

Federation of American Hospitals

Folder Citation: Collection: Records of the 1976 Campaign Committee to Elect Jimmy Carter;
Series: Noel Sterrett Subject File; Folder: Federation of American Hospitals; Container 82

To See Complete Finding Aid:

http://www.jimmycarterlibrary.gov/library/findingaids/Carter-Mondale%20Campaign_1976.pdf



Federation of American Hospitals

STATEMENT OF
DAVID G. WILLIAMSON, JR., PRESIDENT
AND
MICHAEL D. BROMBERG, DIRECTOR, NATIONAL OFFICES
ON BEHALF OF
FEDERATION OF AMERICAN HOSPITALS
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
HOUSE COMMITTEE ON WAYS AND MEANS
ON NATIONAL HEALTH INSURANCE
NOVEMBER 10, 1975

On behalf of the members of the Federation of American Hospitals, we would like to thank the Committee for this opportunity to present the views of our organization on national health insurance.

The Federation of American Hospitals is the national association of investor-owned (proprietary) hospitals representing approximately 1,100 hospitals with over 105,000 beds. Our member hospitals range from small rural facilities to large urban and suburban comprehensive medical care institutions. Investor-owned hospitals in the United States represent approximately 25% of all non-government hospitals. In many communities, investor-owned facilities represent the only hospitals serving the population.

Not only do investor-owned hospitals deliver quality health care, they also pay a substantial amount in taxes, amounting to \$115 million in federal and state income taxes and \$39 million in local property taxes last year alone. It would cost more than \$6 billion in public funds to replace the beds built by investor-owned hospitals.

Investor-owned hospitals have been founded by local citizens to fulfill urgent community needs, but more significant to the scope of these hearings is the fact that investor-owned hospitals have been able

to operate at a rate commensurate and competitive with the rates of other hospitals. This is true even though proprietary facilities pay taxes and are subject to the same requirements for licensing, accreditation and certification for Medicare, Medicaid, and various Blue Cross programs as are other hospitals. Not only are our hospitals committed to providing quality health care at a reasonable cost, but we believe the free enterprise sector of the hospital field can make a significant contribution in the development of a more effective and efficient health care delivery system.

We appreciate this opportunity to set forth those specific goals which our association believes should be established in drafting national health insurance legislation.

After considering a long list of desirable objectives, we would narrow the major goals of a national health insurance plan to the following two:

- 1) Provide a minimum benefits package of health care insurance to all Americans; and
- 2) Provide protection against catastrophic costs of prolonged illness to all Americans.

Timing of National Health Insurance

The state of the nation's economy is often cited as the major reason this Congress is not expected to pass a comprehensive national health insurance bill. The economic

situation and the huge federal budget deficit also led to the President's moratorium on new domestic spending programs this year.

We would suggest to the Subcommittee that the current economic climate is the ideal one in which to consider the issues involved in drafting a national health insurance bill. Fiscal responsibility and the lowest utilization of public sector dollars would be the necessary ingredients of a health insurance program drafted in this period of federal spending restraint. That kind of health insurance program, while drafted now, could, and we believe should, be phased into being over a number of years further cushioning the economy from the inflationary impact of sudden increases in demand for health services.

For these reasons we commend your Subcommittee for scheduling these public hearings and urge you to follow this stage of your consideration of national health insurance with an effort to draft a bill which minimizes public sector spending, payroll tax financing, and government administration, and instead maximizes private sector financing, insurance and administration of health protection.

Pluralism

The general approach supported by the Federation is the restructuring of a pluralistic health care delivery system based on pluralistic methods of

financing and administration. We are confident that if competition is encouraged within the health delivery system, the consumer of health care will receive the benefits of a more efficient system. By competition we mean not only competition among providers of health care, but also competition among health delivery organizations, insurers of health care, and financing and administration systems in the health field.

Having concluded that competition can improve both the quality and efficiency of health care delivery, we do not support any program which would place all funds needed to meet the cost of health care in a single entity -- whether private or public. For that reason, we oppose the concept of a single federal trust fund managed and controlled by a federal agency. Similarly, we believe that any national program should address itself to the delivery of care as well as the financing mechanism.

A pluralistic system of financing and delivering care will benefit the consumer by offering alternatives. By pluralistic health care delivery system based on pluralistic financing methods, we envision a system in which the federal government and the private sector each play a significant role. In this way, the public and private sectors can work together, compete against each other and offer a planned, manageable and accessible health system to the nation's consumers.

We believe, for example, that the federal government should concentrate on the following areas of priority -- first, assuring that those persons without the financial means to pay for needed health care have equal access to the health system and second, that all Americans, regardless of financial means, are protected against the catastrophic or financially burdensome costs of health care. We believe that the private sector, including insurers and providers, can develop an orderly and efficient system for the protection of those working Americans and others who can afford to pay a reasonable price for quality health care that is delivered efficiently and economically. We believe that the impetus to imaginatively restructure the delivery system should and will come from the private sector with encouragement from the government. By maintaining this balance between public and private approaches to the health field, we can assure a dynamic system rather than a stagnant one.

Employer-Employee Plans

The Federation supports the concept that all employers should be required to provide basic protection against the costs of health care for their employees. This protection should meet minimum federal standards.

We believe that a mandated employer-employee health insurance program should be designed in a manner similar

to the workmen's compensation laws, with private rather than public financing.

Benefits

We support unlimited inpatient hospital care and physician's services, home health services of 100 visits per year, and well-child care as some of the major benefits that should be included in any package. In addition, the Federation supports the position of equal inpatient coverage for the mentally ill, with expanded outpatient psychiatric benefits. Individuals should not be discriminated against because their illness is not physical. A mental illness can be every bit as catastrophic as poor physical health (and the two often go hand-in-hand), and should be covered equally.

Catastrophic Insurance

The Federation supports comprehensive coverage including catastrophic health insurance for all Americans as a part of any national health insurance system. Once the deductible under this major medical type of coverage is met, we believe that all illness-related expenses should be covered. This would include cost of prescription drugs, inpatient and outpatient psychiatric care, dental care, long term chronic illness care in nursing homes and all other illness-related care. Catastrophic health costs in any form should be covered as soon as the annual

family or individual deductible is met.

The financing of a catastrophic health insurance program or the financing of the catastrophic illness component of any comprehensive national health insurance bill should in our view be achieved through a combination of insurance purchased in the private sector and the use of general revenues.

We urge you to reject any proposals to utilize a federal trust fund based on payroll taxes as the method for financing catastrophic insurance. Such proposals would expand the Medicare system to cover the major illness expenses of all Americans and would expand the role of the Social Security Administration as regulator, administrator, and payor for health care. Our experience under Medicare for the past ten years leads us to conclude that an expansion of this approach to health insurance would be highly inflationary and unnecessarily complex and costly to administer.

Since the passage of Medicare, health providers have been forced to increase charges to private patients to make up for actual costs incurred but not recognized by the Medicare program. By expanding the Medicare administrative mechanism and its retrospective cost reimbursement system, you would be compounding the inflationary impact of that program caused by increased charges to non-government insured patients.

As alternatives to payroll tax financing and Social Security Administration regulation, we urge the Subcommittee to consider the following suggestions for providing catastrophic illness insurance to all Americans:

- 1) Mandated private insurance with employers required to purchase federally qualified catastrophic insurance policies and required to pay a majority of the premium;
- 2) An employer financed catastrophic insurance program for the unemployed through continued coverage under private insurance policies previously purchased by employers. This approach could be patterned after H. R. 5970, "The Emergency Health Insurance Act of 1975," reported favorably by the Ways and Means Committee this past April. To deduct the cost of health premiums, employers would have to purchase policies which meet federal standards;
- 3) Tax credits for direct medical expenses which exceed a specified percentage of income. This approach could be coupled with tax rebates for low income families where catastrophic medical expenses exceed tax liability. Administration of this tax credit, tax rebate plan would be under jurisdiction of the Internal Revenue Service and would be less costly and far easier to administer than a Medicare

type program; and

4) General Revenue to purchase private catastrophic insurance for non-employed individuals and the near poor. The Secretary of Labor or the Secretary of HEW would administer this kind of program by negotiating with private insurance companies for group rates based on a pool of beneficiaries. By using general revenues, the tax burden for financing catastrophic benefits would be spread more equitably over the entire population than under a payroll tax.

Organization and Delivery of Services

We have already discussed the importance of stimulating competition among health care providers and others within the health field. The successful reorganization and restructuring of our health care delivery system will depend in large part on continuing experimentation. We do not believe there is any single form of health care delivery which can meet the nation's health needs.

A single form of delivery would destroy the power of the health care consumer to select and shape the system or his choice. For example, while we support experimentation with health maintenance organizations, we would not recommend that all or even a majority of consumers be forced, directly or indirectly, to enroll as subscribers in such organizations. Hospital based HMOs in particular offer a most promising opportunity for initiation of this method of health delivery,

requiring a minimum amount of capital expenditures because of the already existing facilities and resources. The effectiveness of a delivery system can only be measured by the relative strengths or weaknesses of competing delivery systems. A delicate balance must be maintained if the consumer is to have true access and true freedom of choice in selecting the system which serves him best.

Role of Carriers

In regard to the role of the carrier, the Federation favors an approach in which the carrier acts in the capacity of a private insurance company rather than as a fiscal intermediary. We feel that utilizing carriers in their present role as private insurance companies is the approach most conducive to strengthening competition and providing for the dual administration of the national health insurance program by both the Social Security Administration and insurance companies. There is a great deal of experience and expertise available in the private sector for the administration and design of health plans and it should be utilized. The Secretary of HEW should be authorized to enter into contracts with carriers as administrators of the benefits offered under a system of national health insurance.

The carriers themselves would have to meet federal requirements before they would be qualified to participate in the program. Such a system creates incentives both

for employers and insurance companies. Since private employers would be required to provide basic benefits to their employees, they would have the economic incentive to contract with carriers offering the most attractive programs. On the other hand, the insurance companies would have an incentive to keep the cost of the plans down in order to attract business. Thus, the element of competition, as well as free enterprise, is introduced into a program of national health insurance. Such would not be the case if the government were to act as the insurer, because competition would be eliminated, as would the incentive to contain costs.

Some proponents of national health insurance favor carriers as fiscal intermediaries, operating much as they now do under the Medicare program. Competition would be eliminated because insurance carriers would cease to be in business for a profit. There would be no incentive to keep costs of operation down. When insurance companies are permitted to function as private commercial enterprises, they would be more likely to "ride herd" on the billions of dollars in claims that will be filed. With prospective payment systems in effect and carriers competing to contract with employers for the basic benefits package, it would be in the carriers' best interest to monitor claims closely to contain costs.

We are also concerned about the provisions in H. R. 21

for the creation of a Security Board which would have the responsibility of administering the national health insurance program as well as the present Social Security program. The Federation has strong reservations about the creation of such a super agency with such vast controls. We feel that it would be a mistake to place administrative and regulatory power in any one organization, when it is possible to rely on the present system of private insurance companies and hospitals and other providers working together under federal guidelines to administer a national health insurance program.

The Federation favors the creation of a separate cabinet level Department of Health. We believe that the federal government should administer only those aspects of the national health program which are financed by general revenues and the Medicare program. We would be in favor of establishing an agency within a Department of Health that would monitor the standard benefits package and administration of the overall program, with private insurance companies handling the financing of the mandated employer-employee program and the payment of providers, subject to federal guidelines. Such a system would provide for dual financing and administration of the massive program, rather than entrusting these aspects to a single government agency.

Hospital Payments

The increasing costs of providing hospital services during the past eight years has brought about a series of arbitrary controls and proposals for government regulation of hospital rates. The Federation has, from its establishment in 1966, called for the adoption of negotiated prospective rates or prospective payment systems as the single most effective device to curb spiralling hospital costs.

Notwithstanding a number of cost-escalating factors, we believe the nation's hospitals can hold the line on inflation given the proper incentives for sound innovative management. To do this we must first rid the system of a prime culprit -- retroactive cost reimbursement.

The system of retrospective cost reimbursement has been a major cause of inflation in hospital services because it penalizes efficiency and gives the hospital manager an incentive to increase costs and maximize reimbursement. On the other hand prospectively determined rates provide incentives for efficiency with economic rewards for those who are able to bring effective management techniques to an institution.

There are many types of systems upon which to base the development of prospective rates. These include negotiated charges, a formula to determine payments, group target rates, and rate review boards with the

resulting payment based on per diem, per admission, per capita, per procedure or other unit of service.

In order to preserve and encourage a pluralistic health system, we favor the use of multiple prospective payment methods similar to those authorized under H. R. 1. We believe that several prospective rate systems should be developed and that hospitals should have the option of selecting from those approved systems. We commend the distinguished Chairman of this Committee for his leadership in providing for the development of such prospective payment methods to hospitals in his own revised health insurance legislation. We urge modification of those provisions of H. R. 1 to strengthen the role of the federal government in establishing guidelines for multiple prospective rate systems and to limit the power of state governments or state commissions in regulating hospital rates.

We recommend that any national health insurance bill reported by this Committee contain hospital payment provisions similar to those contained in Section 236(5)(A) of H. R. 1 with the following modifications:

- 1) The prospective payment methods should be negotiated and developed in the private sector by providers, third-party payors, and other interested parties, under federal rather than state guidelines. The Secretary of HEW would

be empowered to disapprove agreed upon systems only upon a finding that the methodology is inconsistent with the federal criteria. That decision should then be subject to both administrative and judicial review;

2) The federal guidelines should encourage competition among similar providers by providing for payment methods under which similar rates are established for all providers in the same classification based on size, scope of service, and geographical area. The systems should also assure that rates for an individual institution will not be reduced because of a prior year's efficiency of performance, otherwise a provider will be competing against itself instead of other providers, producing an incentive to increase expenditures; and

3) Providers should have an annual election from at least three approved payment methods. The election would be made in advance of the providers' fiscal year and there should be flexibility in regulations governing the election.

We wish to commend the Chairman of this Committee for providing that the rate of return for investor-owned institutions projected in developing the payment method should be related to total assets rather than equity. The attraction of private risk capital is essential to meet the

modernization needs of the hospital industry and to replace substandard, antiquated beds. That will only happen if the basis for return is related to investments of comparable risk, a fact recognized under Section 212 of H. R. 1. The return on equity under Medicare has certainly proved to be far below any return for investments of comparable risk.

We are confident that the private sector can do the job if given the chance and the motivation. The Chairman's proposals for prospective payment methods recognize that the ingenuity of private industry can produce a better health delivery system. We urge the Committee to act favorably on this approach.

State Rate Setting

Some national health insurance legislation calls for the establishment of state rate setting commissions to determine health provider charges. We reject the idea that hospitals should be regulated as public utilities. There is a crucial difference between hospitals and public utilities -- in most communities there are alternative sources for providing necessary health care, unlike the monopolistic system imposed by utilities. Competition can be infused into the health delivery system by utilizing equal bargaining power between hospitals and insurance carriers at the local level. This assures responsiveness to local needs.

Insofar as the Federation is concerned, there is little to recommend about a state rate setting system. Such a system would mean yet another layer of bureaucracy over an industry which is already subject to a great deal of control. The expertise necessary to operate this type of control program at the state level would have to be developed from scratch.

Finally, but quite importantly, it appears that national health insurance in any form will be funded primarily on the federal, not state level. Therefore, it seems unreasonable to delegate to the states responsibility for determining appropriate payment for services rendered under a federal program.

Conclusion

There are many other goals which should be incorporated into a national health insurance bill, such as providing appropriate incentives for cost containment, assuring quality of care delivered, choice of delivery systems, access to health manpower and facilities, administrative simplicity and due process. Those objectives, however, do not necessarily require passage of a national health insurance program to be achieved. That is why we hope the Subcommittee will continue its work on comprehensive Medicare reform.

Although the Federation does not endorse any specific bill in its entirety, we believe that the August 19, 1974

draft prepared by Ways and Means provides an excellent start in the right direction. With the exception of the provision for a payroll tax to finance the catastrophic illness protection, we are in accord with the overall approach of the draft and hope that it will serve as a base for further discussions. We believe that national health insurance legislation can be enacted which is consistent with efforts to hold down federal expenditures, provided the program is phased-in and does not require massive federal spending, but relies on the private sector for administration.

X X X X X X X

SUMMARY OF RECOMMENDATIONS

In conclusion, Mr. Chairman, we would like to summarize some of the recommendations that we have made here today.

1. After considering a long list of desirable objectives, we would narrow the major goals of a national health insurance plan to the following two:

- (A) Provide a minimum benefits package of health care insurance to all Americans; and
- (B) Provide protection against catastrophic costs of prolonged illness to all Americans.

2. We would suggest to the Subcommittee that the current economic climate is the ideal one in which to consider the issues involved in drafting a national health insurance bill. Fiscal responsibility and the lowest utilization of public sector dollars would be the necessary ingredients of a health insurance program drafted in this period of federal spending restraint.

That kind of health insurance program, while drafted now, could, and we believe should, be phased into being over a number of years further cushioning the economy from the inflationary impact of sudden increases in demand for health services.

3. The general approach supported by the Federation is that of a pluralistic health care delivery system based on multiple methods of financing and administration. We believe that such a system will instill the requisite

competition, and the consumer will be the recipient of a more efficient delivery of services.

4. The Federation supports the concept that all employers should be required to provide basic protection against the costs of health care for their employees. This protection should meet minimum federal standards.

5. We urge you to reject any proposals to utilize a federal trust fund based on payroll taxes as the method for financing catastrophic insurance. Such proposals would expand the Medicare system, to cover the major illness expenses of all Americans and would expand the role of the Social Security Administration as regulator, administrator, and payor for health care. Our experience under Medicare for the past ten years leads us to conclude that an expansion of this approach to health insurance would be highly inflationary and unnecessarily complex and costly to administer.

As alternatives to payroll tax financing and Social Security Administration regulation, we urge the Subcommittee to consider the following suggestions for providing catastrophic illness insurance to all Americans:

- (A) Mandated private insurance;
- (B) Employer financed catastrophic insurance for the unemployed;
- (C) Tax credits and rebates for direct medical expenses; and

(D) General Revenues to purchase private catastrophic insurance for non-employed individuals and the near poor.

6. We do not endorse any bill in its entirety, but we believe that the Ways and Means draft of August 19, 1974 can serve as the base for further discussions.

7. We believe that retrospective cost reimbursement is a prime factor in escalating the costs of health care. It should be replaced with prospective rate systems, with incentives for efficient management, negotiated privately by institutional providers and third-party payors subject to federal guidelines.

8. The Federation is totally opposed to state rate setting and recommends that all such references be deleted from any national health insurance legislation. Such vastly empowered agencies with little or no expertise would turn institutional providers into public utilities, causing even greater inflation in health care costs.

9. There are many other goals which should be incorporated in a national health insurance bill, such as providing appropriate incentives for cost containment, assuring quality of care delivered, choice of delivery systems, access to health manpower and facilities, administrative simplicity and due process. Those objectives, however, do not necessarily require passage of a national health insurance program to be achieved. That is why we hope the Subcommittee will continue its work on comprehensive Medicare reform.

Mr. Chairman, we thank you and the Members of this Committee for considering these views and for affording us this opportunity to appear before you.

X X X X X X X