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THE STATUS OF MASS. HOSPITALS:

TWO VIEWS

In November, 1989 the Associated Industries of Massachusetts' Health Care Advisory Committee invited Steve Hegarty, President of the Mass. Hospital Association (MHA) to address the committee regarding the financial status of hospitals, especially since the changes in hospital reimbursement dictated by the Health Security Act of 1988. Hegarty has lobbied vigorously to bring additional revenues to hospitals in what he has described as crisis times for the Commonwealth's ninety-some acute care hospitals.

In December, the A.I.M. committee heard a different view from Alan Sager, Ph.D., professor at the Boston University School of Public Health. Dr. Sager has been studying Mass. hospital finances for several years and concludes that Massachusetts, with the highest cost hospital system in the nation, does not have a revenue problem but rather a cost problem.

This issue of "CMBGH News" will present the two views as presented at the AIM meetings.

HOSPITALS IN REVENUE CRISIS:

Steve Hegarty, President, Mass. Hospital Assoc.

Hegarty points out that Massachusetts has two discrete hospital systems: a community hospital system which is generally efficient with reasonable costs and an academic medical center / high technology hospital system whose costs are higher than community hospitals but, he says, in line with their counterparts across the country. As evidence that Massachusetts, specifically Boston, is the mecca of health research and technology, Hegarty says that one third of money spent nationally on research by the National Institutes of Health is spent in seven medical centers in Boston. Hegarty believes that restraints on revenue such as those he says Chapter 23 impose, jeopardize the lower cost community hospital system. He believes that solutions do not lie in either hospital price regulation (current system) or market forces. He argues that we must bring health care decision-making back to the community and away from state government. **[continued on page 2]**

HOSPITALS HAVE A COST CRISIS:

Alan Sager, Ph.D., BU School of Public Health

Alan Sager, Ph.D. and colleagues of the Boston University School of Public Health have embarked upon a Access and Affordability Monitoring Project of the implementation of Chapter 23 of the Acts of 1988. Dr. Sager presented his findings to date on the effects of the law's hospital reimbursement system on financial status of Mass. hospitals. Sager concludes that we already spend enough, perhaps more than enough. This year in Mass. health spending is $3,000 per person! Dr. Sager says we do not have a revenue problem, but rather a cost control problem which will require internal controls to deal with physicians and trade-offs. Sager's initial report states, "If we continue business as usual in health care, the next recession will result in many bankrupt hospitals and much denial of needed services. Hospitals, patients, and payors all need a new deal." Sager claims the Mass. Hospital Association (MHA) is **[continued on page 3]**

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Hospital Capacity: Hegarty presented his views on hospital capacity. He stated that 2,800 acute care beds have been de-licensed since Chapter 23's enactment, and currently there is a shortage statewide in Intensive Care capacity, specifically high risk obstetrics and adult Intensive Care beds. Capacity problems are intensified by the shortage of nursing home beds and the "collapse of the mental health system." He believes that bed capacity that is removed from the system now will have to be rebuilt by the year 2000.

Capacity reduction is taking place in the community hospital system rather than in the high tech teaching hospital system, and Hegarty feels that this is dangerous. Hegarty believes that closing beds has saved nothing since when community hospitals close down beds or close down altogether, their patients may then be seen in more costly facilities. MHA has contracted with a consultant to do a simulation study of patient movement resulting from hospital closures. Their hypothesis is that the cost of doing business is going up because of closures.

Hospital Financial Status: In 1988, 60% of Mass. hospitals had operating deficits, and 41% had bottom line deficits. The same figures for 1989 were projected to be 78% and 56% respectively. He claims hospital operating margins are far below northeast and national averages.

Medicaid last summer took eight months to pay its hospital bills. Hegarty says that eighty days in Accounts Receivable is average. MHA has filed a suit against Medicaid to have their claims payment system thrown out. MHA claims that Medicaid owes Mass. hospitals $350 million.

"Cash flow to total debt " for Mass. hospitals in 1988 averaged 8%, whereas the figure was 14% in the NE and about 17% nationally. Median "current ratio" for Mass. hospitals was 1.1 to 1.0.

Relationship of Hospital Costs to Health Insurance Costs: Citing information from the Division of Insurance on Blue Cross Master Medical, Hegarty noted that in a three year period since 1986 the cost of Master Medical increased 39%, whereas hospital costs increased 23%. Largest areas of Master Medical spending increases since 1986 were Mandated Benefits (1745% increase), Administrative Reserves (77% increase) and Prescriptions for major medical (43%). In 1986 hospital costs represented 59% of premium costs, and in 1989 hospital costs represented 51%.

Hegarty claims that increases in insurance reserves are subsidizing new product entry, and often the products are not viable. He says the market is driving expansion of benefits rather than contraction.

Hegarty also pointed out that hospitals are the second largest SIC employer code in Mass. and therefore are experiencing higher operating costs, like other employers, as health insurance rates escalate. Labor costs are increasing by about 15% per year while hospital revenues have increased only 4% on average per year.

Staffing Levels: Hegarty presented 1987 data showing that non-teaching hospitals in Mass. were staffed on average at the same level as the national average (MA: 363 FTEs per100 adjusted census; US: 360 FTEs). On the other hand, Mass. teaching hospitals are staffed at a considerably higher level than the national average (MA: 540 FTEs /100 adj. census; US: 453 FTEs). He attributes the higher level to the belief that Mass. teaching hospitals produce 25% more residents and interns than other teaching hospitals thereby requiring additional support staff. This need for higher staffing levels is compounded because Mass. teaching hospitals are on the high-tech end of the scale compared to other teaching hospitals.

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Medicare Payments to Hospitals: Medicare payments comprise, on average, about 40% of hospital support. Medicare reimbursements have been cut back; HMOs, PPOs, and employers are selectively contracting with hospitals; and Blue Cross /Blue Shield has selected hospitals for their PPO. These factors create tremendous pressure for cost containment, and state regulation is inflexible.

The MHA has proposed to bring health care decisions back to the community and away from state government. MHA proposes to put pricing decisions in the hands of the hospital trustees who are answerable to the community. According to Hegarty, the trustees should bear the responsibility of balancing costs with services.

The MHA proposal would (1) maintain the current uncompensated care pool to cover cost of care for the uninsured and under-insured, (2) maintain competition among insurers, (3) re-target government dollars to institutions that heavily serve Medicaid and Medicare recipients and the uninsured (Currently, hospitals in which more than 50% of business is Medicare are fiscally unviable.), (4) remove revenue-setting limits and charge-setting limits from state control and turn these decisions over to hospital trustees.

Forecast: Hegarty predicts that in the next 10-15 years there will be twelve hospital systems statewide. He also believes that in hospitals, quality planning should be a strategic objective of the CEO and foresees use of private industry models of quality. He says that the business community should help to bridge the gap between private industry and hospitals on such matters. Hegarty wants to be available to businesses to do fact-finding at the local level. □

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propagating a number of myths in the quest for increasing revenues.

Myth #1: "Hospital costs are under control". Sager acknowledges that hospitals are experiencing financial distress, but disagrees that the problem is one of insufficient revenues. We have the world's most expensive hospital system with more than 50% of personal health spending going to hospitals. Sager disputes the MHA's claim that hospital costs are under control. In 1988 Mass. was 34.5% above the national mean hospital spending per capita ($845 per capita compared to the national average of $628); whereas, in 1988 Mass. was 39.3% above the national average. Sager attributes the increase to the generous level of payment of Chapter 23. In contrast to high hospital spending, Mass. is the second lowest in the nation in percent of health care dollars going to doctors (10% below the national average), yet we are the second highest in physicians per capita.

Myth #2: Hospitals are losing money on the federal Medicare program so therefore, money from other payors (private and state) must rise. Sager says that while 36 out of 84 did lose money on Medicare in 1988, there was a statewide gain on Medicare in 1988 of $190 million for about a 14% return on Medicare revenue. Ironically, or perhaps amazingly, the state's $50 million yearly "Medicare Shortfall Fund" (instituted by Chapter 23) went disproportionately to hospitals that had already made the most money on Medicare before state aid was applied. Slower Medicare growth is a federal policy decision to which Sager says hospitals will have to adjust since we do not have state resources to offset the slowdown. Sager says that what most hospitals face is a reduction in Medicare's surplus (subsidy to other payors), not a loss on Medicare.

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Myth #3: Hospitals are not being paid money owed under Chapter 23. Sager says that they have been paid 100 cents on the dollar for two fiscal years, and it is only the 6 new cents - Medicare shortfall funds - that are in jeopardy. He says that 94% of the new private sector hospital money is paid automatically through higher Blue Cross, commercial, and self-insured charges.

Myth #4: Hospitals are being underpaid, therefore two-thirds lost money in 1988. Sager says that while it is true that there has been a clear deterioration in margins, there is a very mixed picture. Not all hospitals are in such bad shape. He thinks that the MHA does not want to deal with issues of re-distribution of money, but rather that the "lowest common denominator is always to ask for more money for everyone." Sager says that the MHA prefers "socialization of loss, and privatization of surplus." If we believe that surpluses are the result of good management, one could argue against re-distribution of funds. Reviewing hospital data since 1981 Sager has found no correlation between hospital profitability and case mix-adjusted cost per admission. Furthermore, he says the claim that 2/3's of hospitals have deficits is only true if one looks at Operating Margins. Sager says it is meaningless to talk about hospital Operating Margins because this compares total expense with operating revenues only; whereas parking garages and cafeterias which are included in total expenses also generate non-operating revenues. Looking at the overall margin he claims that in 1988, 55% of hospitals made money ($185 million overall). The remaining 44 hospitals lost in total $215 million. He concludes that if revenue was to be re-distributed among hospitals only $30 million (not $215 million) would be needed. Furthermore, he says that the $30 million statewide loss more than made up - statewide - by the state's own Medicare Shortfall payments.

Another financial indicator of interest is that of hospitals' fund balances which rose by $55 million in 1988 to $2.5 billion. This may be an under-estimate since it does not take into account parent corporations, in which, he states, much of the fund-raising activities are located and where considerable funds are retained, out of general view. Sager's group are assembling consolidated statements of hospital revenues, expenses, and changes in fund balances for all subsidiaries and for the major parent corporations.

Myth #5: Hospitals need higher revenues through higher regulated charges or through charge de-control or they will close and we will all go without vital care. Hospitals need internal cost control. It is the doctors who make the decisions that determine costs and generally administrators are in the role of finding money to cover costs. Sager claims that revenues have grown 8-10% per year in recent years (contrasted to MHA's claim of 4% annual growth). He says revenue growth has been exceptionally rapid from non-Medicare sources. In spite of this, financial margins have dropped and all this has happened in good economic times. If hospitals become dependent on increasing revenue growth, a recession will cause a severe crisis.

Dr. Sager says there are also a number of myths accepted to explain high costs of Mass. hospitals-

Myth #6 : Massachusetts' commitment to teaching and research and care to patients from other countries explain high costs. Sager says that Boston's hospital cost/capita is double that of New Haven, Conn. which is similarly committed to teaching and research. Four major Boston teaching hospitals' cost per admission was 27% greater than five even more specialized teaching hospitals in other states.

Myth #7: A large surplus of acute care hospital beds explains high costs. Not so, says Sager. Mass. has only 2.8% more beds per

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capita and only 4.1% more admissions per capita than the nation as a whole. He, like MHA President Hegarty, feels closing beds may raise spending since it is likely to be the less costly beds that go.

Myth #8: Higher salaries and higher administrative costs cause our high costs. The average hospital wage/employee in Mass. is only 5.2% above the national average and we have high cost of living. Costs of administering health care are "a national scandal," but there's no evidence that things are worse here.

What does cause the high health care costs in Massachusetts? Dr. Sager says this is difficult to say without uniform accounting and cost reporting by hospitals. He does note, however, that we are first in the nation for reliance on hospitals for outpatient care, that surgical rates are 14% higher than the national average, and that Mass. hospitals employ 37% more workers per admission than the national average. The workers are hired to perform clinical services ordered by physicians, and there is evidence that Mass. physicians order a "richer pattern of services than their colleagues elsewhere in the nation." There is no evidence, he says that this is associated with better health outcomes.

Dr. Sager says we cannot tackle high health costs responsibly without involving physicians hospital-by-hospital. We must change price and volume together. He believes cost control will not happen until physicians must operate under a negotiated hospital spending budget. □