UNDERSTANDING MASSACHUSETTS HOSPITAL COSTS

Legislative Briefing
30 September 1991

Access and Affordability Monitoring Project
Boston University School of Public Health
(617) 638-5042

Massachusetts hospital costs are the world's highest. Excess hospitals and beds don't explain them. Competitive incentives used here since 1988 have actually raised costs. They led to sharp increases in outpatient visits and surgery, and even to a rise in hospital admissions. Competition has failed nationally as a cost control strategy.

Fortunately, a proven alternative is available. With Massachusetts health spending expected to reach $24 billion next year, health care is the easiest problem to solve in the Commonwealth, because it is the only one on which we clearly spend enough money.

How Costly Are Massachusetts Hospitals?

1. In 1989, Massachusetts hospital costs averaged $1,043 per person, versus $747 for the nation as a whole.

2. If we had spent at the U.S. average, we would have saved $1.75 billion in 1989 alone. Fully $1.2 billion of this excess is not explained by any reasonable or legitimate factors.

3. In 1992, total hospital costs here can be expected to exceed $8 billion (EXHIBIT A).

Excess Beds and Low Occupancy Rates Don't Explain Our High Costs

4. Our hospital beds per 1000 residents actually dipped below the national average in 1989 (EXHIBIT B), yet our hospital costs per person rose to 40 percent above the U.S. average.

5. Excess beds are not our problem. Our occupancy rate in 1989 was ten percentage points above the national average-- 76 percent vs. 66 percent (EXHIBIT C). Also, our hospitals average one-quarter larger than those elsewhere, so we should enjoy economies of scale.

6. We have closed one-third of our hospitals in the last 20 years (EXHIBIT D), without any measurable impact on hospital costs.

Regulation Does Not Explain Our High Costs

7. Massachusetts' extraordinarily high hospital costs preceded regulation by decades (EXHIBIT E). Our regulation of hospital charges (loosely in 1975 and more tightly in the early 1980s) was a response to high costs, not their cause. Indeed, our chapter 372 and 574 regulations-- despite their many flaws-- helped keep hospital costs between 1983 and 1987 at their lowest ever level, relative to the U.S. average. Their ceilings on revenues and their removal of incentives to provide more care worked to hold down costs.

Massachusetts Hospital Costs Rose under Chapter 23's Competitive Incentives and Generous Regulatory Increases

8. Chapter 23's regulations awarded hospitals much higher revenues by raising rates faster than inflation, by paying them retroactively for volume increases, and in other ways.

9. To try to control costs, the law featured new competitive provisions. Competition advocates hoped that by promising generous revenue increases to hospitals that gained patients, they could induce hospitals to compete for patients by cutting prices and improving efficiency. Prices may have been cut somewhat, though this is not clear.

10. But competition advocates forget that the volume of care is not a fixed amount to be divided among hospitals; competitive incentives may promote unnecessary increases in care. During chapter 23's first two years, volumes of care increased markedly:

> the admission rate rose here for the first time in five years, while it continued its nine-year decline nationally (EXHIBIT F-1)
>
> the number of outpatient visits rose by 1.1 million even though our rate was already highest in the nation (EXHIBIT F-2)
>
> the surgery rate rose to 19 percent above the national average

11. Even worse, competition did not save money. Our analyses show that the less efficient hospitals-- those with higher cost per discharge, after adjusting for patient severity-- were likelier to gain patients. Teaching and larger hospitals were also likelier to gain patients.

12. Competition advocates are obsessed with getting hospitals to cut their prices. They tend to ignore the volume problem that results when, to promote competition for patients, they give hospitals financial incentives to increase volumes of care. Even if some hospitals do cut their prices for a time, continued bed reductions and higher volumes of inpatient care can be expected to push occupancy rates even higher in the future, which will allow hospitals to raise their prices again.

13. The cost problem in Massachusetts has more to do with the intensity of our practice patterns and with our high-- and growing volumes of care-- than with inefficiency.

Nationally, Competition through HMOs Has Not Slowed Hospital and Health Cost Growth

14. The share of a state's people enrolled in HMOs is often used to measure the amount of competitiveness in its health care market. Yet between 1980 and 1990, the states with more people in HMOs tended to suffer bigger hospital cost increases (EXHIBIT G). Massachusetts is already second-highest in HMO market share.

15. Overall health costs in states with higher HMO enrollment rates rose even more sharply than their hospital costs (EXHIBIT H). This suggests that HMOs may be shifting costs out of hospitals but doing little to contain overall health costs. Note that California's total health cost increases were almost as great as ours, despite its even-heavier reliance on HMOs and its very high share of people without insurance.

What Does Work?

16. Maryland has shown that smart, simple, tough, and fair regulations can cut costs while protecting hospitals. This is the necessary foundation for holding down health insurance premiums for everyone who is insured-- and for extending coverage to everyone who is not yet protected. The problem with hospital regulation in Massachusetts has not been regulation itself but rather how we have regulated. The contrast with Maryland shows what we need to do (EXHIBIT I).

EXHIBIT A

MASSACHUSETTS HOSPITAL COSTS, 1980-92

$ MILLIONS

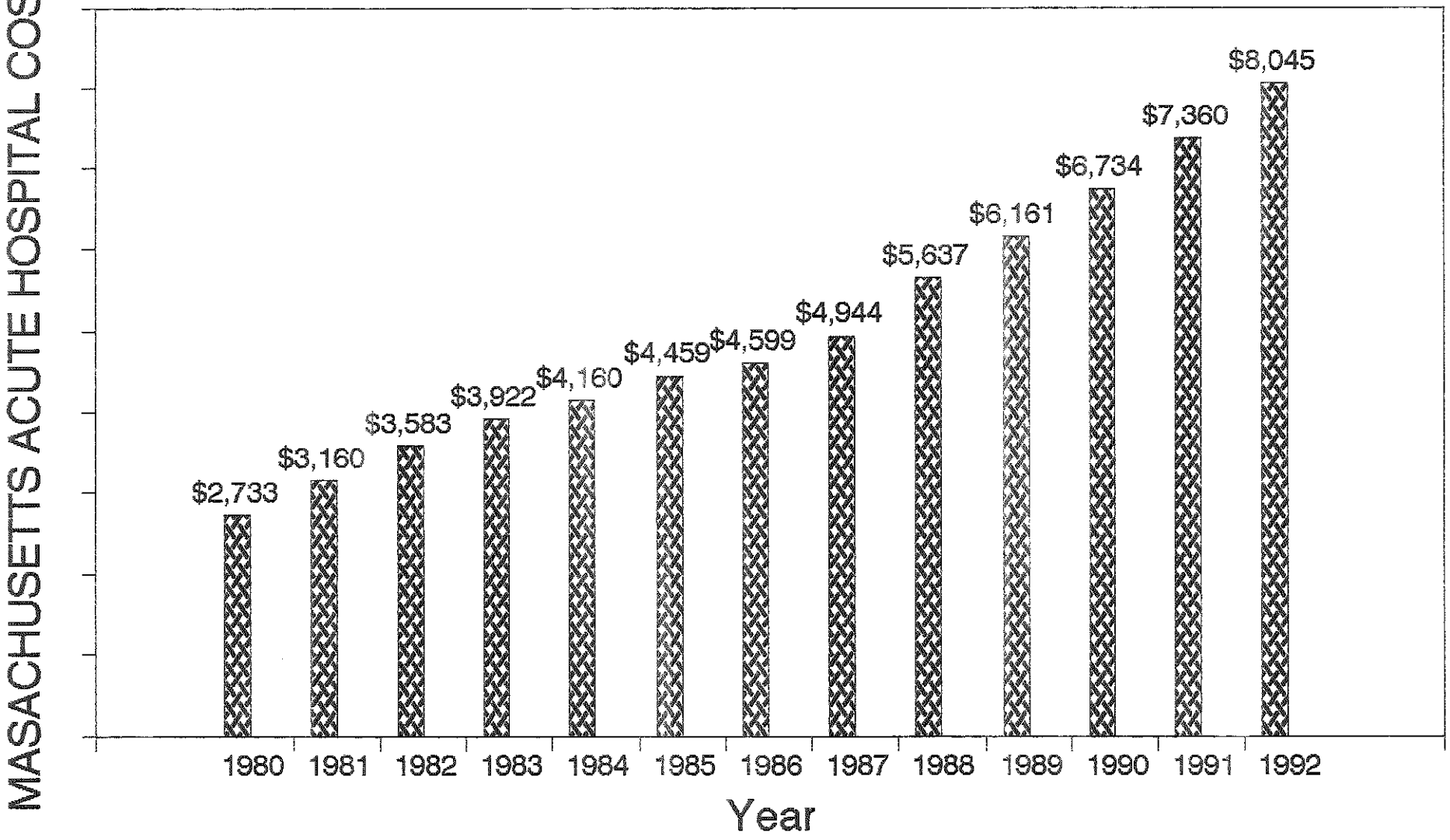


EXHIBIT B

HOSPITAL BEDS PER PERSON, 1960 - 1989

Massachusetts as percent of U.S. total

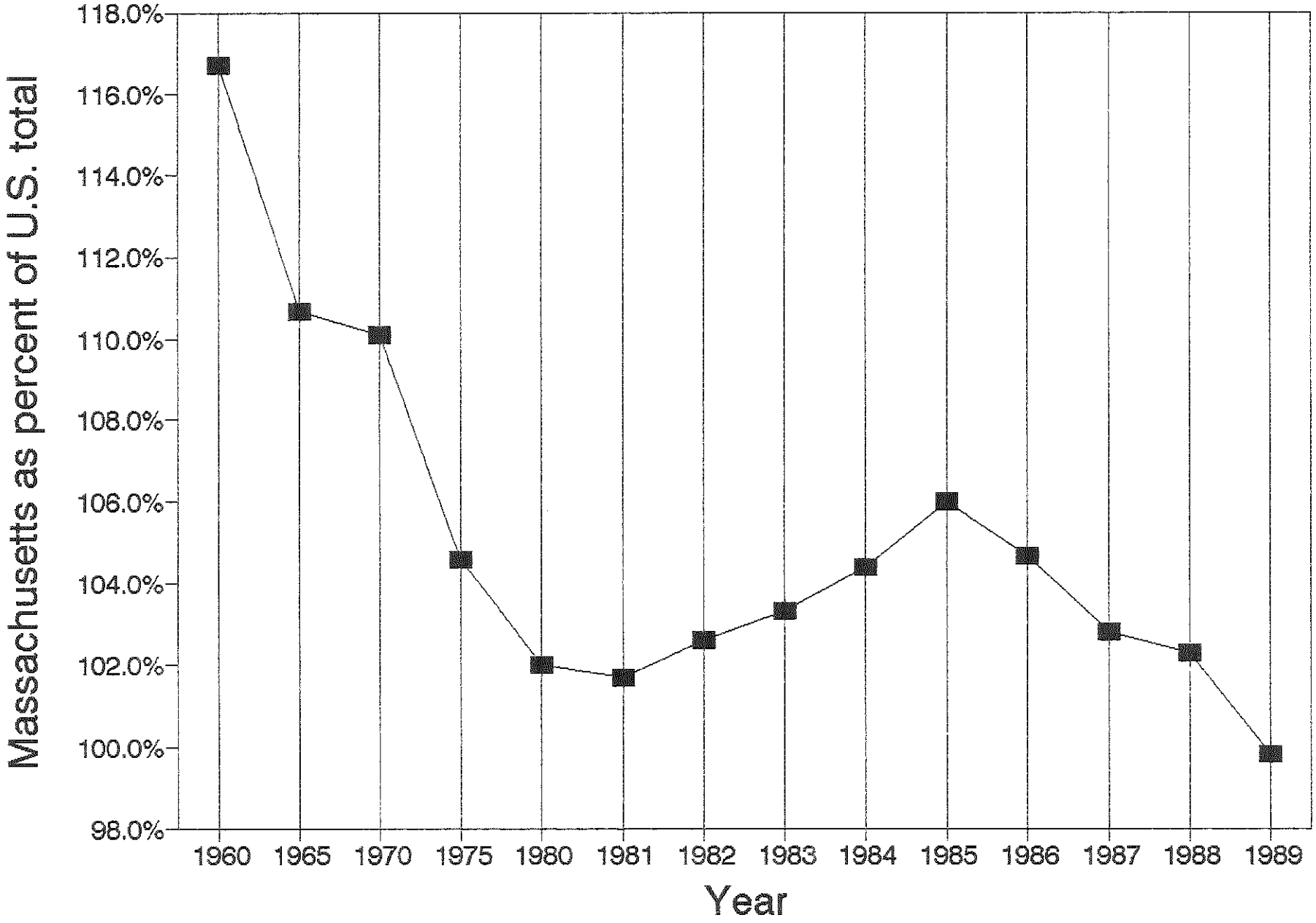


EXHIBIT C

HOSPITAL OCCUPANCY RATES, 1960 - 1989

Massachusetts and United States

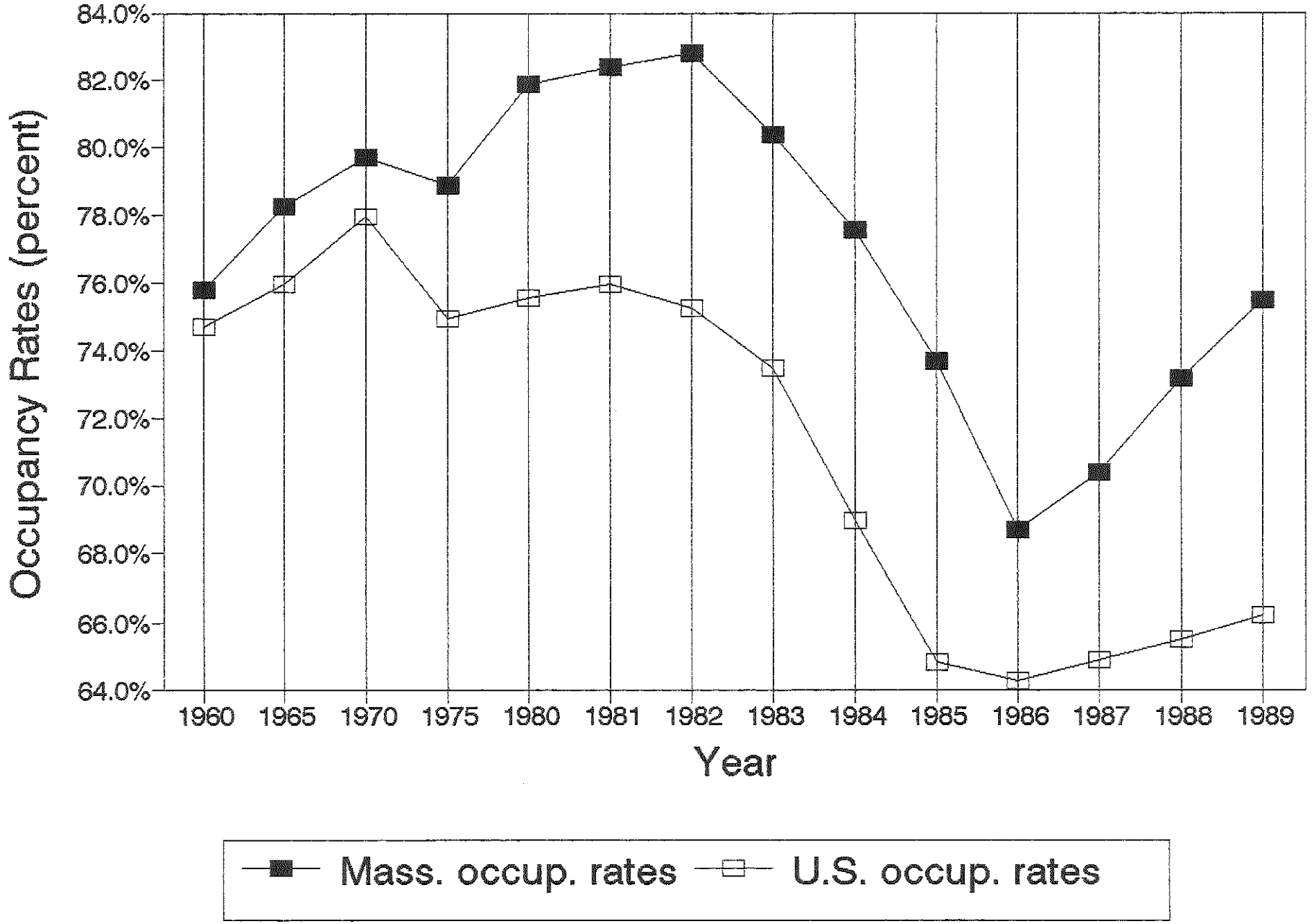


EXHIBIT D

NUMBER OF MASSACHUSETTS HOSPITALS
1960 - 1991

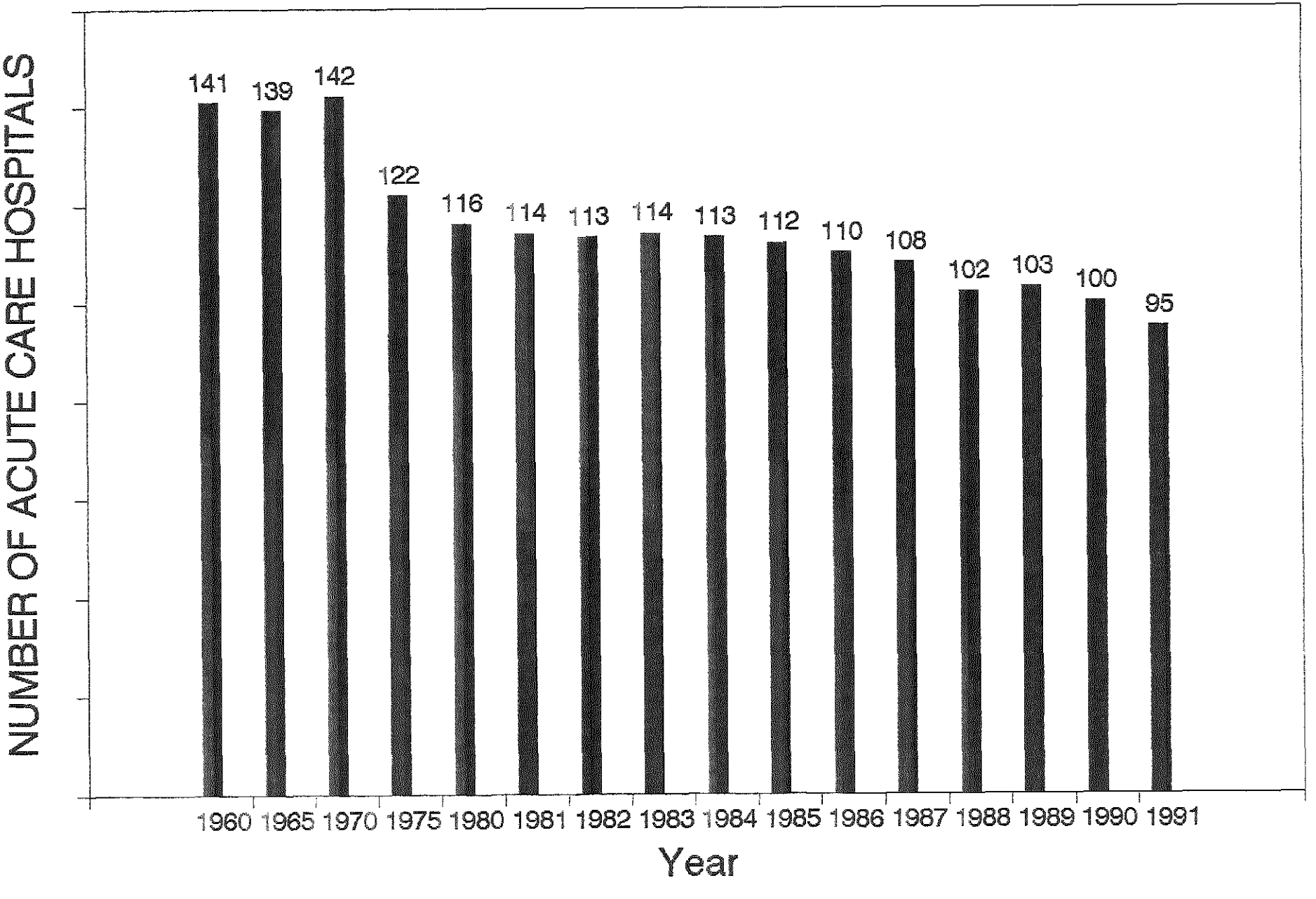


EXHIBIT E

HOSPITAL COSTS PER PERSON, 1960 - 1989

Massachusetts as percent of U.S. total

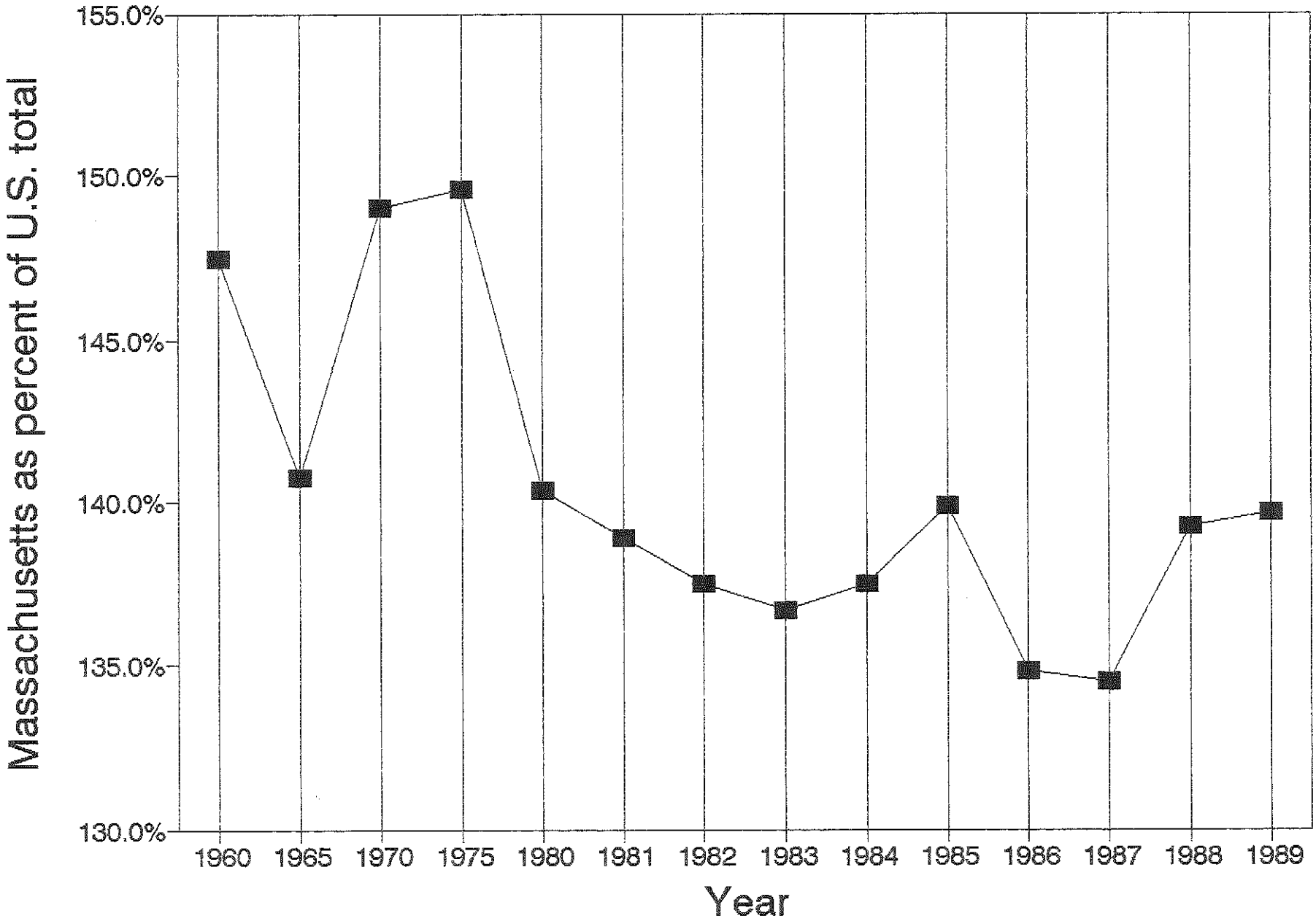


EXHIBIT F-1

HOSPITAL ADMISSION RATES, 1960 - 1989

Massachusetts and United States

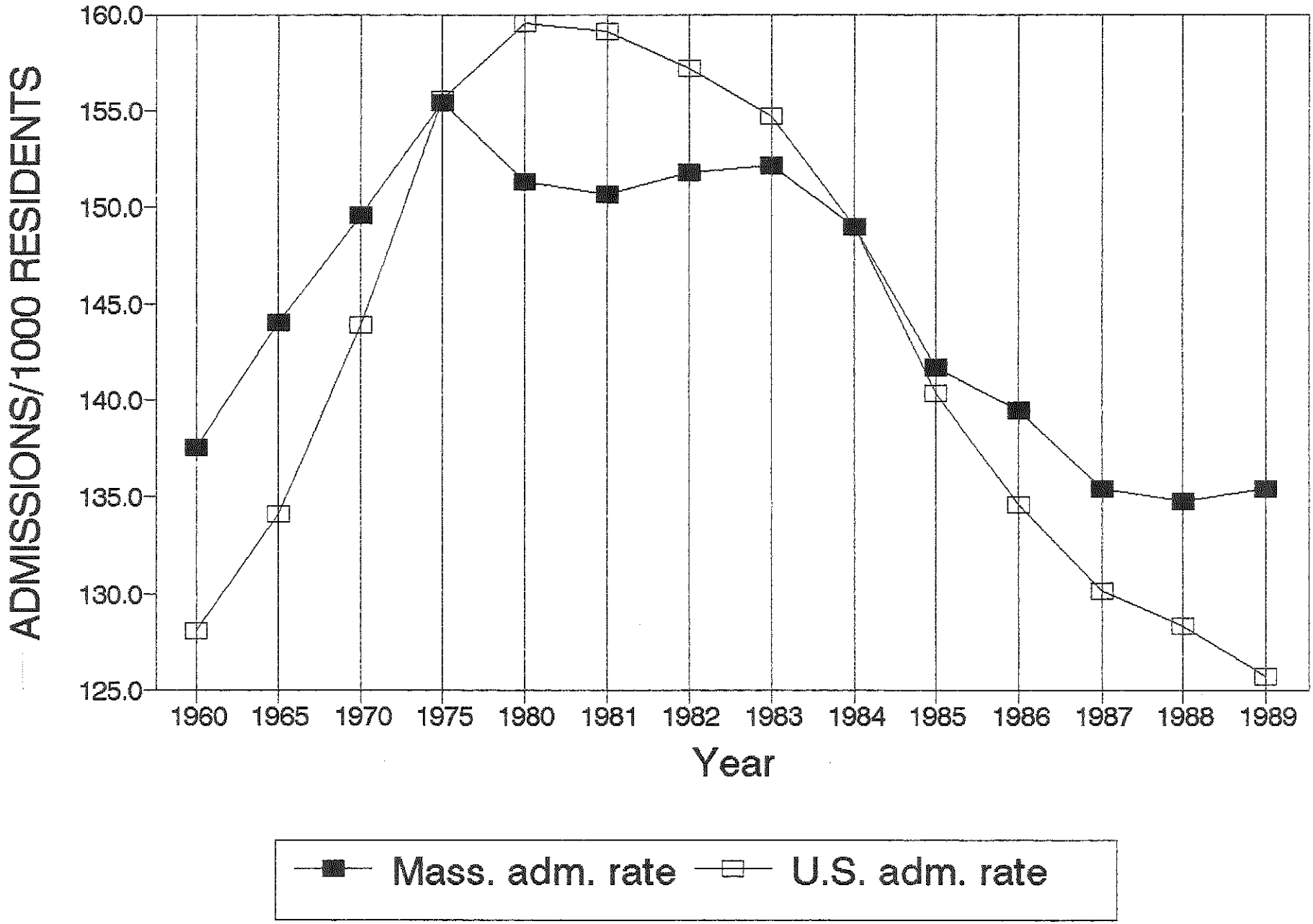


EXHIBIT F-2

OUTPATIENT VISITS, 1975-89 (000s)

Massachusetts, Non-Emergency Only

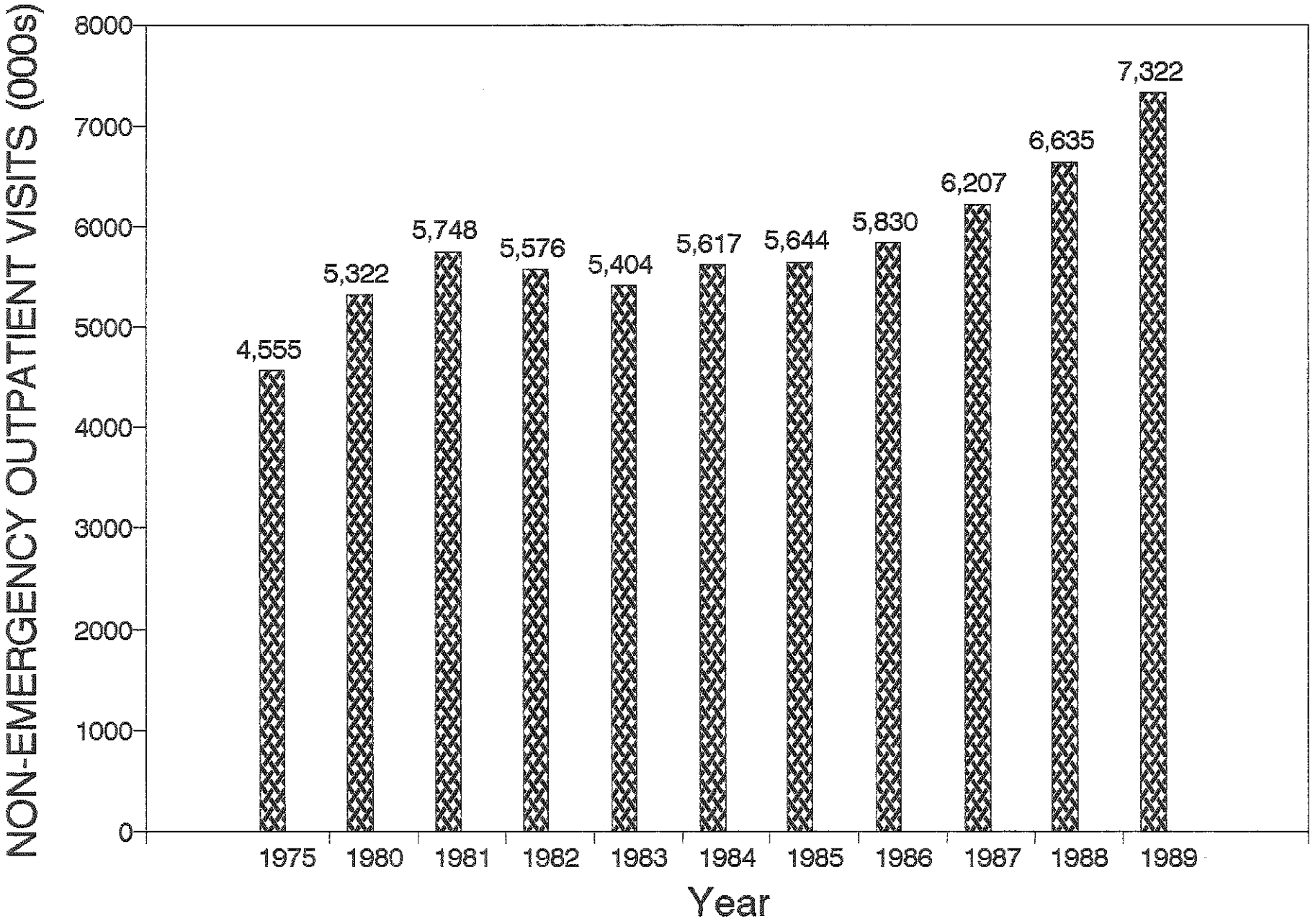


EXHIBIT G

HMO MARKET SHARE AND HOSPITAL COSTS
1980 - 1990

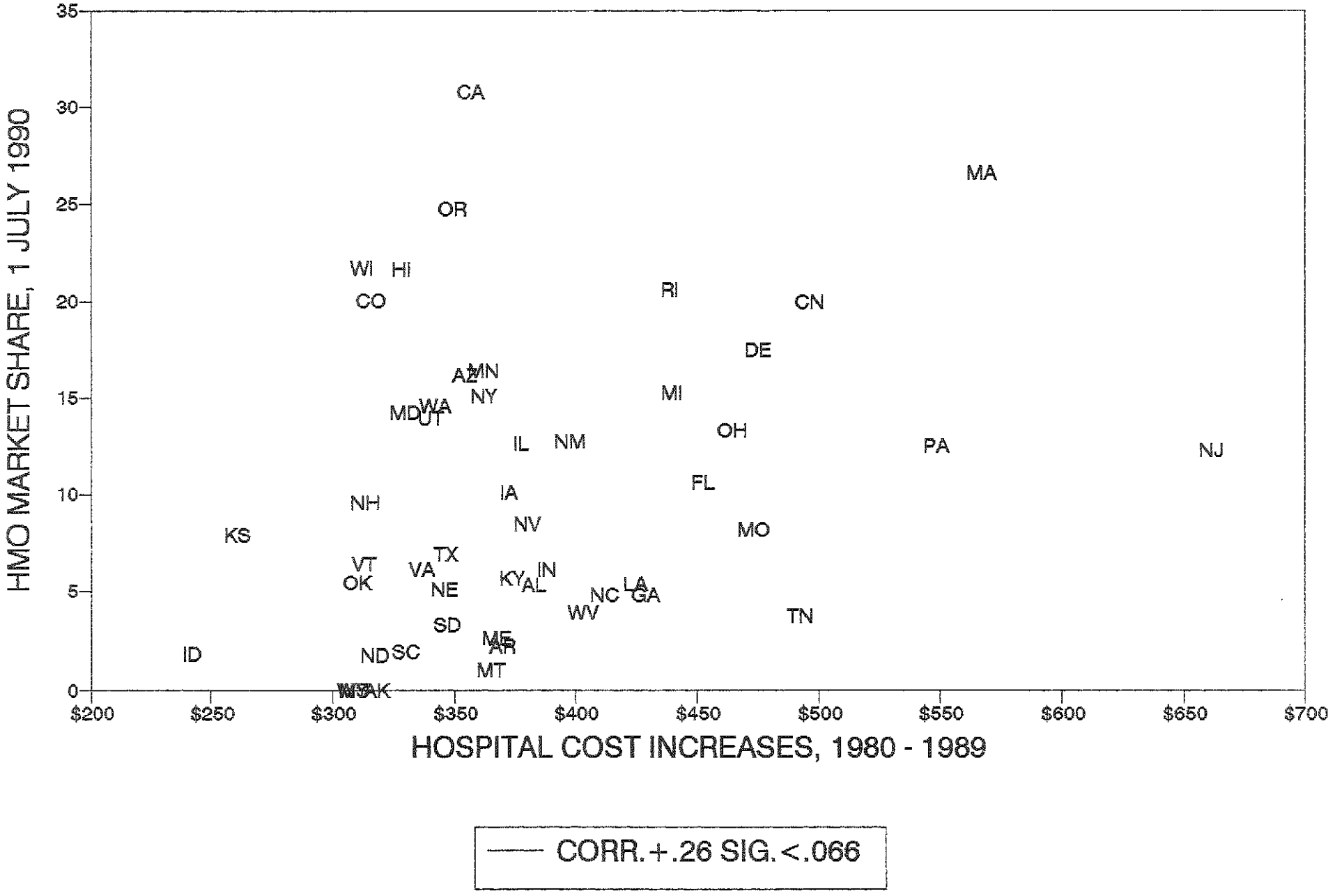
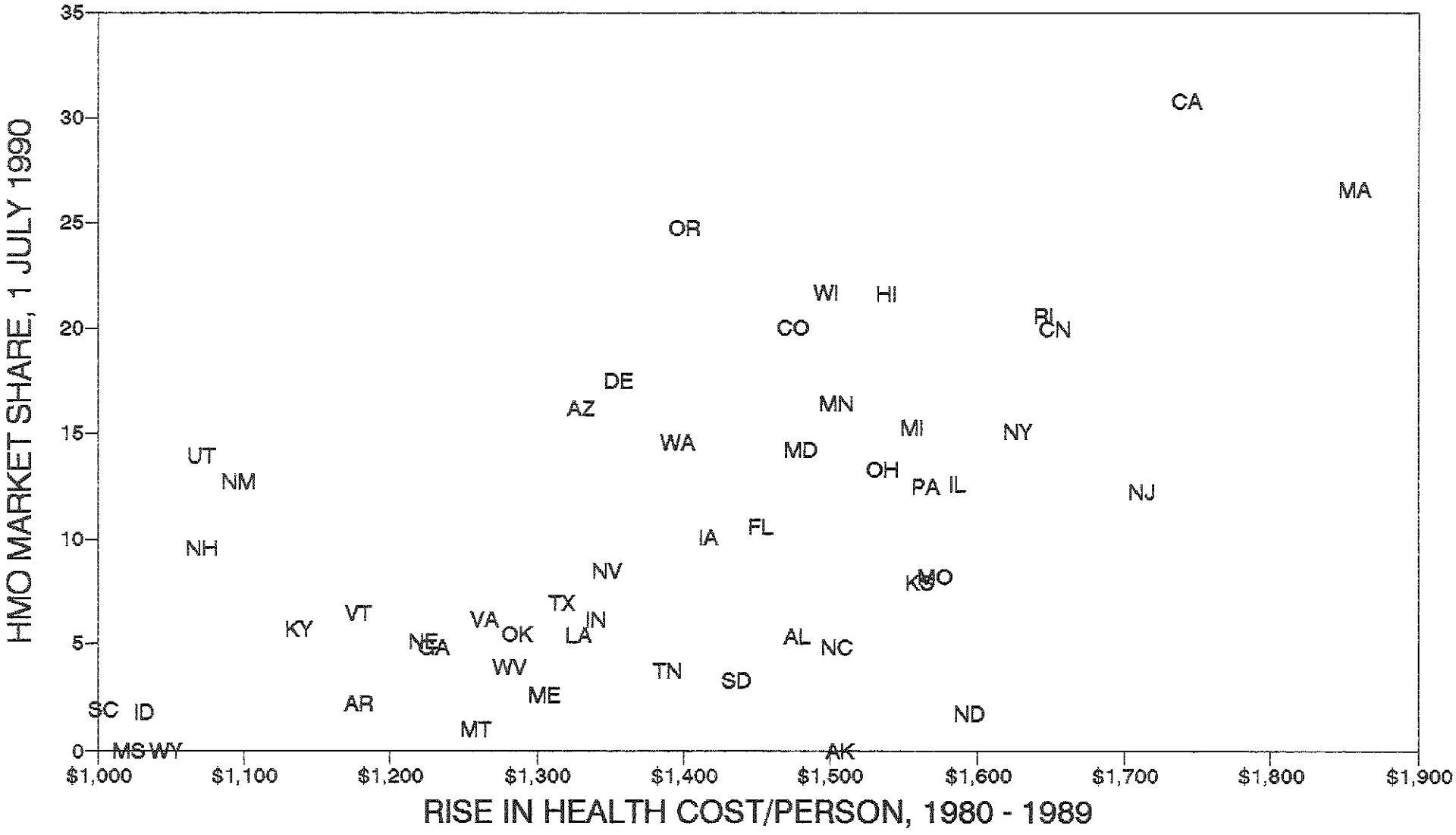


EXHIBIT H

HMO % OF POP. VS. HEALTH COST RISE
1980 - 1990



CORR=+.55 SIG<.000

EXHIBIT I

MARYLAND and MASSACHUSETTS: The Experience with Regulation

The differences between hospital payment rules in Maryland and Massachusetts in the past decade demonstrate that strong and simple regulations save money and protect hospitals. High Massachusetts hospital costs long antedated regulation. Our regulatory efforts to constrain volume and costs made progress in the mid-1980s, as the gap between our hospital costs per capita and the nation's shrank in 1987 to the smallest in decades. But those hospital payment rules were complex and inequitable, inviting contention.

Then in 1988, chapter 23 unleashed our costs, combining competitive incentives that encouraged volume growth with generous regulatory increases in hospitals' rates. It proposed to rely on hospital closures and managed care to save money. From 1987 to 1989, hospital costs per capita rose from 34.5 to 39.7 percent above the U.S. average.

In contrast, consistent and simple regulations over 15 years brought Maryland's hospital costs below the U.S. average, without closing hospitals or compromising quality. Comparing the two states reveals the kinds of regulations that work to contain costs, improve inter-hospital and inter-payor equity, and keep open all needed hospitals.

Maryland's hospital payment method:	Massachusetts' hospital payment method:
1) uses a fair base on which to build future revenue increases and holds all hospitals to fair standards	1) has used 1981 costs as a base since 1983, disadvantaging hospitals that were efficient in 1981
2) -- gives hospitals' predictable, guaranteed revenues, enough for efficient hospitals to stay open -- gives a motive to economize because hospitals keep the money they save -- focuses hospitals on efficiency and quality, not marketing, lobbying, litigating or corporate empire-building -- prohibits cost-shifts and discounts, ensuring that all payors both pay their shares and benefit from cost control	2) -- set caps on allowable revenues, rather than guaranteeing revenues -- closed hospitals as a central cost control technique, leaving them even more insecure and, since 1988, anxious to raise volume; the number of Mass. hospitals has dropped by a third since 1970, while Maryland gained six -- undermined efforts to limit cost-shifts by allowing discounts for HMOs
3) was designed in collaboration with hospitals, so they trusted its rules	3) invited contention, as it was complex, inequitable, and allowed exceptions
4) pays revenue equal to incremental costs only, for volume increases, and subtracts an equivalent amount when volume declines	4) -- adjusted for volume changes using incremental cost, from 1983 to 1987 -- but, to encourage competition, used full average cost since 1988, thus rewarding hospitals that add patients, by paying more than their added costs
5) pays most hospitals' actual cash needs (principal and interest) for capital	5) rewards capital-rich hospitals with unwarrented cash gifts
6) has effectively contained costs -- in ways acceptable to hospitals, doctors, and payors -- for 15 years	6) contained costs for a time, but raised them under chapter 23, while needed hospitals face financial distress