EXECUTIVE SESSION

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TUESDAY, APRIL 10, 1979

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United States Senate,

Committee on Finance,

Washington, D.C.

The committee met, pursuant to notice, at 10:25 a.m. in room 2221, Dirksen Senate Office Building, Hon. Russell B. Long, chairman of the committee, presiding.

Present: Senators Long, Talmadge, Byrd, Nelson, Bentsen, Matsunaga, Baucus, Boren, Bradley, Dole, Danforth, Chafee, Heinz, Wallop and Durenberger.

The Chairman. Let's talk about the proposals for Medicaid and Medicare reform.

I would hope that we can get some decisions made at this point. As I understanded, Senator Nelson, you wanted to have Mr. Hale Champion be here, that you want him to present a statement for the administration position. I will be glad to hear him.

Senator Nelson. Well, I figured that, at some stage, we were going to take up the administration bill and amend it, change it, recommend it for adoption or not, and it had been my understanding that we were to take it up today. That is why Mr. Champion is here.

So I would ask, Mr. Chairman, that Mr. Champion be permitted

to proceed to present an outline of the administration proposal and then I would like to have passed out at this time the blue book which has the administration commentary on the staff comments appended to it, inside the book. I think it would be helpful if everybody had a copy of that book with the administration comments to some of the comments of the staff.

The Chairman. Here is how I would propose to proceed. I would suggest that we consider some of the key problems that we are going to have to decide and then having decided that -- in other words, if we decide on issues we can then see what we have when we do that. It would then be in order to anyone to offer a substitute for the whole bill if he wants to, but I would hope no matter what you are offering you tend to go step by step, and I have found when we are out there on the Senate floor, no matter how you try to move a bill, anyone can get into offer something out of order anyway.

What I would like to do is decide some of the key points first and see where we stand and what direction we are heading.

Mr. Champion, would you care to make a statement, sir?

Mr. Champion. Thank you, Senator. I will be very brief.

Senator Nelson. Let me say I think you ought to present the concept and the main issues and what you believe the cost containment bill will achieve and compare it to the most recent figures that have just come out on where the American Hospital Association figures compare with those states that already have adopted a

mandatory program so that the concept of it all will be clear.

There are many things in Senator Talmadge's bill that I would agree with. I think that the administration would, too, but there is a fundamental difference, and that is this has an approach to hospital containment that is specific and achieves a tremendous savings and I think that is where the basic difference in the two bills arises. So I think you ought to address that question.

The Chairman. What I propose to do, after we hear from Mr. Champion, we will separate the issues and go through this thing point by point and see what the committee wants to do. Then we will see whether our decisions are more in line with what Mr. Champion wants to do, or more in line with the latest version of the Talmadge bill.

Go ahead, Mr. Champion; say what you want to say.

Mr. Champion. Thank you very much, Mr. Chairman.

Senator Talmadge. Mr. Chairman, if the Chairman will yield briefly, these bills are not mutually exclusive. I think we might consider both of them.

We have almost completed marking up S. 505. We have not yet got to S. 570, which is the administration bill. I think we can probably mark them both up and report them to the Senate floor.

I would hope that the administration would modify some of their propositions, which I think they are in the process of

doing, are you not, Mr. Champion?

Mr. Champion. Yes, Senator. All of the bills that I am presenting today are really dealing with the basic principles, but I think you are quite right. They are both seeking the same ends in many ways and I think there is room for accomodation of the two bills together to deal with the fundamental problem we are all trying to face -- holding down hospital costs.

Senator Byrd. Are you presenting today the modified bill or the original bill?

Mr. Champion. No, Senator. I am presenting the basic concepts and approaches of the original bill which we would hope to have included in this accommodation. There are not any final sort of compromises or agreements, I think, on some of these provisions, although many of them do work together.

Should I proceed, Mr. Chairman?

The Chairman. Yes.

Mr. Champion. I do not think that I need to restate the basic problem that we have here, the fact that hospital costs are inflating faster than almost anything else in the economy. We are worried about the economy's going into double digit inflation. Hospital costs have never been anyplace else since 1974. They usually have been about double. The rate has usually run between 15 to 20 percent.

And because the Federal government pays 40 percent of the nation's hospital bills, slowing that rate of growth is not only

effective in fighting inflation, but it is a potential major tax saver as well. The question is how to do it.

You are offered, I think, three basic approaches. The first is the entirely voluntary effort that the hospital industry began after we first introduced legislation two years ago. There is some legislation which is now in the process of change which would deal with Medicare and Medicaid only, which would hold down several tax costs by several million dollars by restricting only Medicare and Medicaid payments to hospitals and the bill which the administration has submitted, S. 570, which encompasses both of these in some ways, but also goes beyond it.

First, our proposal accepts the voluntary principle, but only as far as it works, and it does set a sterner standard for success and it does put a price on failure.

It proposes that if the voluntary effort does not work that we not only hold down Federal tax payments to hospitals through Medicaid and Medicare, but that we hold down all other hospital user payments as well.

As a consequence, if the voluntary program fails and the mandatory program goes into effect and 1980 would be the date, the Federal government would save an estimated $1.4 billion in 1980 and a total of $22 billion in five years and the other payers, the states, the insurance companies, individuals, would not only be protected from having to compensate for those Federal savings by having costs pushed over to them by the hospitals that

were taken out of Medicare and Medicaid, but would benefit from further savings themselves. The savings would be a little more than $4 billion in 1980 and more than $50 billion over five years.

That is a very important figure in terms of inflation.

Senator Talmadge. If you will yield at that point. When you talk of savings, you do not mean a net production; you mean a reduction of escalation, do you not?

Mr. Champion. Exactly, Senator. Absolutely.

Senator Nelson. So I have that clear.

The $22 billion in five years is savings and escalation, as Senator Talmadge, puts it, in Federal expenditures. Is that correct?

Mr. Champion. That is correct, against our projections, against cost in current law.

Senator Chafee. The next figure was 50 that the private insurers would save?

Mr. Champion. That includes the Federal figure. That is for all payers, the $50 billion.

Senator Chafee. You are talking about $28 billion, the private?

Mr. Champion. That is about right.

Senator Chafee. In five years.

Mr. Champion. I wanted to stress with that statement the fact that this is not only major anti-inflation legislation, but

a major federal tax saver as well.

The blue book sets forth the provisions of 570 in a very straightforward way, and I would just like to make some observations about the way in which we anticipate those provisions would work.

First, as the book sets forth, we have suggested both a new way of building the CAP figure this year as against last year and a new provision for adjusting it to meet increases in costs over which hospitals have little or no control. And I think that it is worth going through the way in which that figure is built up and how it adjusts in order to understand the change in approach and why we think it is especially appropriate at times when the general rate of inflation is rising.

We would propose what we did in fact propose, a 7.9 percent allocation for the goods and services and an increase in the cost of goods and services, and that was based originally in November on the Presidential guidelines on wages and prices.

We proposed a .8 percent figure for population which is the estimated population growth during the year. We recommended 1 percent for a net service intensity that very simply is defined as the cost of increase or improved services minus what productivity the hospitals might be able to bring about, so that if they got a 2 percent increase in productivity, they, in effect, would have available 3 percent. Add 1 percent to that for improved services.

That total of 9.7 percent, that is the figure in the bill. However, we also provide that there should be an adjustment at the end of the voluntary year to recognize reality, what really did happen in the market basket that the hospitals had to buy during that year, both in terms of wages and in terms of prices, and that we would reset that figure to test whether or not a mandatory program would be available.

Here, I think, we can illustrate that with some of the latest figures, some of the latest things that have happened since that was first formulated, energy increases from OPEC and so on.

If, as some now estimate, that market basket will actually cost during the year not 7.9 percent but 9.1 percent, which is a 1.2 increase, we would add that 1.2 to the original figure of 9.7 and you would not have a mandatory program unless the national average exceeded 10.9.

There is an automatic adjustment for reality in terms of what the hospitals cannot control. The effort is to try to get them to control those things that they can control.

If, during the year that that market basket of wages and prices, wages and prices for goods, rises -- which indeed it is doing -- then that will be recognized before there is a mandatory program. I think that the figure that the American Hospital Association reported yesterday raises the kinds of questions that I am dealing with here.

They reported a 14.4 percent increase in costs from January,

1978 to January , 1979. They noted that the wage guidelines were holding, but almost nothing else was, and they conceded that it would be very difficult to make its own goal of 11.6 percent which is the goal that they have had for some time, in 1979.

The major problem, they said, was major inflation in the market basket, especially energy and our formula will accommodate that. What our formula does not accommodate are having the controllables, the increases in services, go up, the adjustments above and beyond those things that are necessary in order to meet the real cost of inflation.

We are trying to get at the difference between the general inflation and the hospital cost inflation.

Senator Nelson. Do you have a figure on the mandatory states?

Mr. Champion. There are nine mandatory states and some of the states have review programs in which they stay fairly close to the review, even though the sanctions are limited. We do not have the figures for 1978 over 1977 yet because the panel finds it very difficult to break those out by states. The early figures we get are based on a panel sampling rather than on the annual report.

We will have the annual reports later this year, but we have made some estimates, the best estimates that we could. We also have the actual rates and what happened in '77 over '76 in the mandatory states.

I can run those down for you to give you an indication of the impact of the mandatory program which has been very substantial. As a matter of fact, they have been the success story of all efforts to hold down hospital costs.

Colorado in '77 was up 15.1 percent. They had a new program this year. Their estimate for '78 is 13.3.

Connecticut, which started in '74, had 11.4 percent in '77 and an estimate of 9.9 percent in '78.

Maryland, 11.8 in '77; 10.5 in '78.

Massachusetts, 13.7 in '77; 8.2 in '78.

New Jersey, 11.8 down to 9.

New York had gotten down to 6.2 in '77; they had a long series of decreases. It went back up, but only to 8.5 in '78.

Rhode Island went from 11.1 to 10.

Washington State went from 15.2 to 8.9 and Wisconsin went from 12.4 to 11.

In every single case, the mandatory states, where there was a mandatory law, went down. And, as a matter of fact, it was looking at some of these programs that helped us redesign the way we went about the market basket.

Senator Talmadge. If you would yield at that point, do any of those states have a mandatory pass through for nonsupervisory wages?

Mr. Champion. I am not sure of that point.

Ms. Davis. Several of the states have market basket approaches

where they have put into them explicit allowances for wages.

For example, Massachusetts follows that approach and the state of Washington.

Senator Talmadge. Would you comment on that, Mr. Constantine?

Mr. Constantine. Senator, our information was, you will recall at the hearing that the Secretary was asked that same question and said he would provide the information. It has not been received.

Our understanding is that none of those states have a mandatory wages pass-through.

Senator Talmadge. None of them do have?

Mr. Constantine. No, sir.

Senator Talmadge. Senator Durenberger?

Senator Durenberger. Do you have any of the review states there?

Mr. Champion. I happen to know Minnesota from having discussed the situation with the local rate review. They tell me that in Minnesota they anticipate from the coming year it will be 10.2 to 10.5, if you take their projections in inflation. It would appear Minnesota would be exempt, although it is not a fully mandatory state.

Its program will not qualify because it is not mandatory, but the result would qualify.

Senator Durenberger. Thank you.

Mr. Champion. I would like to touch briefly, then, on the

way in which the mandatory program would operate if it is triggered, because it brings up this point of who would be exempted and who would not and some other aspects.

The proposal before you would exempt new hospitals, non-metropolitan hospitals under 4,000 admissions and those hospitals in which they do 75 percent of their business with HMO's as well as those hospitals that meet the limits individually or are in states that do meet them on an average basis or which have qualified mandatory programs.

As a result, even if the mandatory program were triggered, substantially fewer than 50 percent of the hospitals would be regulated.

Senator Chafee. Mr. Chairman, one question?

The Chairman. Senator Chafee.

Senator Chafee. All the Federal hopsitals are also exempted, are they not?

Mr. Champion. Yes, but there was an OMB instruction to all of the Federal hospitals to get under those. My understanding is that those appropriations for those years are under those limits. I know the public health service hospitals are.

Senator Chafee. Thank you.

Mr. Champion. These provisions, as a matter of fact, pretty well track those of Senator Nelson's compromise proposal which passed the Senate last year which had many of these exemptions in it. We have in the mandatory program retained Senator

Talmadge's principle of rewarding the efficient and penalizing the inefficient, although we have used a somewhat different system to do so because of the new way in which we have attempted to build the cost base for the program, and we think it is important to have an ultimate restraint rather than simply having the hospitals seek a median, no matter how high that median may be.

So what we think the median approach to penalizing the inefficient not efficient is the right way to go and is an important contribution to dealing with this problem, we would also like to see a cap to make sure that median does not go up and take everything else with it.

We also have tried to leave broad authority to make exceptions as they come up rather than to fasten the administrators into an inflexible situation where they could neither recognize the special problem, increased population growth, or something of that kind in an area, or stop the exploitation of some fixed perception.

As I talked to the State Hospital Cost Containment officials, I was repeatedly cautioned that that was a solution to carrying out a successful program, that they stay flexible, that they try to recognize real problems but that they do not try to build themselves into -- build in some loophole, like a cap, or something of that kind -- that could be exploited.

Finally, we have worked hard to hold down the amount of paperwork and the level of complexity in the mandatory program. The

only new reporting required of hospitals is of nonsupervisory wages and while meeting the hospital's concern about having a bill that recognizes their various special problems and recognizing that doing this does add to the complexity, I think this bill is substantially simpler in concept and in administration than the proposal of last year.

There are some other lesser changes and approaches, but I think that covers the basic approaches of the bill and I thank you for this opportunity to reveal it.

Senator Talmadge. Thank you, Mr. Champion.

Mr. Constantine, would you like to comment on the administration proposal in the abstract?

Senator Dole. May I ask a question first?

Senator Talmadge. Senator Dole.

Senator Dole. I was not here in time, but were we commenting on something before us, or something that may be before us?

Senator Talmadge. We are commenting on propositions, as I understand it, not legislation. Mr. Champion was explaining the administration's proposal, as I understand it -- the most recent modifications. Is that not right, Mr. Champion?

Mr. Champion. That is correct, Senator; the legislation which was introduced in this committee 5/70.

Senator Talmadge. In other words, the bill as it exists. Is that not what you are proposing?

Mr. Champion. The two are the same. We discussed various

changes with the staff to accommodate various things, but this is the bill as it now stands.

Senator Dole. S. 570, you have been discussing?

Mr. Champion. That is correct, Senator.

Senator Talmadge. Mr. Constantine, would you like to comment?

Mr. Constantine. Mr. Chairman, I will try to be abstract. I think that we ought to point out that in evaluating a change in a given state's increases in hospital costs, you have to take into consideration factors as whether the state has a dynamic population, static population, or declining population. Additionally, you have to also look at the base cost in the state. That is, a state such as New York which has very high underlying costs per admission may, in a given year, have a lesser rate of increase additionally, but in the aggregate their costs are much higher than a state which actually went up somewhat more.

Additionally, you also have to take into account factors such as the closing of beds. In New York, they have closed something like 10,000 hospital beds in the last three years, which, to some extent, obviously would affect the rate of increase in the state that is not minimizing the state's efforts.

Those are simply factors which should be taken into consideration in evaluating it. I guess the abstract comments, the comments that we have, were based upon what staff believed to be concerns previously expressed by the committee with respect to

last year's bill as well as this year's proposal and we had -- for example I do not know whether the fact that this year's proposal does not have a sunset provision, that is it runs indefinitely with no termination date, is an abstraction or you would consider that an abstraction or an omission or a principle for the committee to consider.

If you were looking at a standby system, do you want to have a termination date on it, or do you want to leave it open-ended?

Senator Dole. If you are triggered in, are you ever triggered out?

Mr. Constantine. No, sir. Not under the administration proposal. I hope Secretary Champion will correct me on this. We have no desire to misrepresent their proposal.

Mr. Champion. Senator, first of all, we have not had a chance to do so. We agree with the staff's comments that there should be a sense of provision. Five years in said provision we think should be adequate to cover the period in which this bill ought to operate.

No hospital would be triggered out. However, if it were under the bill as it got its expenses under the median, it would be rewarded or permitted a greater increase in its net service intensity factor. It could spend more on new services and there is a fairly complex carryforward provision that would permit that to happen even if it were not done in a given year.

So the effort, while a hospital once under would stay under,

if it got below the median of hospitals in terms of cost, there are provisions for rewarding that hospital and giving it some extra room to operate.

Senator Dole. In other words, it is considered to be a positive thing to stay in the program, I guess?

Mr. Champion. No, Senator. I think probably most hospitals would no so regard it. But once in, the trigger pulls once in a mandatory thing. If they meet the standards, there is really not any great penalty except that we continue to examine to look to see if they meet the standards. They do not go out of the program for a year.

The Chairman. Gentlemen, if we keep going the way we are going, there is not going to be any cost containment bill for the simple reason we will never get around to voting on the cost containment bill.

What I want to do -- you know, we do not have consent like the Appropriations Committee does and the Budget Committee does to meet while the Senate is in session. We can only meet while the Senate is not in session and, nowadays, the Senate stays in session practically all the waking hours of the day, so what little chance we have to meet, we ought to do some voting.

Mr. Constantine, would you separate out one simple issue we can vote on?

Senator Talmadge. The agreement on the five year sunset provision. I move its adoption.

The Chairman. All in favor, say aye.

(A chorus of ayes.)

The Chairman. Opposed, no.

(No response)

The Chairman. The ayes have it. We are in business.

Can you think of something else that we can vote on?

Mr. Constantine. Yes, sir. The question is whether the test of compliance, the definition of the voluntary effort -- in the last Congress, the voluntary effort was defined as the hospitals and Blue Cross and the others propounded it. That effort was accepted by everyone in their work last year.

As a matter of fact, the voluntary effort as defined by the hospitals was that on which the Senate voted.

This year, the administration proposal has a new definition of the voluntary effort inconsistent with last year. This year they have a 9.7 percent limitation. The voluntary effort of the hospitals themselves is 11.6 percent.

The administration's definition of success or failure assumes compliance with the President's wage and price guidelines. The hospitals' definition assumes another significant decrease and a rate of increase in aggregate hospital expenditures.

The staff would recommend that, as a matter of consistency and good faith, that the test should be of the voluntary effort itself, the one that the hospitals developed in response to the request of the Ways and Means Committee and other committees and

consistent with the test approved by the Senate last year.

The Chairman. Which is that, 11.6?

Mr. Constantine. 11.6.

Mr. Champion. That would be a fixed, rather than a flexible kind of formula that we talked about, which while it has a lower beginning figure, is adjustable for the actual rate of inflation.

The Chairman. Let me understand this.

Is this 11.6 percent something that the administration agreed to and the hospital people both agreed to?

Mr. Constantine. Last year the administration accepted that, the voluntary test, in its support of H.R. 5285, which was approved by the Senate. This year, however, there is a different test.

As far as future years, our concern, Mr. Chairman is that the approach could be to add in the factors of the voluntary effort used which, I believe, are to adjust for inflation and intensity of service and add that to the basic market basket inflation rate that just adds continuity to what has been done in the past.

There is a basic difference here. One is whether you go along with the hospitals' own test which they met last year as a test of their success or whether you accept a new test as proposed this year by the administration.

Mr. Champion. Mr. Chairman, if I could speak to that. The hospitals have 11.6 in the voluntary this year. We have discussed

this with the hospital. That does represent a change for them, building up to the 11.6 percent, rather than using the old declining argument that we have had for most of the last two years.

The arguments between us are the percentages to be allocated to each of those factors. We started out with 7.9. They have a larger market basket projection because they were not consistent with the President's wage and price guidelines. We said if that is, in fact, what happened, we will accept that. We posited point A, the actual growth, population. They took a much larger figure for population, 1 percent. 1.1.

We took a 1 percent net new services productivity, new services minus productivity. Their figure in that 11.6 is 1.4. The real differences here are we have been tighter on what we regard as the controllable factors, and I think that is what the committee should recognize in its determination of this matter.

The Chairman. I would like to vote first. From my point of view, it should be our painful duty to vote on whether we are going to exclude labor from the cost containment bill. The economic indicators that they put on my desk every week indicate that only 5 percent of the gross national product is the result of profit or return on investment. The 65 percent is the result of labor services and is it correct that most hospital costs is labor?

Senator Talmadge. 40 percent, Mr. Chairman, is nonsupervisory labor in the average hospital.

The Chairman. The supervisors are supposed to be under it.

Mr. Constantine. Yes.

Mr. Champion. Yes, they are.

The Chairman. Why should not those who are supervised also be under it, especially if they are organized? The chances, for example, right now are organizing, everything they are organizing, everything from the policemen to the waitresses in the restaurants, and I guess the kitchen help as well.

If we are going to put supervisors under controls -- half the time they are not even organized, why should not the rest be under control?

Mr. Champion. There are two points, I think, that need to be raised in connection with that, Mr. Chairman. The first is that the rest of the wage force is not under compulsory controls.

The Chairman. The rest of business is not under compulsory controls either.

Mr. Champion. That is correct, Senator. This industry is a very different industry; it is noncompetitive. It is a cost-plus industry, and that is the only way we have been able to deal with the price problems. The rest of business has not been rising at the rate of inflation at this business.

The other question with respect to nonsupervisory wages is, in fact, the question of performance. The American Hospital Association reported yesterday that the only guideline that has held is the wage guideline.

That was the report of their panel for January of this year.

The Chairman. Would you repeat that, sir?

Mr. Champion. The American Hospital Association reported yesterday that in reporting this 14.4 percent increase of January '79 over '78 that the one place where the figures had conformed to the guidelines within the wage guidelines, that the wages had not risen, and with the other problems in the economy.

The Chairman. Here is the point that occurs to me. If you are going to have control, I do not see how you can leave the biggest single item out.

What the staff suggested was if you are going to have controls on everything, you ought to have the biggest item under it, too. I believe the staff suggested -- did you not, Mr. Constantine? -- that you ought to say that you would look at the prevailing wage rate. What was the staff suggestion about wages.

Mr. Constantine. Yes, sir.

What we suggested was that the only pass-through be, in an area using area prevailing wages rather than what an organizing committee can get out of a hospital, use area prevailing wages to determine whether wages in a given hospital are substandard.

If, in the D.C. metropolitan area, hospital workers are paid less and nonsupervisory workers are paid less than prevailing wages for comparable work, to the extent that they are increased up to the prevailing wage level, that that could be passed through, that you not use a blank check, open-ended exemption so

very honestly someone can go into Mississippi, say, join our union or some other group and we will get you the San Francisco wage levels because it can be passed through.

It is those kinds of awkward things.

Senator Nelson. Let me say, that is a nonsensical argument. The fact is it is an open marketplace and has been for years. For Mr. Constantine to say now if you do not have wages to pass through, then go to Mississippi and demand San Francisco rates, why in the hell do they not demand it today? It is nonsense.

The Chairman. It is nonsensical from your point of view.

Senator Nelson. That argument about demanding San Francisco rates has been open for hospital employees to demand for 50 years so if it is open now and in the past, why have they not done it? They have not done it because they do not have the bargaining position to do it. That is why the guidelines were met in the American Hospital Association at 7 percent. They met them.

Senator Bentsen. Mr. Chairman, this sounds like shades of Davis-Bacon. I am trying to understand. Would this, then, be an open invitation to raise the wages in that particular area?

Mr. Constantine. Do you mean if you had an open-ended wage pass-through without limitation? I am just speaking of a specific area, no, sir. It could be under the administration's proposal, or it might not be. The point is, the opportunity is there.

What we are suggesting, the invitation would be at most only up to the prevailing wages in that area, today, under Section 223

of the Social Security Act.

Senator Bentsen. That is the point I am making. Does that mean an open invitation to raise?

Mr. Constantine. To the prevailing, at best.

Senator Bentsen. That is Davis-Bacon.

Mr. Constantine. It is a lesser invitation than an open-ended one.

The Chairman. Here is the thought that occurs to me. Labor has been pleading with me year in and year out on Davis-Bacon. I have voted with them many times on that, which is to say, let's get the prevailing wage rate; and for many, many years, in one reason hospital costs have been going up so much, you had so many employees who were making less than the prevailing wage rate.

That is one of the big items, moving it up to now. Now we see the administration fighting against the Davis-Bacon Act. Davis-Bacon -- not that Davis-Bacon is too much; it is not enough.

It seems to me if the Teamsters want to go to work and organize all the hospital help, all the orderlies and the people that clean the place up and the kitchen help and everybody else in the hospital, they can organize them and move it up as long as they are organizing other people and what they are paid is the same thing they are paying for other people in the area.

But to say -- the argument has been made by the administration that the reason that hospital costs keep going up is that

these people are insured and the insurer just raises the rate and that is all there is to it and nobody asks any questions about it.

If you are going to put any control over it, it would seem to me that the same constraints that apply to the average employer also ought to apply to the hospital with regards to wage increases. We have some pretty good indications. I know of a situation down my way of these public employees being organized. We have some pretty good indications as to the ambitious demands that are made to increase the wages in my own home town.

You have to give them credit; they did a great job. All the money that was available for equipment for the city government has now been dedicated to pay raises for the public employees and there is no provision in the budget anymore, as I understand it, to provide any equipment.

It would seem to me if you want to control the price, the largest single item should not be left just entirely open-ended when all they have to do is raise the insurance rates to pay for it. If that were the case, it seems to me as though labor wanted Davis-Bacon, and they ought to have the benefit of it.

You can organize in the area; you can go out on strike; you can get whatever you can get for this type of labor, but the people in the hospital will get the same thing everybody else gets in the area.

Youdo not just have an automatic pass-through to double or

quadruple or quintuple it. That is a distinct possibility, if you do not have that under control along with the rest of it.

It seems to me that to go out and say, "We want control, but not on labor. Labor can go sky high. We will not have any control there."

Senator Baucus. Mr. Chairman, I have a problem with an automatic pass-through. Several questions come to mind.

One, the definition of prevailing wages in the area. Would you include a broad category of medical personnel, nonsupervisory personnel, nurses who work in clinics, et cetera? That is one question I have.

Second is that I have heard -- I am sure every group says this -- among nonsupervisory medical help in the country, they feel they have been paid generally substandard wages and have had more difficulty keeping up with inflation than some other people who are wage employees.

I am wondering the degree to which you are able to assess whether nonsupervisory medical help has been held below other levels, not necessarily for comparable. I am trying to figure out a way to not agree to the item on a pass-through, but find something that is fair to the employees.

Mr. Constantine. Senator, I will try to answer the second question. Bob Hoyer here can have a whack at the first.

As far as BLS has found out, hospital workers are slightly ahead of service workers generally. That is a national number,

not necessarily -- obviously, it varies from area to area, but nationally it is above the service workers generally. They have caught up.

It is sort of like the teachers after World War II. There was a lag. Obviously there are individual variations, but they have caught up to that extent.

We now use under Section 223 to determine limits under routine costs under Medicare. Those also are adjusted. I believe they have 250 or 300 areas where they use area prevailing wage levels to determine whether the hospitals' routine costs are out of line with other hospitals.

Bob has the information concerning the composition of the index.

Mr. Hoyer. Senator, the Bureau of Labor under the Davis-Bacon Act is required to establish prevailing rates both inside a given workplace and outside. This really has not been done in the hospital area yet.

There is a lot of argument among economists as to exactly what in the private sector might be equivalent to a nurse doing general nursing at a hospital. Some people suggest that it might be a teacher's salary.

In any case, what would have to be done in this case, as has been done in others, is for the Bureau of Labor Statistics to determine what occupations are similar to those in the hospital based on the professional qualifications of the people, based on

the arduousness of the work and similar factors.

Mr. Champion. Senator, I have some figures that do not totally cope with the problem that Mr. Hoyer just raised, but the BLS does show that in hospitals in '78, the average wage was $5. This was for nonsupervisory, $5.23; and for the private sector, nonagricultural industry generally, they were $5.90.

With respect to annual rates of increase, in the three prior years '75 through '78, hospital nonsupervisory wages in hospitals went up 7.9 percent. Those in the private sector of nonagricultural industry went up 8.1 percent.

There has not been -- at least in the last three years -- any surge. As a matter of fact, that 7.9 is exactly the market basket figure we are using for goods and prices.

The Chairman. Let me tell you what is wrong with your bill, as I see it. Professor Milton Feldman is a very good economist from the point of view of an academician; I think you would agree with that, Mr. Champion.

His reaction to your cost containment bill, just to put it in a nutshell, as I understand it, he says that your bill does not prevent costs from going up; it has open-ends; it let's the cost just go on skyrocket. All kinds of ways that costs can go up.

All it really does is prevent some little hospital from improving its service. I do not want to be subject to that kind of choice, to leave a big item of 40 percent wide open.

There is the open end, so we vote for your cost containment

bill and then the cost just skyrockets. How could that happen? Because we left an item that involves 40 percent that is not subject to it. In some respects, you are comparing apples and oranges -- help inside hospitals compared to help outside hospitals.

If we started to get in government and the hospital business, most people working in hospitals were not even making the minimum wage. Now they are making more than a minimum wage; a lot more than minimum wage.

I am just saying that labor has, for a long time, wanted us to vote for the prevailing wage rate. My reaction is, would not your suggestion be, assuming they are getting the prevailing wage rate that they could get an increase like everybody else gets. They just could not get an open-ended one?

Mr. Constantine. Yes, sir.

If the effect of moving up in an area where they were below the prevailing wage levels, if an effect of an increase brought them above whatever limit was established, that could be passed through only in terms of the service workers wages in that area.

The Chairman. Suppose they are already getting whatever you determine to be the prevailing wage rate in the area. They are already getting that.

Could they get this 11.6 or the 9.7, as the case may be?

Mr. Constantine. Yes, sir, if it was within that limit. Of course, as the administration points out, they can get more than that, if productivity from productivity increases the limit,

there is a wage factor in there, but obviously it varies from hospital to hospitals. There are hospitals that have a lot more staff than similar hospitals do. If they get more productive like everyone else, they can get more money.

The Chairman. My reaction to this thing, I am willing to vote to give it all. Let them come up to the prevailing wage rate. In addition to the prevailing wage rate, let them have 11.6 or 9.7, whatever one you want, while the administration is fighting for 7 percent; let them have all of that.

But I am not going to vote for just a complete open-ended -- the administration, if I do say so, has made a convincing case in the areas of hospital costs. There is nothing, practically nothing, to control the cost because all they have to do is increase the insurance rates.

When we increase the tax from Medicare and Medicaid, if that is the case, then that ought to be under it, too.

To go and say we have to control hospital costs; we are going to leave the biggest item out, the biggest single item, that, to me, does not make a whole lot of sense.

Senator Nelson. Mr. Chairman, let me say to that, most of the time when we legislate we legislate on some theory that is ill-founded. Now we have an opportunity to legislate based upon experience.

Last year's experience was the only item that stayed in line in open and free market negotiation was the cost of labor.

Number two, when you say your economist says it is an open ended deal, take a look at the nine mandatory states plus three or four others and the proof is in the pudding. There they are; much lower by the same standards that the American Hospital Association is using except that they brought them in control themselves at the state level.

Minnesota has done it without a mandatory program. Wisconsin and eight others have done it with a mandatory program. The proof is there.

The Chairman. How many of your nine states have a wide-open pass-through of labor costs?

Senator Nelson. I do not know. What is the condition of the other several thousand?

The Chairman. Those are the ones we are trying to control. I am told there is not one of your nine mandatory states that have a wide-open pass-through of labor costs.

What do you know about that, Mr. Constantine?

Mr. Constantine. That is our information, Mr. Chairman.

Senator Nelson. Mr. Constantine, how many of the American Hospital Association hospitals do not have a pass-through and how many do have a pass-through?

Mr. Constantine. I would imagine, Senator, that today they all have a pass-through.

Senator Nelson. Then they are not comparing apples and oranges. If everybody has got a pass-through and the mandatory

states are running much lower than the rest of them, then the proof is in the pudding.

Mr. Constantine. Senator, by that, I do not mean -- it is not a question of pass-through, because there is no regulation on those hospitals today. There are a lot of hospitals that are considerably below some of the rates of increase in the mandatory states that are not states with mandatory programs as well.

Senator Nelson. You are not comparing apples and oranges. You have a miscellaneous collection of states here, and there is a group that you can show, some mandatory and some not, that have held their hospital costs down.

They are some of the best hospitals in America. There is no better place than Boston, Massachusetts, for example, in delivery of medical care and they have held them down.

The Chairman. Let's just vote on the issue.

Do you think we ought to have any control whatever on the so-called nonsupervisory help?

Those who do think you ought to have some, say aye.

(A chorus of ayes.)

The Chairman. Those opposed, no?

(A chorus of nays.)

Senator Nelson. Would you like to rephrase that? Have you stopped beating your wife, or something?

The question is, I assume, that you are going to propose something specific vis-a-vis the pass-through. What is it?

Explain it to us, and let's vote on that, and not on are you opposed to any conceivable controls that the mind of man can think of. Give us a proposition to vote on.

The Chairman. That is how I tried to get this off into some kind of decision. One, do you want to do anything about it? Two, do you want to do nothing about it?

If you want to do something, then you can decide how much you want to do.

Let's just call the roll. Call the roll on should we have some kind of control on the nonsupervisory help, some kind of control. If we decide we want some kind, we can decide what kind we want to have, how much, how little.

Senator Bentsen. I thought we just did that in a voice vote.

Senator Dole. Eleven to two.

The Chairman. If nobody wants a roll call but me, it is all right with me.

Senator Nelson. I am already recorded, so you do not need a roll call, I guess.

The Chairman. I would suggest, then -- what would that be, Mr. Constantine? You say that they would be limited to whether you are going to have 11.6 or 9.7, whichever one we zero on. That would be the rate of increase that they could have and pass it on through provided that that -- let us say, assuming they get the prevailing wage rate, they could come up to the prevailing

wage rate, and they could get whatever the figure -- might ultimately be the 9.7 or the 11.6 in addition to the prevailing wage rate.

But if they are already at the prevailing wage rate, they could not pass it through except to the extent that it stayed within the 9.7 or 11.6, whatever we agreed to.

Do you understand that?

Mr. Constantine. Yes, sir. As I understand it, what you are suggesting is that the measure be the area prevailing wages for comparable services and that if the effect in an area where the wages are below prevailing wage levels, the effect of increasing wages of the hospital workers to the prevailing wage levels brings the hospital above whatever limit you agree on, that that limit would be increased by that amount.

That is the pass-through based on area prevailing.

The Chairman. That is right, which would be more than the 7 percent. In any event, it would exceed 7 percent.

Mr. Constantine. It could, yes, sir.

Senator Dole. Is that the same that they have in S. 505?

Mr. Constantine. Essentially yes, sir. Virtually identical.

Senator Nelson. Mr. Chairman, I assume what you are doing here is voting on a principle. I would like to see --

The Chairman. This is pretty specific here.

Senator Nelson. Let me ask a couple of questions, then.

Let us assume we have one case in our state where we are the

tenth largest clinic in America. It is in a little town of 60,000 with 150 doctors. I have never looked at their wage rates, but I would assume that is the biggest industry and I would assume they are above it, if you can find the prevailing rate, and I think you are going to get BLS problems on that.

If you can find what a prevailing rate is, let us assume they are substantially above what comparable is paid in the rest of the community.

What do you do with them?

The Chairman. Let's say that they can get whatever increase they vote, assuming they are already above the prevailing, they can get whatever increase we vote here.

Mr. Constantine. Mr. Chairman, the language dealing with that is in S. 505 and does exactly what I think Senator Nelson is concerned about. It recognizes where there is an existent wage rate above the prevailings that that will be recognized for that first year.

Senator Nelson. What do they do? Go hungry the second year?

The Chairman. Each year they can get the same increase that everybody else can get, even if they are getting more than the prevailing.

If they are not getting the prevailing, they can come up to the prevailing and get the increase in addition to that.

Senator Nelson. Tell me, how do you determine the prevailing

rate when many of these jobs are jobs which are in hospitals, so the prevailing rate is the prevailing rate paid in the hospitals?

So you are going to say you can have the prevailing rate the rate that you get?

Next, on the nurse side, there are all kinds of places in this country where you would find no prevailing rate to compare it with. The prevailing rate is the rate being paid the nurses in the hospital. You are buying a can of worms here which is going to give you a lot of trouble unnecessarily in view of the fact of what the experience shows.

The Chairman. What we are agreeing on what we want to do here, you are going to help us perfect it. You have some good ideas yourself of how to perfect it. How would you suggest that that be done?

Mr. Hoyer. Senator, first of all, in many of the occupations in the hospital, you have a direct counterpart outside and the workers move in in all the hospital, the kitchen workers and the like, in other areas. For example, where you may have a rural hospital without a counterpart, to say some of the highly skilled people in the hospital, you would have to go to comparable geographic areas elsewhere where you could make the comparison.

It is not the easiest thing in the world, you are quite right, but it has been done in other areas.

Senator Nelson. Then when you go elsewhere, the argument becomes "which elsewhere?" So you pick out a community in which

the wages are very high, the hospital administrators pick one where it is very low and they say this is the fair way to do it.

The Chairman. One thing you do not need to know about on these decisions about prevailing wage, I have not had anybody from labor come and complain about that decision. I have had many people from business complain about it. That decision is made over in the Labor Department. I have never had anyone from labor come and complain that that prevailing wage rate was too low.

Basically the people who are over there, the people in labor, their thinking is compatible with theirs, and it is their Department.

Senator Nelson. Since you have prevailed in your position anyway, can we not move on?

The Chairman. Let's vote on it anyway. Those in favor, say aye.

(A chorus of ayes)

The Chairman. Those opposed, no?

(A chorus of nays)

The Chairman. Call the roll.

Mr. Stern. Mr. Talmadge?

Senator Talmadge. Aye.

Senator Baucus. Could we have a precise explanation as to what this provision is? I am unsure as to what we are doing here.

Mr. Hoyer. I will try.

There is a concept of the prevailing wage for workers in hospitals and the rule would be, as I understand it, in setting the limits as to how much hospitals could retain in revenue that there would be room enough in that limit to pay all the hospitals employees up to that prevailing rate. If they exceeded it, they would be subjected to some sort of penalty unless they could find money someplace else to pay those rates through increased productivity.

Senator Dole. It also addresses Senator Nelson's problem in an area where you have higher wages, does it not?

Mr. Hoyer. What you could do if you wanted to, in effect, freeze at this higher wage level until the general wage level catches up with them.

Senator Bentsen. Are you not taking this out of 505?

Mr. Hoyer. Yes.

Senator Bentsen. Read that. That is precise. You have given a lot of thought to it; you drafted the language. Just read what you have in 505.

The Chairman. Let's just vote on that, with the understanding that subject to amendment --

Mr. Constantine. Section 2 of subsection, on page 6 of the bill, subsection 2(ii)(E), it starts on line 22. It reads like this.

Senator Nelson. We want to hear it. I just read it before and I read it three times now and I would like to hear an

explanation of it.

Mr. Constantine. Except that the personnel component shall be adjusted using a wage index based on general wage levels for reasonably comparable work in the areas in which the hospitals are located. If the Secretary finds that in an area where a hospital in any category is located for the most recent twelve month period for which data with respect to such wage levels are available, the wage levels for such hospitals are significantly higher than such general wage levels in that area relative to the relationship within the same hospital group between hospital wages and general wages in other areas; then such general wage level in the area shall be deemed equal for the wage level for such hospital only with respect to the hospital's first accounting year beginning on or after July 1, 1980.

That is the exception for the hospital which has the wage levels above the prevailing.

Senator Dole. Could you give me an example of how it would work? Just give me an example so we could understand it.

Mr. Constantine. Bob can correct me on this, but if the average wage in the area for comparable work for kitchen help, nurses outside the hospital and so on, administrative help, clerical help, is, say, $5 and in that hospital the average is $6, that would be recognized, deemed to be $5 for purposes of determining the limitation on that hospital.

Senator Dole. $5 or $6?

Mr. Constantine. Deemed to be $5.

If that was what was in effect when the program became operative, you would accept what was there.

Mr. Hoyer. The $6 would just be set aside and disregarded.

Senator Heinz. Disregarded by whom for what?

Mr. Hoyer. In determining what the hospital's costs are. The hospital costs would be matched against the limit that the program is set.

Senator Heinz. With respect to the $6, is the $6 used as a base figure or is the $5 used as a base figure in calculating the cost? What is used as the base figure, or is neither used?

Mr. Hoyer. What is used is what you referred to as a base figure, the $5. That $6 is passed through and disregarded.

Senator Heinz. The $5 is passed through. The difference between the $5 and $6 is not?

Mr. Hoyer. The other way around.

Senator Heinz. The $6? Which way?

Mr. Constantine. The excess dollar.

Senator Heinz. The excess dollar is disregarded.

The Chairman. Let us vote. Call the roll.

Senator Nelson. Are we voting on that language that was just read?

The Chairman. Yes.

Mr. Stern. Mr. Talmadge?

Senator Talmadge. Aye.

Mr. Stern. Mr. Ribicoff?

(No response)

Mr. Stern. Mr. Byrd?

Senator Byrd. Aye.

Mr. Stern. Mr. Nelson?

Senator Nelson. No.

Mr. Stern. Mr. Gravel?

(No response)

Mr. Stern. Mr. Bentsen?

Senator Bentsen. Aye.

Mr. Stern. Senator Matsunaga?

(No response)

Mr. Stern. Mr. Moynihan?

(No response)

Mr. Stern. Mr. Baucus?

Senator Baucus. No.

Mr. Stern. Mr. Boren?

Senator Boren. Aye.

Mr. Stern. Mr. Bradley?

Senator Bradley. No.

Mr. Stern. Mr. Dole?

Senator Dole. Aye.

Mr. Stern. Mr. Packwood?

(No response)

Mr. Stern. Mr. Roth?

Senator Dole. Aye.

Mr. Stern. Mr. Danforth?

(No response)

Mr. Stern. Mr. Chafee?

Senator Chafee. Aye.

Mr. Stern. Mr. Heinz?

Senator Heinz. No.

Mr. Stern. Mr. Wallop?

Senator Wallop. Aye.

Mr. Stern. Mr. Durenberger?

Senator Durenberger. No.

Mr. Stern. Mr. Chairman?

The Chairman. Aye.

Senator Nelson. Mr. Chairman, I have the proxies of Senator Moynihan and Senator Ribicoff. I understand on all issues, that while both of them vote no, but I am assuming that this is open for the rest of the day and that if their staff, speaking for them, or they themselves, can change that vote.

The Chairman. Nine ayes and seven nays and we will let the absentees record themselves.

Absent are Gravel, Matsunaga and Danforth.

Senator Talmadge. I have Mr. Gravel's proxy, Mr. Chairman, but I do not know how he would want to vote on this issue, so I will not cast it.

The Chairman. All right.

What is the next thing that we can vote on?

Senator Nelson. May I make a motion on the next one, if I may? Senator Dole earlier on raised a question which I think is an important one, and I think that it can be accommodated. That was the question, and I think that it was raised last year.

If you were ever triggered under, is there any way to get out? The answer has been no, with Mr. Champion saying that it would not make much difference anyway.

I do think there is a way to handle that and I would ask Mr. Champion whether or not this might work out.

There is a provision in the bill and a provision last year that any state which adopted, went ahead and adopted a mandatory provision which, after examination by the Secretary was determined by him to his conclusion that it would be effective, they would be exempt from mandatory controls even though they were above the trigger percentage; the assumption being within a year or whatever it was --

Mr. Champion. A 1 percent allowance above the general level for a state program.

Senator Nelson. Let me ask you this. Is there any reason why you could not have a provision that would provide if a state came under the mandatory controls subsequent to that, adopted a mandatory program of their own which upon examination of the Secretary he determined would, in his judgment, worked, that they then could come out, leave it in effect for a year or whatever and,

if then, they did effectively reach the goal and they had their own program, they came out from under the mandatory controls. Could that not be done?

Mr. Champion. As a matter of fact, the bill is designed to encourage mandatory state programs.

Senator Nelson. A question of after the trigger, after they are covered can they get out?

Mr. Champion. If they have a mandatory state program, we would have no objection.

Senator Nelson. My question is, is there any reason why that question cannot be in there so that if they adopted and a year later it is effective that they then come out from under the controls?

Mr. Champion. I think it was our intention to have that happen in the bill. If there is any question about it, we will be glad to work out language to make it possible.

Senator Nelson. Mr. Chairman, I do not know whether it is necessary to move, but I would like to have it clear that some provision of that kind be in there. I would so move.

Mr. Constantine. Mr. Chairman, as consistent with the provision with 505, 505 with respect to Medicare and Medicaid lets the state come in at any time subsequently when it develops its program. The only question is a minor one.

Inasmuch as you have voted a five-year limitation on this, in the future, otherwise, it does not make any difference. We

see no problem with it.

Senator Wallop. I am confused by what Mr. Champion said; could I inquire? This could only take place in a mandatory state program?

Mr. Champion. To have a state come out once that state has been triggered would need a mandatory program to come out from under that trigger so that the individual hospitals in the state would have to perform. You could not look at the state.

Senator Wallop. That flies in the face ofa question I asked earlier when the Secretary was here, whether one hospital operating outside of the guidelines would trigger the whole state coming under it. The answer was, at that time, no, it could not.

Mr. Champion. The original trigger, Senator, is based on a statewide average. That is the original trigger. If there were one state outside and the rest were under, the rest of the state's average would not be triggered.

Senator Wallop. That is missing my question.

Mr. Champion. Once they are in, then the individual hospitals would be looked at as individuals and treated that way. But they would be in as a state; they could not go to the state standard after they are inside the program unless they adopted a mandatory program.

Senator Wallop. One hospital operating the closest could trigger this mechanism for all the hospitals operating, while

assuming that hospital operated badly enough to raise the state over the average?

Mr. Champion. If they raised the average, yes, it would indeed.

Senator Wallop. Would it not be better to go after the hospital?

Mr. Champion. The only effect after that happened would be that all the good hospitals would not be covered. They would have no problem with that. It is only the hospital that is over in that state which would come under the mandatory program. There is not a penalty there for the hospitals that are under.

The hospitals who are under are protected.

Senator Nelson. You will recall last year on the amendment on the floor which we accepted raised that question, that a provision was if you come under a mandatory program in the state, every single hospital that meets the mandatory percentage increase is exempt from mandatory controls.

Senator Wallop. That is called contemporary voluntarism.

Senator Nelson. That is not bad.

So -- well, if you had ten hospitals in the state, in essence you are talking about ten, twenty, thirty, all within the rate but the average brings them under controls. Once the state is brought under control, each individual hospital then that meets the standard is exempt.

Mr. Champion. That is correct.

Senator Byrd. Are those hospitals also exempt from the paperwork requirement?

Mr. Champion. The only additional paperwork requirement is the reporting of nonsupervisory wages. They would not be exempt from that.

Senator Wallop. Does the increased paperwork under this become a measurement within the guidelines, the cost of providing the paperwork and other regulatory obligations? Is that exempt from the cost increase, or is that including?

Mr. Champion. We would be willing to have it so because there is almost no language here. There is one additional language for nonsupervisory wages. Because we pay about 40 percent of the hospital bills in this country, the Federal government does that, they demand a lot of billing information in order to assure the taxpayers that we are accountable for those dollars.

We have all the information that we need except that one report on prevailing wages to carry out the bill without additional paperwork for the hospitals.

Senator Wallop. If that is the case, surely there would be no objection.

Mr. Champion. That is what I said.

Senator Wallop. Assuming that there was other additional paperwork later on. That is possible.

Mr. Champion. I would like only, Senator, to avoid the problem of the so-called New York Study on Paperwork which said

that they took all the records they kept for every purpose and said that the cost of regulation was 25 percent of their total cost, and we would need to define very carefully what was, in effect, additional or required.

The Chairman. While we are on this, let's agree to the Nelson amendment. There is no objection to it. Without objection, we will agree to that.

What is the next thing you can take us to?

Mr. Constantine. Mr. Chairman, in view of your desire to make decisions, you could determine what kind of a trigger you want to use, as we started to earlier. Whether you wanted to accept the voluntary effort adjusted for the five-year period that you agreed to which, in effect, is 11.6 percent this year or you go with the administration's formula which aggregates 9.7 percent this year.

Which figure, in other words; you can make a decision.

The Chairman. Let's vote on it. Why do we not vote on it?

Senator Durenberger. Mr. Chairman, before we do that, I wonder, I think Mr. Champion while you were out of the room earlier talked about a year-end adjustment that I had not been aware of before. I wonder if you could re-explain that?

Mr. Champion. Yes, Mr. Chairman. That is really at the core of our approach. I think nobody anticipates that the result of our bill will be 9.7 percent is the trigger. The real trigger will be 9.7 plus what happens during 1979 to that market basket

which we projected of 7.9. There are various estimates at this time as to what it would actually be because of the increased cost of oil, but I freely predict it will not be 9.7. It will be clearly over 10 and may very well approach 11, depending on what the rate of actual increase because of inflation is during the year.

What we tried to do is to let that figure move with real costs rather than establish a fixed figure, either too low or too high.

The Chairman. As of now, we have the prospect of saving a lot more money because we are talking about saving a lot more expenses. What is the figure in the Talmadge bill?

Mr. Constantine. Mr. Chairman, the Talmadge bill is a reimbursement bill. It is not a hospital revenues limitation.

The Chairman. You are actually talking about two figures, one proposed last year and the other proposed this year?

Mr. Constantine. Yes, sir.

Senator Byrd. If I may ask a question, does that mean that the total cost of operation could go up by what is it, 11 percent, 9.8 percent?

Mr. Constantine. Senator, under the administration proposal, the inflation rate plus .8 of a percent for population and 1 percent for intensity of service, that they estimate at 9.7 percent, that is a kind of a fiction, because that assumes that the wage and price guidelines are effective and they are willing

to adjust that upward to meet reality of inflation greater than that.

The voluntary effort established by the hospitals has a target rate this year of 11.6 percent. In effect, the two numbers we are comparing are 11.6 percent and 9.7 percent.

Senator Dole. Plus.

Mr. Constantine. That is right.

The Chairman. As I understand it, the 11.6 is a target that was set by the hospital people themselves.

Mr. Constantine. Yes, sir.

Senator Byrd. And agreed to by the administration?

Mr. Constantine. Yes, sir, last year.

Senator Bradley. This is a mandatory target of 11.6?

Mr. Constantine. If they fail to meet the target, then the mandatory program is a test of the success or failure of the effort. If they meet the 11.6 percent, the mandatory program does not go into effect. If they fail to meet it, if they exceed it, then the mandatory program will go into effect, I believe January of '80, is that right?

Mr. Champion. That is correct.

Mr. Constantine. January of '80.

Senator Bradley. You could get into a situation where under the 9.7 the energy costs skyrocket or insurance costs skyrocket, and provide more flexibility but the 11.6 provides no flexibility.

Mr. Constantine. That is correct. You could provide some

flexibility in that 11.6 if you wanted to. The differences are two items between the two: one, the voluntary effort assumed, as we understand it, an inflation rate somewhat higher than the administration's: 7.9 versus 9.1 percent.

The administration had an .8 percent factor for population change. The hospitals had 11.1 percent, .3 of a percent higher. The administration estimated was allowing 1 percent for increase in intensity of care, improvements and so on, and the hospitals had 1.4 percent.

The essential difference really is a matter if you agreed on the inflation rate whether it is an voluntary test or the administration test, that the test is a market basket. The inflation rate plus some factor for population and intensity. If you took the hospital's figure, you are talking essentially .6 of a percent of the numbers the administration is using.

Mr. Champion. Which number?

Mr. Constantine. The hospitals are using--

Mr. Champion. The difference outside the market basket is .7.

Mr. Constantine. That is right.

Senator Bradley. As it is perceived now. That can change in three months or six months.

Mr. Constantine. The market basket could change.

Mr. Champion. The market basket, not the other two.

Senator Bradley. It could wind up being more than 11.6.

Mr. Constantine. It could wind up, either way, being more

than 9.7. The key variable is that the differences are in those two things, that .7 of a percent for population and intensity of service.

Senator Nelson. Let me ask a question. This is a rigid, mandated 11.6 by statute.

Mr. Champion. It would be if it were inserted in the section in this bill. It would be 11.6 regardless of what happened, even though it was arrived at by the same build-up method. It has no flexibility.

Senator Nelson. You may end up with every state in the union under a mandatory program, whether it makes any sense or not. Right, if your inflation went high enough.

The next question is, now we have set this by statute without a formula such as the administration bill. That seems to me to make good sense.

You take a market basket that rises with inflation. What are the figures for years two, three, four and five?

What do we do; legislate it every year?

Mr. Constantine. How could it be done, Senator?

Senator Nelson. Yes.

Mr. Constantine. Assuming you took the numbers, assuming you adjusted for the market basket inflation for the goods and services that hospitals purchased, your choice would be for those five years or four years, I guess, of whether you wanted to use a number. You could use a fixed number for population change

and intensity during each of those years and you could choose between the 1.8 of the administration or the 2.5 of the hospitals. Granted the population number gets fixed for a few years there. That is essentially what the difference boils down to.

Senator Nelson. However, if you adopt 11.6 here and everybody in the country, the average of every state is above it, then every state is covered by the mandatory program.

Mr. Constantine. That is correct. If you put the specific number in, it is a number established by the hospitals themselves and obviously they did not anticipate the inflation rate. Nonetheless, it is their number.

Senator Nelson. It might be a good argument for it. They are screaming against mandatory controls. Now they are giving us a figure that will make it mandatory whether they want it or not or need it or not.

I think it makes a whole lot more sense to follow the administration proposal. If you want to argue about the market basket being fair or not fair or being too much in it or too little, which I do not think is argued about, then you have a market basket, and if the costs of the necessary goods and services over which the hospital has no control at all, raises the market basket, the administration bill accommodates for it. Is that not correct?

Mr. Champion. Yes, Senator. As a matter of fact, we worked out the weights in the market basket with the American Hospital

Association so that it conforms, so they are weighting what they buy.

So there is obviously no argument between us about it. We accepted their weights.

Senator Wallop. Could I suggest one other possibility that I think provides more flexibility initially to the hospitals and would end up being the same thing, that is the Congressional Budget Office figure for the rate of inflation rather than the administration's. That is still hanging at 7.9 and everybody agrees that is unrealistic. The CBO figure is 8.9; 1 percent difference. But what it would mean, at the end of the year when you recalculated what had happened, they would have a percent more flex in trying to do a responsible job.

Senator Nelson. I had assumed they picked their 9.7. I had assumed --

Senator Wallop. It is based on an inflation rate, a forecast of an inflation rate, of 7.9. CBO's figure is 8.9. We would use the same manipulation; it just would be a percent higher. That is what it would be.

Senator Nelson. Unless I am misunderstanding, it will not make a difference in my interpretation at the end of that period you make the accommodation for what the actual rate was?

Senator Wallop. The only difference is that it would be, while everybody realizes that it is not going to be 7.9 unless something miraculous happens, it would give them a percent more

flexibility in the interim period on the calculation.

Mr. Champion. It would give them more certainty as to what was going to happen.

The Chairman. Let me ask this question, Mr. Constantine. Could you work on something, an amendment that we might be able to agree -- when is this thing triggered; 1980?

Mr. Constantine. It is based on 1979. If the voluntary effort fails, it would become effective in 1980.

The Chairman. Here is something that I thought we could work out, and it might be a fair compromise, to tie what they could have to what the actual experience has been on inflation plus about one or two points above that. If you will simply round it off, round off whatever figure you get, then you add about two points to it. Maybe we might be on something that everybody could agree on.

In other words, the administration's talking about 9.7, they are hoping to hold to a 7 percent inflation.

Mr. Constantine. 7.9.

The Chairman. 7.9. That is 1.8 below what the experience that they are planning on. It seems to me that maybe if we take whatever the inflation rate should prove to be fore the year and add the 1.8 onto that, that might be something we could settle for.

Mr. Constantine. Mr. Chairman, that is the administration's proposal. The 9.7 is a loose number. They just took 7.9 as their

estimate and added 1.8 to that for these other factors, population change and intensity of service. If inflation were 10 percent, then the administration's number would be 11.8.

Mr. Champion. That is correct.

Mr. Constantine. Another alternative --

Senator Nelson. I would like to move adoption of the Chairman's proposal.

The Chairman. Let's hear a little bit more.

Mr. Constantine. Mr. Chairman, essentially, at least initially, it boils down to a difference of .7 of a percent between the two. If you took the market basket, the inflation rate and added 2.5 percent to that, you would come up to essentially what the hospital numbers are.

If you took the administration's proposal adding 1.8 percent to it, the difference is .7 of a percent.

Senator Wallop. The point that I am trying to make, they are going to have to start planning now as to how they are going to comply and the CBO figure, 8.9, would give them a net basis of 1 percent leeway in the initial planning.

At this moment in time, it seems to be a more practical item. It seems more realistic at this point in time.

Senator Nelson. I would assume that all that has happened here is that at the time the bill was drafted or the proposal made, whether the administration adopted what they thought would be the inflation rate, if they were drafting new numbers today,

I suppose you would start with a realistic number today. Is that not correct.

Mr. Champion. We would go -- we do not know precisely what that number is. That number is what is projected by the CBO.

Senator Wallop. The other is a projection, too. It appears that this is probably closer and more on target than the administration figure. All that I am arguing for is for the hospitals to have that leeway in the initial planning to try to achieve compliance.

Mr. Champion. There are two ways to do that. One of the things we had planned to do as a regular matter anyway is to post the hospitals orderly as we compile data as to what was happening so they could keep up-to-date, but only make the shift at one time; that is, at the end of the year. But have the hospitals understand and actually be working with them to determine what the marketbasket actually was, as things happen.

The Chairman. Mr. Baucus?

Senator Baucus. As I understand it, the issue here is not so much what the inflation rate is going to be, because that is a given in both proposals. Rather, it seems it is the validity of 1.1 percent or .8 percent for population growth, and the validity of 1.4 percent versus 1.0 percent for the intensity increase.

I am wondering, as staff pointed out, that is a difference in total of .7 percent. I am wondering if staff, for my amplification, could comment on the merits of each of those two assessment

for each of those two categories. That we can focus on where we are here.

Senator Wallop. The only thing is that the Hospital Association's figure is a hard and fast one, not adjustable.

Senator Baucus. I understand that, but you include that to arrive at their 11.6.

Mr. Constantine. The hospitals assume an aging factor that the population is aging. Therefore, services are required on a somewhat greater intensity factor. That is awfully hard to judge.

This is a very imprecise area. People are pretending expertise which is just not there. We just do not know what the valid number is, whether it is 1.1 -- in both cases they are arbitrary numbers, and the staff recommendation would be to err on the side of being somewhat more generous until such time as the administration and everybody could be more precise.

Mr. Champion. Could I add the information, Senator, that we base those two choices -- we went on the population of .8; actually in the '78 panel figures on hospitals, the increases of admissions in total days reflecting population was only .5. We think that we have already, in fact, been generous.

We find no evidence that an aging population has increased, either the number of the additions. These are questions that can be argued.

The Chairman. I have to be on the floor; the Senate is in

session. It is all right if you want to go ahead and ask a question, and you can go ahead and preside. I have to go to the floor.

Senator Nelson. Do you want me to move your proposal?

The Chairman. I would have to insist that we not have any more votes today, but if you want to, go ahead and discuss the matter more fully.

Senator Nelson. May I ask one more question before the chairman goes? When do you plan to meet again on this proposal?

Mr. Stern. Mr. Chairman, the committee has scheduled an executive session May 1st. May 1st is the conclusion of the multilateral trade negotiations. On May 2nd, you would be back on the health proposals and start here again on Wednesday, May 2nd and then you would have meetings scheduled for that Thursday and Tuesday through Thursday the following week.

Senator Dole. May I just ask -- maybe you have answered it. I have been looking -- if we took the market basket provisions, the calculations based on today's rate of inflation, what figure do you have?

Mr. Constantine. Senator, today I guess the estimate is 9 percent for inflation.

Mr. Champion. We do not have a precise measure for the market basket, but I would not be surprised.

Mr. Constantine. CBO says it is 9 percent.

Senator Dole. Then you add on your .8, so you end up with

what?

Mr. Constantine. About 11. If you added 2.5, which we were suggesting here, the hospitals -- 1.1 for population change and 1.4 for intensity -- you wind up close to 11.6.

Senator Dole. But, as I understand it, these are national averages. I have taken a peculiar interest at New England of late, and you look -- and so have many others -- when you look at the energy cost, are we going to have any local consideration or is this a national average that would not take care of the 80 cents a gallon heating oil?

Senator Wallop. I have some proposals that will address that when we get to it, because they will be distorted all over the country for a variety of reasons.

Senator Dole. We do not consider local conditions.

Mr. Constantine. In their bill, they leave latitude for put downs specifically referred to that in the Talmadge bill as a specific exemption in the reimbursement approach on energy and some other costs which are variables which are too tough. Energy is a very tough one.

Mr. Champion. Senator, the ideal solution to this problem, of course, is to all states to have their programs. New England is fortunate in having three programs: Massachusetts, Connecticut and Rhode Island. As a matter of fact, the regional average hospital cost for New England for 1978 over 1977 was only 7.9 percent.

Senator Nelson. That is because of the three mandatory states.

Mr. Champion. The three mandatory programs dominate the population.

Senator Dole. There may be other reasons, too.

Mr. Constantine. They have very high base costs in Massachusetts.

Senator Dole. That is the thing we have overlooked throughout all the discussion of how successful the mandatory programs have been. In New York, they have very high base costs in New York. They should not be the example here.

Mr. Champion. They both have higher energy costs, Senator, which is the reason they have the high base. If you look at Washington, a mandatory state, it is not a high-cost state and they have had the same kind of record.

Senator Dole. It seems to me, if we look at today's -- if we look at the calculations based on what the facts are today, then we are probably not talking about any difference, any real difference, between 11.6 and 11.5.

Mr. Champion. Senator, the 9 or 9.1 or whatever it is is not what exists today. It is what CBO estimates will happen during the year. It, too, is a protection so we are not talking about an existing situation and our concern is that we not project or anticipate, in effect, index inflation into these calculations.

Senator Chafee. I do not understand the problem here, as far as the accepting that CBO figure. Is anybody suggesting that is unrealistic?

Mr. Champion. No. It may very well be realistic. It is certainly a much higher figure than we had in our projection as realistic; what precisely it is. We think it ought to be measured at the end.

Senator Chafee. Is not one of the problems if you take a lower figure -- you can take a 5 percent figure, if you want, but what you are saying to these hospitals, you are working with their money as opposed to their ability to charge. In theory, at the end, they will make it up.

Mr. Champion. No. They will perform exactly. They are in a voluntary year so they are under no constraints during 1979 as to what they do except to try to reach what they thing the target is going to be.

My suggestion is what we ought to do is to keep them -- they will keep themselves as well-informed as they can. In fact, we helped them do that by helping to finance their panel surveys. We will also try to keep them informed.

The question is, how many times, really, do you want to change the figure, or do you want to start out with a somewhat higher base. If we start at a higher base, there is one question in the way the legislation is written. Anything under that as we wrote it, we would not attempt to hold people below the 9.7. In case

the inflation rate goes down, we would fix the inflation rate at that base.

If you would move the inflation rate up -- and we happen to have somewhat less inflation than that under the bill as now written -- we would still be left with a higher rate, so if you did want to move out that inflation base, which I agree represents some reality, then you ought to be careful not to get it above some figure, then we might do more than just actual rate of inflation.

Senator Chafee. I appreciate what you are doing. I think you should come in as realistic as possible. Your theory is to keep their feet to the fire and they might do better.

I would like to touch on one thing that Mr. Constantine said about the states with a high base. You blithely said, of course, they have been closing hospital beds, so that is easy. I think that there are few tbings that are harder for a hospital to do and enail more costs than closing hospital beds. I do not think that was one of your valid arguments.

Mr. Constantine. I was thinking of New York.

Senator Chafee. No matter where it is, closing beds is both expensive and a dramatic undertaking of will.

Mr. Champion. Naturally, there is an incentive in the bill as written to promote that. It recognizes in the base services or reductions in costs through bed closings or service alterations so you get credit for that in the base even when you have done it,

and that does give you some operating room in the bill.

Senator Danforth. Is not the basic question that we have to answer not what the rate of inflation is going to be. Nobody intends to try to hold hospitals below whatever the rate of inflation is. The big question, as I understand it, and Senator Baucus made the same point -- the big question is what sorts of upward adjustment are you going to permit for population and intensity, is that not correct?

Is that not really the difference of position between the hospitals on the one hand and the administration on the other hand?

Mr. Champion. Well, plus the fact that the hospitals have thus far suggested only the fixed rate, but I am sure that that would not be a problem.

Senator Danforth. That is not what they are arguing for, obviously. Is not the real argument between you and the hospitals inflation plus some factor, and the factor is a composite of population and intensity increases, right?

Mr. Champion. Right.

Senator Danforth. Is that not all we have to cite as to what those figures should be?

Mr. Champion. If you are going to do mandatory, because the hospitals also oppose mandatory.

Senator Danforth. I do not know why we are proceeding this way. I would like to get right to a question of voting for either

the Nelson approach or the Talmadge approach. That is the basic thing. But apparently what we are doing is chewing up the Nelson approach first so we will have something to chew on later.

I am not the Chairman of the committee. What we are trying to do is to make this decision. Is that not the issue that we have to decide?

Senator Nelson. May I say, as to that point, before he answers the question, I would kind of like to see a roll call on that mandatory 11.6 because I would like to get back on the good side of the hospital administrators again, and when you give them that program, and I vote against it, I am their friend, you see.

Senator Danforth. The issue is not a mandatory 11.6. The issue is inflation-plus. Is that not right?

Mr. Champion. Yes.

Senator Danforth. And what the plus is, the plus is either 1.1 for our population or .8 for population-plus; 1.4 for intensity or 1.0 for intensity. Is that not the question?

Mr. Champion. That is the essential dollar issue.

Senator Danforth. Is there any problem why we cannot resolve that issue other than nobcdy is here?

Senator Nelson. That is the time to resolve it, when nobody is here.

There is one more problem and that is the automatic adjustment provided in the administration proposal which is flexible and accommodates for the inflation factor automatically.

Senator Danforth. Would anybody argue against that? Would the hospitals say, "No, if the rate of inflation goes up, we do not want an adjustment for it"?

Senator Nelson. I was not making that point. The point, as I understand the proposal of Mr. Constantine, is the flat 11.6.

Senator Danforth. I do not think that is his proposal at all. I think, as I understand it, the question is between 2.5 and 1.8.

Is that not the issue?

Mr. Constantine. On top of inflation, assuming there is agreement on what that market basket is, or the elements of the market basket with the hospitals in terms of the measurement.

Senator Danforth. Can that not be worked out? It is inconceivable to me that that is the issue.

Mr. Constantine. The issue really is whether the committee started off with, I guess, first things first, whether you support a stand-by mandatory program.

Senator Danforth. That is right. For some reason, the procedure we are following does not get us to the big questions, so we are answering the little questions. The little question is 2.5 versus 1.8, right?

I move 2.5.

Do we have a Chairman? I move 2.5.

Senator Nelson. The Chairman, with whom I must get along off and on -- and you, too -- said that he did not want any votes.

But if you want an expression -- that was his last comment. I assume that with the few numbers we have got here --

Senator Danforth. If it were in order, I would move 2.5.

Senator Nelson. It is not in order.

Senator Matsunaga. It is out of order. We have no quorum here.

Senator Nelson. Now we have a technical person. I had understood that Mr. Constantine was saying a few months ago, 11.6 and it would be legislated and if it went above 11.6, everyone in America is covered by mandatory controls.

The difference between that and what the administration position is is a flexible market basket that will reflect inflation -- an eminently sensible approach, it seems to me. As a matter of fact, Senator Long sat there and came up with his formula. It happens by coincidence to be exactly what the administration is proposing.

That is why I wanted to move to adopt Russell Long's formula, because that might be a stronger position to work from.

Mr. Constantine. You could take 11.6 this year and for future years again if the committee approved a mandatory standby, take 11.6. It would probably approximate the 2.5 plus the inflation rate, and that is the hospital's own target for this year, and then add 2.5 in the additional out years to the market basket rate of inflation.

So if next year, inflation is 6 percent and the market basket --

it would be, in effect, 8.5 percent; this year, 11.6 and in subsequent years, the test. Then if they meet it this year, you need a test for subsequent years.

What we were suggesting was a market basic plus 2.5 percent in the subsequent years.

Senator Nelson. Why it gets that 2.5 percent when the administration has a sensible proposal that does realistically exactly what happens? Why sit here predicting what is going to happen?

Mr. Constantine. The administration bill does not deal, Senator -- it has to deal with the intensity.

Senator Nelson. Let the administration explain what the bill is.

Mr. Champion. The difference between the 1.7 and 2.5 are differences of opinion between the hospitals and we as to how these things could be measured. We took straight population increases as the basis for the population formula. They argue that you should, because of an aging population, increase that amount.

We went back to the record to see whether, in fact, that was a valid concept. It proves not to be.

As a matter of fact, in the recent experience, the increases in admissions and stays was about .5. We think that .8, recognizing the general population, is a highly generous proposal.

With respect to net service intensity, I believe, with Mr.

Constantine, that there is no world expert on that subject. The question is simply how much pressure do you want to put on new technology and what we have suggested is to put the pressure on by letting them deduct productivity from the usefulness of that new technology or new service.

Therefore, you can have up to three or four if, in fact, through productivity you could get that net intensity factor down to one.

Senator Danforth. Then you have to measure that, right?

Mr. Champion. What figure you set for net intensity is really a fixed figure. That is a fixed figure that you would take as a given, a judgment. How much pressure do you want to put?

Senator Danforth. An adjustment for productivity requires some sort of calculation.

Mr. Champion. Whatever they get out of that, they get. It is not in the market basket; it is not in population; it is not in net intensity.

Senator Danforth. Somebody has to figure it, do they not?

Mr. Champion. No, they do not.

Senator Danforth. What is it?

Mr. Champion. Take a net figure of 1 percent; you set it at 1 percent. However, the productivity goes up and down; they get that much more in terms of their productivity. It is a net figure.

I am sure they arrived at it the same way that we did.

looked at all the other factors and you say how much pressure and we say more pressure and they say less pressure. That is the difference between 1 and 1.4.

Senator Danforth. I will tell you, you know the problem with this, with all due respect to the whole administration-Nelson approach, is that you are just grasping at straws, frankly. I mean, you are just guessing and we are quibbling about whether it is 1.1 or .8, as though we have some wisdom that we are dealing with.

Mr. Champion. Senator, we are following the technique that has been successful in nine states.

Senator Danforth. How about the Talmadge approach? Has that been tried in any states?

Mr. Champion. Not in that form, to my knowledge. The basic problem, however, is that in adjusting to the median you keep no control of the median. The median can rise and the adjustments above and below conform to the median, so there is not any real cap.

I think the Talmadge formula would have a successful effect on the present circumstances, but it does not put the kind of controlling certainty.

Senator Danforth. Of course not. Basically, the fundamental question is do you believe that we, in Washington, have the wisdom to make these kinds of determinations on cost control?

Mr. Champion. The same kind of decision that you make, or I

make as a private purchaser. What are we willing to allow in terms of those things that we want to buy?

Senator Danforth. That is not at all the administration's proposal, as I understand it. You are not determining what you want to buy. You are determining what can be paid by anybody.

Mr. Champion. What we want to pay, but let me put it in the context of a private institution when it is bargaining with somebody as to what it ought to pay for, a given item, an incision. I know your costs are going up this much; we know you have that problem. You get different views and you agree on the price.

That is what we are trying to do in this situation.

Senator Danforth. Nobody does this. Nobody stands around and talks about the difference between 1.1 and .8 except HEW.

Mr. Champion. Senator, I am sorry to say when I was in an educational institution, I sat around doing that with funders all the time.

Senator Nelson. I think there is an important point to be made here, Senator Danforth. Number one, everybody, including the hospital administrators that I have talked to privately just says the increase is outrageous but we will take care of it ourselves. So you have an outrageous increase, twice the national rate of inflation.

Okay. All this bill is really saying is put your house in order and you will never hear from the federal government. If you do not put it in order, it is important enough in terms of the

billions of dollars involved in federal monies, Treasury monies and taxpayer monies, $50 billion. So we say we are glad to have you comply; you go ahead and do it. You will never hear from us if you do not; we have got a responsibility to make you comply. That is the heart of the matter.

Senator Danforth. No, it is not. I do not think there is any difference between a standby cap and a cap, myself. You either buy the idea of cost control in the sort of cap-rigid manner that the administration is proposing, or you do not, but the standby cap is just a cap, you know?

Saying the speed limit is going to be 30 miles an hour in this block and if you drive under it you are perfectly free to drive under 30 miles an hour and you will not hear from us.

Senator Nelson. Exactly correct; that is a good way to put it. How long should they be robbing the Treasury and the people's pocketbooks? Better than 25 percent of all the states are now meeting the standard on their own. We are just saying the rest of you go ahead and meet it. Otherwise, what is the answer? You continue to let them go at 14, 15, 16 percent? What is the alternative?

Mr. Champion. I think we make another distinction in this cap. We try to control that which the hospitals can control and not control those things which are beyond their immediate ability to control?

Mr. Stern. May I announce that Senator Matsunaga and Senator

Danforth have voted no on the Chairman's motion relating to non-supervisory wage increases, so at the moment, the vote stands nine to nine with Senator Gravel and Senator Packwood yet to be recorded. So, at the moment, it fails on a tie vote.

Senator Nelson. We might as well adjourn until Wednesday, May 2nd at 10:00 on hospital costs.

(Whereupon, at 12:20 p.m. the committee recessed to reconvene on Wednesday, May 2, 1979.)

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