routine costs for hospital inpatient care annually from 1974 to Sept. 30, 1982.

In brief, the calculation of Section 223 limits for hospitals involved: identifying the inpatient general routine operating costs for each hospital, adjusted for certain factors; classifying hospitals into groups, based on bed size and urban/rural location; calculating the mean (average) of the adjusted routine operating costs of the hospitals in each group; applying the reimbursement limit (effective Oct. 1, 1981, the limit is 108%) to the mean to establish a limit for each hospital grouping; and making certain

adjustments to the limits when applying them to individual hospitals. All hospital inpatient routine per diem amounts in excess of the applicable Section 223 limit were nonreimbursable. If the hospital's per diem costs were under the limit, it was reimbursed its actual costs.

Section 101 of P.L. 97-248, the Tax Equity and Fiscal Responsibility Act of 1982 (approved on Sept. 3, 1982) contains four provisions affecting Medicare reimbursement to hospitals. First, the existing "Section 223" limits were modified by: extending them to include ancillary and special care unit operating costs; increasing the limits to 120% in FY83, 115% in FY84, and 110% in FY85 and subsequent years; providing for case mix adjustments; and applying the limits on a per-admission or per-discharge basis. Second, the law establishes a new 3-year ceiling on the allowable annual rate in increase in operating costs per case for inpatient hospital services, with incentive payments to hospitals that keep their costs below their targets. On Sept. 30, 1982, HHS issued rules and regulations (47 FR 43282 and 43296) implementing the "Section 223" reimbursement limit changes and the rate of increase limits, effective for hospital cost reporting periods beginning on or after Oct. 1, 1982.

Third, the law requires that HHS develop legislative proposals for the prospective reimbursement of hospitals (and other providers) by Medicare to be reported to the Committees on Finance and Ways and Means no later than Dec. 31, 1982. This report, entitled Report to Congress: Hospital Prospective Payment for Medicare, has been submitted to Congress. The important features of this proposal are:

-- The unit of payment would be the case, or discharge.
-- Patients would be classified using the diagnosis related group (DRG) classification system.
-- Hospitals would be paid a predetermined rate for each case within a given DRG.
-- DRG prices would be payment in full, which means that hospitals would not be allowed to bill Medicare beneficiaries for any differences between the rates and their actual costs.
-- Rates for each DRG would be adjusted to account for variations in local wage levels.
-- Certain costs would not be included in the payment rate, but would be reimbursed on a reasonable cost basis, including direct capital costs, direct medical education costs, and outpatient care.
-- DRG prices would be updated annually to account for such factors as inflation, improved industry productivity, and changes in technology.
-- Efficient hospitals that incur costs less than the payment rate would be allowed to keep the savings.
-- Psychiatric, long term care, tuberculosis, and pediatric hospitals would be excluded from the prospective payment system.
-- Additional payment would be provided for less than one percent of all cases identified as atypical long stays.

Fourth, the law authorizes the HHS Secretary to reimburse hospitals in a State according to the State's hospital reimbursement control system rather than according to Medicare's reimbursement methods if the State requests this change and if HHS (1) determines that the State's system will apply substantially to all nonFederal acute care hospitals in the State and to at least 75% of all revenues or expenses in the State for inpatient hospital

services and to at least 75% of revenues or expenses for such services under the State's Medicaid program; (2) is assured that there will be equitable treatment under the State's system of all payers, hospital employees, and hospital patients; and (3) is assured that, over 3-year periods, payments made by Medicare according to the State's system will not exceed the payments which would have been made according to Medicare's method of reimbursement. No regulations have as yet been issued implementing this provision. However, HHS has issued a statement of policy which changes the requirements which States must meet in order to obtain waivers under previously existing authority to conduct hospital reimbursement demonstrations (See item d., Federal Demonstrations and Experiments, below).

c. State Programs to Limit Hospital Reimbursement. Programs to limit hospital costs have been initiated in several States by State governments, Blue Cross plans, hospital associations, or a combination of these. Many of these State systems resulted from the Department of Health and Human Services' program of experiments and demonstrations in alternative hospital reimbursement methods, as described below in section 4d. Other programs were initiated by States in order to control State Medicaid reimbursement to hospitals. More States have initiated such activity in recent years because of rising hospital costs and strained State budgets, and more recently because the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) allowed States more flexibility in their reimbursement to hospitals under Medicaid.

State programs to control hospital costs vary considerably as to the administrative body responsible for the program (for example, a State commission, State insurance department, State department of health, Blue Cross/Blue Shield plan, a State hospital association); extent of program (mandatory or voluntary); extent of controls (regulatory or advisory); payers covered (for example, Medicaid, Medicare, Blue Cross, private insurers, private payers); program methodology (budget review, formula, etc.); method of control (total revenues, revenue per case, cost-based, limit on charges, etc.); and the unit of payment (charges, per diem, cost per case, annual percentage of total budget).

Mandatory programs (i.e., programs requiring hospitals both to participate and comply) have been established in a number of States, including Connecticut, Maryland, Massachusetts, New Jersey, New York, Rhode Island, Washington and Wisconsin. Approximately 20 other States have voluntary programs.

d. Federal Demonstrations and Experiments. The Social Security Amendments of 1967 and 1972 authorized broad programs of experimentation in prospective reimbursement and other alternative reimbursement and rate setting methods under the Medicare and Medicaid programs. Under this authority, the Department of Health and Human Services has supported a variety of efforts to develop, demonstate, and evaluate various prospective reimbursement systems and State rate setting programs. In 1974, the then Social Security Administration funded evaluations of several of the early prospective reimbursement programs, including those in Western Pennsylvania, Rhode Island, upstate New York, downstate New York, New Jersey, Indiana and Michigan. Beginning in 1978 and continuing to 1983, the Health Care Financing Administration (HCFA) is funding an evaluation of prospective reimbursement programs, the National Hospital Rate-Setting Study, which covered programs in the States of Arizona, Colorado, Connecticut, Indiana, Maryland, Massachusetts, Minnesota, Nebraska, New Jersey, New York, Rhode Island, Washington, Western Pennsylvania, and Wisconsin. In addition,

developmental and demonstration projects have been sponsored in Maryland (whose system includes all third-party payers, both public and private, in the State); Rochester, New York (utilizing areawide budgeting); Washington (the effects of various payment methods and payer participation within a Commission review model); New Jersey (payment on a diagnosis specific per-admission basis); and New York (a comprehensive data system and a case-mix adjusted per-admission reimbursement system) to test the effectiveness and efficiency of various types of prospective reimbursement systems. New demonstration projects were recently approved in Massachusetts and New York, whose systems include prospective reimbursement of all third-party payers in each State.

On Oct. 8, 1982, HCFA published a statement of policy in the Federal Register (47 FR 44612) establishing the general criteria it will use in the future to approve demonstration projects using a Statewide hospital reimbursement system. In light of data already accumulated during previous demonstrations and expected information from ongoing projects, HCFA has narrowed its research focus to projects which:

-- are applicable Statewide;

-- result in combined Medicare and Medicaid savings each year;

-- use diagnosis related groups (DRGs) as the unit of payment;

-- limit sharing of risks for Medicare and Medicaid; and

-- do not preclude HMOs from negotiating their own rates.

HCFA indicates it will consider exceptions to these criteria for "proposals using highly innovative, competive prospective reimbursement systems such as capitation or competitive bidding".

e. Hospital Cost Containment Legislation Under the Carter Administration. In April 1977, the Carter Administration sent to Congress a proposal to (1) set a mandatory limit on total national hospital revenues for inpatient services by limiting increases in payments from all third-party payers (including Blue Cross, Medicare, Medicaid, private insurers and individuals paying their own bills) to approximately 9% in the first year (FY78), with controlled increases for subsequent years; and (2) establish an annual national limit ($2.5 billion) on new capital expenditures by acute care hospitals. Although the original bill (H.R. 6575/S. 1391) and its numerous revisions were actively considered by the four congressional committees to which it was referred, only the Senate Human Resources Committee had ordered an amended version of the bill reported by the end of 1977.

In 1978, an amended and weakened version of the original bill was reported by the House Interstate and Foreign Commerce Committee. The Finance Committee rejected the Carter Administration's version of hospital cost containment and reported instead H.R. 5285, a bill introduced by Senator Talmadge in 1977 as S. 1470. S. 1470 included a modification of Medicare and Medicaid reimbursement to hospitals by classifying hospitals into comparable groups and reimbursing hospitals not more than a certain percentage of the group's average costs. An amended version of H.R. 5285 passed the Senate in October 1978. The bill as passed included both the Talmadge prospective

payment approach to limiting hospital reimbursement under the Medicare and Medicaid programs and an amendment sponsored by Senator Nelson which contained voluntary goals for hospital costs nationwide, with mandatory standby controls if these goals were not met. The House did not consider a hospital cost containment bill before adjournment.

The Carter Administration reintroduced its cost containment bill in 1979 (H.R. 2626/S.570). The 1979 Carter Administration proposal was more like the compromise bills of the 95th Congress, rather than the 1977 mandatory limit proposal, since it established mandatory standby controls on hospital costs which would be imposed only if certain voluntary goals were not met. The bill also did not include the capital expenditure limits proposed in the 1977 and 1978 versions. By the end of 1979, amended versions of the bill had been reported by the Senate Labor and Human Resources Committee, the House Ways and Means Committee, and the House Committee on Interstate and Foreign Commerce. In addition, the Senate Finance Committee had reported H.R. 934, which incorporated the Talmadge approach to prospective payment of hospitals under the Medicare and Medicaid programs. In November 1979, the House decisively rejected the Administration's bill and instead approved a substitute bill (H.R. 5635) offered by Representative Gephardt. The substitute created a commission (1) to monitor a voluntary effort on the part of the hospital industry to lower cost increases and (2) to report on long-term measures to control health care costs. In addition, grants were authorized to assist States in establishing their own hospital cost containment programs. After defeat in the House, the Senate did not vote on the Administration's proposal, and the Carter Administration's long battle for mandatory hospital cost controls was over.

f. The Health Care Industry's Voluntary Effort. In December 1977, a partnership of professional organizations in the health field announced the formation of a Voluntary Effort (VE) to control health care cost increases. The organizations included the American Hospital Association, the American Medical Association, the Blue Cross/Blue Shield Associations, the Federation of American Hospitals, the Health Industry Manufacturers Association, the Health Insurance Association of America, the National Association of Counties, Knauer and Associates (a consumer affairs organization), and a business representative. Each year since 1977, the VE has formulated goals and objectives for reducing the rate of growth in health care expenditures, and particularly hospital expenditures, in subsequent years. The goals for hospitals have included:

-- reductions in the national annual rate of increase in community hospital total expenditures (2 percentage points per year for 1978 and 1979)

-- reductions in the national annual rate of increase in community hospital inpatient expenditures (1.5 percentage points in 1980 over the 1979 rate of increase and a reduction from the 1980 rate for 1981)

-- no net increase in the total number of staffed hospital beds in 1978, 1979, 1980 and 1981

-- reductions in new capital investments

-- improvements in hospital productivity, including a decline in the number of employees per daily patient

census, and

-- improvements in hospital utilization review.

The 1982 VE goals include a comprehensive utilization restraint program (headed by the American Medical Association); special attention to Medicare utilization patterns (led by the Blue Cross and Blue Shield Associations); expansion of local business community activities (headed by the Business Roundtable and the Washington Business Group on Health); and efforts to improve hospital productivity and technology management (led by the American Hospital Association).

The Subcommittee on Health and the Environment of the House Committee on Energy and Commerce held a hearing on Dec. 15, 1981, to explore the increases in hospital costs and the effect of the Voluntary Effort.

g. The Carter Administration's Anti-Inflation Guidelines. In late December 1978, the Carter Administration asked the Nation's hospitals to voluntarily hold their 1979 total expenses to a 9.7% increase over their 1978 total expenses. This request was made as part of President Carter's economy-wide voluntary anti-inflation program. According to the Department of Health, Education and Welfare (now Health and Human Services), the 9.7% figure included the following components: 7.9% for hospital market basket inflation, to reflect increases in the prices of goods and services (including labor) that hospitals purchase; 0.8% for population growth; and 1.0% for additional services, less productivity and efficiency. In addition, a voluntary $3 billion national limit was set on capital expenditures by hospitals for projects and equipment costing more than $150,000.

On Aug. 1, 1980, the Department of Health and Human Services (HHS) and the Council on Wage and Price Stability called on the hospital industry to voluntarily reduce the rate of increase in total hospital expenditures by 1.7 percentage points in 1980, after adjusting for changes in inflation. The 13.4% guideline was a composite of three factors: 11.6% for projected increases in the costs of goods and services purchased by hospitals; 0.8% for population growth; and 1.0% for net new services and technology. The Health Care Financing Administration, HHS, planned to monitor compliance with the voluntary guideline by comparing national, regional, and State hospital cost increases with the guideline every quarter and by monitoring annual expenditures of individual hospitals.

5. Reagan Administration Proposals. Early in 1981, the Reagan Administration announced its intention to develop an Administration bill to reform health care financing and control rising health care costs by promoting competition among the providers of health care (See CRS IB81046, Health Insurance: The Pro-Competition Proposals, for background information on the competitive approach). A task force to develop such a proposal was established in May, 1981, by Secretary Richard Schweiker within the Department of Health and Human Services (HHS). In addition, a private sector task force was established to advise the HHS group. Option papers were developed and presented to a White House Cabinet Council on Human Resources in late 1981/early 1982. Under consideration have been a number of options, including proposals to: establish a tax cap on employer contributions to health insurance premiums; encourage employers to offer a multiple choice of health plans, with certain coinsurance requirements, and an equal employer contribution to each; increase Medicare coinsurance with added coverage for catastrophic illness; offer a Medicare voucher which would allow

beneficiaries to enroll in private health plans (see CRS IB81179, Health Insurance: the Medicare Voucher Proposals). The Administration has not as yet announced what its policy on the competition approach might be.

The Reagan Administration's FY83 budget indicated that later in 1982 it planned to "propose major reforms of the current health care financing system to introduce more price discipline into the health care market and moderate the explosive growth of health care costs." In support of the objective of strengthening market forces, the FY83 budget proposed "elimination of ineffective Federal regulatory activities, including the health planning and Professional Standards Review Organizations (PSRO) programs." The major specific FY83 budget proposal affecting hospital costs was an interim 2% reduction in Medicare reimbursement to hospitals until "forthcoming Administration proposals to improve market forces in health care can reduce the rate of increase in industry costs."

6. Issues. Many questions concerning hospital cost containment have been debated. Among these are broad issues such as whether we are indeed spending too much on hospital care and, if so, how much should we be spending? Can or should only one sector of the health care industry (hospitals) be controlled, even if it represents the largest portion of national expenditures for health care (approximately 40%)? What impact would economic constraints have on the quality and availability of health care provided by hospitals? What would be the impact on the hospital industry itself and its employees?

Can a program of cost control for hospitals be administered equitably so that efficient hospitals are not harmed? What should be the relative roles of the Federal Government, the States, and the hospital industry in any cost containment efforts? Should controls be limited to reimbursement under Federal programs, such as Medicare and Medicaid, or extended to all third-party payers? Should there be short-term control measures to attempt to lower immediately the increase in costs of hospital care, or should permanent, long-term controls for the hospital industry be considered? What would be the impact of any such Federal regulation on the private sector? What impact would controls have on the Federal deficit?

More specific issues include the type of hospital costs to be controlled; the method of control (e.g., a percentage increase limit, comparison with average hospital costs); what type of hospitals should be included under controls; the nature of exceptions to a control program; recognition of State cost containment programs; the method of enforcement; and the nature of any limits on capital expenditures.

LEGISLATION

The major legislation in the 97th Congress affecting hospital reimbursement included:

P.L. 97-35, H.R. 3982

The Omnibus Budget Reconciliation Act of 1981.

Among other items, contains the following provisions limiting or otherwise affecting hospital reimbursement:

Section 2141 reduces the Medicare plus factor payment to hospitals for

inpatient routine nursing salary costs from 8.5% to 5%.

Section 2143 reduces the Medicare hospital reimbursement limit for inpatient routine operating costs ("Section 223" limits) from 112% to 108% of the mean costs of groupings of comparable hospitals.

Section 2161 offsets by one percentage point the reductions in the Federal matching payments under Medicaid for States with qualified hospital cost review programs in effect on July 1, 1981.

Section 2173 deletes the requirement that State reimbursement to hospitals under the Medicaid program follow the reasonable cost rules as defined under Medicare. Instead, requires State payments for inpatient hospital services to be reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to meet applicable laws, regulations, and quality and safety standards. In addition, requires the Secretary of HHS to develop a model prospective payment system for inpatient hospital services which may be used for reimbursement under the Medicaid and Medicare programs. Requires the Secretary to report to the Congress on the development of such system no later than July 31, 1982.

Introduced June 19, 1981; signed into law Aug. 13, 1981.

P.L. 97-248, H.R. 4961

Tax Equity and Fiscal Responsibility Act of 1982. Among other items, contains the following provisions limiting or otherwise affecting hospital reimbursement:

Section 101 modifies the existing Medicare limits on hospital reimbursement ("Section 223" limits) by extending the limits to include hospital ancillary and special care unit operating costs; increasing the current limit from 108% to 120% in FY83, 115% in FY84, and 110% in FY85 and subsequent years; applying the limit on a per admission or per discharge basis; providing for case mix adjustments; exempting rural hospitals with less than 50 beds from the limits; and including adjustments for psychiatric hospitals and hospitals serving a disproportionate number of low-income or Medicare patients. Second, establishes yearly Medicare limits over a 3-year period on the rate of increase in inpatient hospital operating costs equal to 1 percentage point above the rate of increase in a market-basket measure of prices paid by hospitals for supplies and services. A hospital with operating costs below its target rate would be paid its costs plus 50% of the savings, not to exceed 5% of the target rate; a hospital with costs above the target rate would receive, for the first 2 years, 25% of its costs which are in excess of the target rate; none of any excess costs would be reimbursed in the third year. Third, directs the Department of Health and Human Services to develop, in consultation with the Senate Finance Committee and the House Ways and Means Committee, legislative proposals under which hospitals and other providers would be paid by Medicare on a prospective basis. Requires the Department to report its proposals within 5 months of enactment. Fourth, permits Medicare reimbursement to hospitals in a State to be based on the State's hospital reimbursement system if it meets certain conditions, including that it will not result in greater Medicare expenditures over a 3-year period.

Section 103 eliminates the Medicare 5% hospital routine nursing salary

cost differential, effective Oct. 1, 1982.

Section 106 requires the HHS Secretary to provide, by regulation, that the costs incurred by a hospital in complying with its free care obligation under the Hill-Burton Act would not be considered reasonable costs for purposes of Medicare reimbursement. Reported by the Senate Finance Committee July 12, 1982 (S. Rept. 97-494). Passed Senate, amended, July 22, 1982. Health provisions agreed to by House and Senate conferees on Aug. 12, 1982. Reported by the Committee of Conference on Aug. 17, 1982 (H.Rept. 97-760, S.Rept. 97-530). Conference report approved by the House and Senate on Aug. 19, 1982. Signed into law Sept. 3, 1982.

H.R. 5084 (Wyden)

Medicare Hospital Reimbursement Reform Act. Modifies reimbursement to hospitals under the Medicare program to allow States or legal entities (defined as a hospital, an association of hospitals, an entity which operates in one or more States, or a unit of State or local government) to apply to the Secretary of HHS to reimburse hospitals according to an alternative reimbursement system rather than under Medicare's current retrospective cost reimbursement rules. Requires that expenditures under the alternative system be no greater than the expenditures which would otherwise have been made under the Medicare and Medicaid programs. Introduced Nov. 20, 1981; referred to Committees on Ways and Means, and Energy and Commerce.

HEARINGS

U.S. Congress. House. Committee on Energy and Commerce. Increase in hospital costs and the effect of the voluntary effort. Hearings, 97th Congress, 1st session. Dec. 15, 1981. Washington, U.S Govt. Print. Off., 1982. 222 p.
"Serial no. 97-71"

----- Prospective reimbursement systems for hospitals. Hearings, 97th Congress, 2d session. Nov. 19, 1982. Unprinted.

U.S. Congress. House. Committee on Ways and Means. Impact of the admininistration's budget cuts on the nation's public hospitals. Hearings, 97th Congress, 2d session. Jan. 12, 1982. Washington, U.S. Govt. Print. Off., 1982. 229 p.
"Serial no. 97-42"

U.S. Congress. Senate. Committee on Finance. Hospital reimbursement systems used by third party payors. Hearings, 97th Congress, 2d session. Sept. 16, 1982. Unprinted.

----- State hospital payment systems. Hearings, 97th Congress, 2d session. June 23, 1982. Washington, U.S. Govt. Print. Off., 1982. 249 p.

REPORTS AND CONGRESSIONAL DOCUMENTS

U.S. Congress. Committee of Conference. Tax Equity and Fiscal Responsibility Act of 1982; conference report to

accompany H.R. 4961. Washington, U.S. Govt. Print. Off., Aug. 17, 1982. 723 p. (97th Congress, 2d session. House. Report no. 97-760; Senate. Report no. 97-530.)

U.S. Congress. House. Committee on Ways and Means. Explanation of H.R. 6878; the Medicare, Unemployment Compensation, and Public Assistance Amendments of 1982. Washington, U.S. Govt. Print. Off., Aug. 2, 1982. 95 p.
At head of title: Committee print.

U.S. Congress. Senate. Tax Equity and Fiscal Responsibility Act of 1982; report on H.R. 4961 together with additional supplemental and minority views. Washington, U.S. Govt. Print. Off., July 12, 1982. 435 p. (97th Congress, 2d session. Senate. Report no. 97-494, vol. 1).

CHRONOLOGY OF EVENTS

12/31/82 -- Department of Health and Human Services submitted report on the prospective reimbursement of hospitals by Medicare to Congress.

11/19/82 -- Hearings held by Subcommittee on Health and the Environment, Committee on Energy and Commerce, on prospective reimbursement systems for hospitals.

10/08/82 -- The Department of HHS issued a statement of policy regarding criteria for approval of Statewide hospital reimbursement demonstration projects (47 FR 44612).

09/30/82 -- The Department of HHS issued rules and regulations implementing the hospital cost limits and the rate of increase limits in P.L. 97-248 (47 FR 43282 and 43296).

09/16/82 -- Hearings held by Subcommittee on Health, Senate Finance Committee, on hospital reimbursement systems used by third-party payors.

09/03/82 -- The Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248) was signed into law.

08/19/82 -- Conference report on H.R. 4961 approved by the House and Senate.

08/17/82 -- H.R. 4961 reported by the Committee of Conference (H.Rept. 97-760, S.Rept. 97-530).

-- H.R. 6877 reported by the House Committee on Energy and Commerce (H.Rept. 97-757, part I).

08/12/82 -- Health provisions of H.R. 4961 approved by the House and Senate conferees.

07/28/82 -- Rep. Dingell et al. introduced H.R. 6877.

-- Rep. Rostenkowski et al. introduced H.R. 6878.

-- H.R. 6877 approved by the Energy and Commerce Committee.

07/22/82 -- H.R. 4961 was passed, as amended, by the Senate.

07/12/82 -- H.R. 4961 was reported by the Senate Finance Committee (S. Rept. 97-494).

06/23/82 -- Hearings held by Subcommittee on Health, Senate Finance Committee, on State hospital payment systems.

04/14/82 -- The American Hospital Association released its "Proposal for Medicare Prospective Fixed Price Payment to Hospitals."

12/15/81 -- Hearings held by Subcommittee on Health and the Environment, Committee on Energy and Commerce, on hospital cost increases and the effect of the voluntary effort.

11/20/81 -- Representative Wyden introduced H.R. 5084.

08/13/81 -- The Omnibus Reconciliation Act of 1981 (P.L. 97-35) was signed into law.

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