STATE OF PENNSYLVANIA

OFFICE OF THE MAJORITY LEADER

REPORT ON HEALTH LEGISLATIVE ALTERNATIVES

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STATE OF PENNSYLVANIA

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REPORT ON HEALTH LEGISLATIVE ALTERNATIVES

I. Background of the Study

A. Introduction

Early in 1973, the leadership of the majority party in the State House of Representatives identified health care as a major priority item on its agenda. The spiraling costs of health care required the immediate attention of the legislature to determine if legislation was needed to assist in containing this cost rise or if new approaches to delivering health care should be encouraged.

Because of his prior experience in developing analyses for the Cost of Living Council regarding hospital pricing regulations, Thomas O. Jones was asked to assist the Office of the Majority Leader in developing legislative alternatives which would help to alleviate the problem of rising health care costs in Pennsylvania. On a national basis, the inflationary situation in health care is best illustrated by the following statistics, compiled by the Cost of Living Council:

TABLE I

Hospital Price Trends

	Annual Percentage Increase			
	1969	1970	1971	1972
Consumer Price Index, All Items	5.4	5.9	4.3	3.3
Hospital Room Charge	13.4	12.9	12.2	6.6
Hospital Cost Per Day	15.5	13.9	12.3	10.4
Hospital Cost Per Admission	15.5	10.3	10.2	8.9

From the above data, one can see that rates of inflation had been slowed dramatically, by 1972, particularly due to the control programs established by the Cost of Living Council. Comparatively, Pennsylvania was well below the average for the United States in 1971 for hospital costs per day and well below the average for the neighboring states of New Jersey and New York, as follows:

	Average Cost Per Inpatient Day (1971)
United States	$ 92.31
Pennsylvania	$ 85.90
New York	$ 117.08
New Jersey	$ 89.62

The Scope of of Problem

The quality of health care in the United States is probably the highest in the world, however our means of delivering this health care have not kept up with the needs of our population. Besides rising costs, we have severe shortages of health resources in certain areas such as rural communities and the inner city. In summary, then, the problems that need to be addressed are:

1. The rising costs of health care; and
2. The accessability of all our citizens to quality health care.

Controlling the Rising Costs of Health Care

Faced with the inflationary situation in health care costs in 1971 when inflation in general had become a national concern, two approaches were open to state and federal governments. First, government could encourage improvements in productivity through the use of para-professionals, physician assistants, pre-paid group practice plans (HMO's), or incentive reimbursement programs to hospitals.

On the other hand, because there was an immediate need to restrain the spiraling costs of health care, the federal government turned to direct methods of controlling costs by initiating the Economic Stabilization Program and the Cost of Living Council. Several state governments instituted direct regulation of hospital prices and budgets. Later in this report, we will discuss the efforts of California, Connecticut, Indiana,

Maryland, New Jersey and New York in establishing rate-setting commissions or other approaches to direct control of costs.

The Federal Experience under the Economic Stabilization Program

The Cost of Living Council described its experience in controlling hospital care costs in an appendix to its publication of the "Final Phase IV Regulations" in the Federal Register of Wednesday, January 23, 1974, as follows:

"First Attempts at Economic Controls - Phase II

> In 1971 hospital room charges were rising at 13 percent per year, and hospital costs per patient day were rising even faster, at 14.8 percent. The tremendous increase in the use of inputs, especially non-wage inputs, continued, and wage rates were now rising at 10 percent per year. Prices in the general economy were rising faster than at any time in the previous twenty years (at 5.1 percent per year).
>
> The decision was made by the President in the summer of 1971 to place the economy under a 90-day wage and price freeze with a series of phase II economic controls to be established by the end of the freeze. Because of its unique characteristics, the health industry was singled out for separate controls that would deal with the special nature of inflation in that sector of the economy. These controls, issued by the Price Commission in December 1971, were developed in conjunction with the Health Services Industry Committee.
>
> Phase II Controls
>
> The Phase II health controls included regulations for institutional providers of care (hospitals and nursing homes) and non-institutional providers of care (predominantly physicians and dentists). While the goal of the institutional provider regulations was based on the Price Commission goal for the general economy, a halving of inflation rates in each sector, it was impossible to implement health controls that were the same as, for example, shoe controls.

As indicated previously, there are factors other than a narrow definition of price per unit of service that enter the picture; cost reimbursement, technological advance, greater use of inputs, and the ambiguous nature of the product produced by a hospital.

The first major problem was how to correlate hospital care paid for under cost reimbursement contracts with that paid for on the basis of charges per service. Using a limitation of 6.0 percent on increases in aggregate annual revenues due to price increases as the basic control, a per diem limitation of 8.0 percent was instituted for cost reimbursers, with the additional 2.0 percent for increased intensity of services per day. Thus, there was an explicit limit on price increases for both charge paying patients (revenues generated through increases in prices) and cost paying patients (maximum allowable per diem increases in costs). Combined with the 6.0 percent increase in aggregate annual revenues due to price increases was a 5.5% limit on increases in the wage bill, not the wage rate. This meant that additional employees had to be balanced against funds for old workers. This 5.5 percent wage bill increase produced an allowable 3.3 percent increase in total costs. The remainder of the 6 percent allowance was divided between a 2.5 percent increase in non-wage costs (the general goal for the entire economy) and a 1.7 percent factor to allow for increases in expenditures for new technology not directly billed to patient services. This was a residual intensity factor not specifically defined.

The Social Security Administration estimates (unpublished data) that in 1971 about 54% of all hospital care was paid for under cost reimbursement contracts.

Labor costs in a hospital are estimated by the Social Security Administration to be about 60% of total costs."

"Results Under Phase II

The 13 months under Phase II saw a halving in increases in the hospital room and board rates. The semi-private room rate rose only 6.6% during 1972, and only 5.4% between November 1971 and January 1973.

Analysis of just this measure of cost alone would have led one to believe that the problem of health care cost inflation was over. Yet economists, as was demonstrated previously, caution that the average daily service charge omits a large and growing fraction of costs that grows differently. Therefore, it was necessary to review the performance of other indices of cost such as cost per patient day and cost per admission. It became clear that while the rate of increase in room and board rates declined by over 50% during Phase II, cost per adjusted patient day and cost per adjusted admission declined by much less - only about 25%. What appears to have happened was that hospitals were willing to sacrifice some part of price increase revenues from charge payors as long as they knew that cost reimbursers were still there to pay the majority of the bills.

The Phase II regulations produced some unusual results in hospitals especially during the extension periods of Phase III/IV in 1973. Hospital charge increases were contained, and revenue increases from charge payors reduced accordingly. On the other hand, costs continued to increase at almost the pre-ESP rates. To the extent that they found them reasonable, cost reimbursers were continuing to reimburse for all incurred costs, thereby assuming a relatively larger share of reimbursed expenses than they had in the past. Aside from the general implications to the system this result was of special concern to the public programs such as Medicare and Medicaid. Although it is difficult to explain the reasons behind this result with any precision, it is also clear that admissions increased under Phase II. Whereas in 1971 admissions had only risen .4 percent and patient days went down 1.5 percent, during 1972, admissions rose 2.6 percent and patient days increased 1.8 percent. The trend toward shorter length of stay did, however, continue.

Phase IV Controls

The Phase IV hospital controls switch the emphasis from individual prices as a proxy for costs to a more aggregate measure of price - total cost of a hospital stay. Under the Phase IV regulations, changes in the number of admissions is used as a means of adjusting the hospital's volume of services and allowable cost increases.

Two important departures from the Phase II system are the separate treatment of increased costs due to new and approved capital expenditure and the separation of the controls on inpatient and outpatient services. The Phase II system had included a single 6% control limit which was to be an average for every hospital service.

For the institution that was not expanding, such a limit was more than sufficient to meet its expenses. However, new construction generally requires a new pricing structure, and that required an exception which was not easy to obtain. Further, complicating the situation was the fact that it was often impossible, to obtain financing unless some assurance could be given that when the project was completed, the hospital pricing structure could be changed. Such an assurance was generally unobtainable, even in the exceptions process.

The Phase IV health regulations now provide that an institution planning a capital expenditure of more than $100,000 can recover such costs if it has demonstrated the need for the project and the reasonableness of the costs. The approval of the state agency designated under section 1122 of the Social Security Act (comprehensive health planning provisions) is to be taken as demonstration of community need. This change makes the process more reasonable and manageable since capital allowances are included in addition to those allowed for current operations. The new provisions also reinforce the development of area-wide and state-wide planning activities rather than the continued predominance of Federal controls.

In order not to discourage the trend towards increased use of outpatient services, a separate limit of 6 percent was established for hospital outpatient services. Such a limit could be implemented either on an aggregate weighted (by service) basis, similar to the physician limitations, or a 6 percent increase across the board for all services. This provision does not place any limits on the amount of outpatient services provided.

The controls dropped the requirement of cost justifying all price increases in order to maximize managerial flexibility. The only internal cost constraint remaining is the 5.5% wage limitation plus all allowable fringe benefit increases."

B. *Objectives of the Study*

This study has been designed to determine what actions might be taken by the Pennsylvania House of Representatives to control the rising costs of health care, to improve the allocation of scarce health resources, and to assure access to quality medical care for all of our citizens. Specifically, our study objectives are as follows:

1. *Review the major legislative alternatives in the health area that can affect the overall objectives stated above.*
2. *Review, in brief, the efforts of other states in applying direct controls in the form of rate regulation to hospitals.*
3. *Develop a plan for meeting the legislative needs identified above and begin writing appropriate legislation.*
4. *Integrate the state plan with current regulations and thinking at the federal level.*

C. *Review of Major Legislative Alternatives*

Over the past eight months, we have worked closely with the staff of the Majority Leader to identify legislative needs in the health area for the State of Pennsylvania, focusing our efforts on the following items:

1. Modification of current legislation to encourage the establishment of Health Maintenance Organizations (HMO's);
2. Physician Assistants;
3. Certificate of Need and Licensure;
4. Hospital Rate Regulation.

Federal Government Initiatives

In deciding which bills to submit to the legislature, it will be important to keep aware of major federal legislative issues and the research which is now being undertaken to define these issues. In this report, we will outline a number of major study efforts which could help the Pennsylvania legislature in their deliberations.

Specifically, the changing federal role can be defined by the following new administrative and legislative initiatives:

1. The Cost of Living Council has developed and announced a new set of cost control regulations under Phase IV of the President's Economic Stabilization Program. The major thrust of these regulations is to hold down the costs of hospital stays by providing some incentives to reduce length of stay and substitute outpatient care for more costly inpatient care.

2. The Professional Standards Review Organization Program (PSRO) has been created under Section 249 of Public Law 92-603 passed at the end of 1972 to develop safeguards against overutilization of expensive hospital facilities and to encourage the use of lower cost health services wherever possible.

3. A new HMO bill was signed by the President only a week ago to encourage the creation of approximately 100 demonstration HMO's to provide further insight to the Congress as to whether this innovative approach can improve the delivery of health care with built-in incentives for effective use of high-cost facilities.

4. Utilization Review will be required for all cases covered under Medicare and Medicaid.

5. The U.S. Department of Health, Education and Welfare has initiated two major contractural efforts to evaluate first, the effectiveness of prospective rate setting as practiced in twenty or more locations throughout the country and second, the effectiveness of State and Regional Health Regulation in three areas -- health facilities expansion, provider costs, and health insurance.

6. *It is widely expected that the Administration will submit legislation to the Congress in January for a National Health Insurance system.*
7. *Legislation is being prepared by Congressman Roy, with administration support, to create Regional Health Authorities which will assume the responsibilities of the Comprehensive Health Planning agencies and the rate regulation aspects of the COLC.*

Overall Strategy Alternatives

The basic overall strategies can be broken down as follows:

1. *Develop and write separate bills for each of the areas identified earlier on page 9.*
2. *Since the Certificate of Need and Licensure portions are acceptable to most of the interested parties, this bill should be submitted as soon as possible to take the initiative and obtain passage of a bill which can help to stem the rising costs of health care.*
3. *Since the spiraling cost of health care is the major public issue, a comprehensive bill covering certificate of need, licensure and hospital rate regulation should be written and submitted to the legislature as soon as possible.*

4. *Since the federal government has made so many recent moves in the area of rate regulation, the state should hold off introducing new legislation for rate regulation until the furor over Phase IV subsides and the evaluation of prospective rate setting has been finished.*

5. *Since the New York State law seems to have been the most effective state cost control law in the nation, the Pennsylvania legislature should write a bill incorporating the best aspects of the New York State law, the federal Cost of Living Council regulations, and those other suggestions which might include incentive payments to health providers for holding down the overall costs of health care.*

6. *Develop a step-by-step legislative plan, detailing those bills that the majority plans to submit to the legislature. This plan would emphasize the need for a balanced step-by-step approach for solving current health care delivery problems. Some effort at making the public aware of these overall plans could gain wide-spread support for this strategy.*

II. Hospital Rate Regulation: Brief Review of Other State Laws

Very basically, no real market mechanism exists in the field of medical care. Over two-thirds of all hospital payments are made by third party reimbursement on the basis of "actual cost to the provider". Unfortunately, very little incentive exists to hold these costs at reasonable levels, since it is well known by providers, unions and doctors that most, if not all, cost increases can be passed on to the consumer, whose bills will be paid by a third party.

It has become increasingly clear that some form of rate regulation for hospitals is the only effective method of controlling inflation. The evidence in states such as New York indicates that rate regulation can be effective in controlling inflation in health costs.

State Regulatory Experience

Several attempts have been made by State government to provide legislation and regulations that would hold down the rate of increase in costs. The following states have initiated legislation within the past 5 years: New York, California, Maryland, Massachusetts, New Jersey, Rhode Island, and Connecticut. In addition, several states, such as Indiana, have developed voluntary approaches to cost control.

New York passed a tough hospital reimbursement control law in 1970 and amended it in 1971. There is no doubt that this law has been instrumental in slowing the

rate of inflation in New York State. A recent article in the Washington Post quoted a New York State official as saying, "Hospital charges were rising as much as 17% a year before the law but only 7% per year after the law went into effect." Our studies of a large teaching hospital in New York City indicate that hospital expenses were rising at a rate of 30% per year before the law went into effect, and this rate of increase slowed to 15% the first year after the law was passed.

The Expected Benefits of Rate Regulation

1. The fiscal responsibility for setting reasonable prices for hospital care is established with each hospital's administrator and Board of Trustees.

2. The Rate Regulation mechanism is the best process for communicating the public's general concern about the rising cost of providing medical care.

3. Increases should be held to reasonable levels until alternative methods of providing care are developed.

4. Uniform reporting of financial information.

Methods of Regulation

1. *Setting of prospective rates with adequate appeal mechanisms and incentives to keep total costs within a certain fixed amount.*

2. *Prior approval of line-item budgets.*

3. *Price regulation.*

4. *Capital Expenditure control.*

Administrative Alternatives

1. *Establishment of an independent Hospital Commission*
    a. *reporting to the Governor;*
    b. *reporting to the Secretary of Health.*

2. *Setting responsibility with Department of Health*

A. *California*

In 1971 California passed the California Hospital Disclosure Act to require all hospitals to file for public disclosure a uniform report of hospital cost experience. In early 1973, several bills have been filed relating to rate setting with the following objectives:

1. *Establishment of a system to retard inflationary cost increases for health care;*

2. Establishment of a single approval authority for construction of new health care facilities:

3. Reconstitution of areawide health planning agencies; and

4. Establishment of a system to certify health services.

B. Connecticut

On April 30, 1973, the State of Connecticut enacted and signed into law "An Act creating a Commission on Hospitals and Health Care". The commission will consist of fifteen persons, chosen as follows:

Appointed by the Governor (nine persons)

	Names submitted by
1	Connecticut State Hospital Association
1	Connecticut Nursing Home Industry
1	Connecticut State Medical Society
6	Public at large

Appointed by Speaker of the House

1

Appointed by President Pro Tempore of the Senate

1

Ex Officio Members (four persons)

1	Commissioner of Health
1	Commissioner of Mental Health
1	Commissioner of Insurance
1	Commissioner of Finance and Control

The Commission is authorized to conduct inquiries and to carry out a continuing state-wide health care facility utilization review, including a study of existing health care delivery systems. Effective July 1, 1974 every hospital must submit to the commission proposed annual operating and capital expenditure budgets at least ninety days prior to the proposed adoption date of such budgets.

In addition, the law provides for public hearings on requests by hospitals for price increases beyond those limits set in the law (6% increase for any one year or 10% increase for any two years in its per diem room rates or its aggregate special services charges per patient). Filing of reports will be required for capital expenditures in excess of $25,000 but less than $100,000, with approvals within 30 days. For proposed expenditures of $100,000 or more, the commission requires ninety days to hold hearings and either "approve, modify or deny such request."

C. Indiana

In 1959, the Indiana hospitals, in concert with Blue Cross, established a voluntary system to review rate increase requests based on careful review of proposed operating budgets and other supporting financial data.

The process is controlled by a Rate Review Committee which serves as an extension of the Blue Cross Board of Directors. Members of the Committee are selected by the

Chairman of the Blue Cross Board of Directors, under the following guidelines:

Number of Members	Representing
2	Voluntary, non-profit hospitals
2	County hospitals
2	Catholic hospitals
2	Blue Cross Board Members (not hospital administrators)
5	Public at large

The Indiana System has been effective in holding down cost increases. Over the 10 year period from 1958 to 1968, per diem cost increases in Indiana hospitals were almost 25 percent less than the national increase.

D. Maryland

Maryland's Senate Bill 359 established a seven-member, quasi-judicial, independent Health Services Cost Review Commission appointed by the governor and charged with causing, beginning July 1, 1971, public disclosure of the financial positions of all hospitals and related institutions (nursing homes included), and the verified total costs actually incurred by each institution in rendering services.

Beginning July 1, 1975, the commission shall assure all purchasers of health care institutional services that the total costs of the institution are reasonably related to the total services offered by the institution; that the institution's aggregate rates are set in reasonable relationship to the institution's aggregate costs; and that rates are set equitably among all purchasers of services without undue discrimination.

It is also the commission's permanent responsibility "to keep itself informed of whether the financial resources of each institution are sufficient to meet its financial requirements, and to concern itself with solutions when resources are inadequate."

E. New Jersey

In August 1972, New Jersey's "Health Care Facilities Planning Act" became law, wherein the Department of Health was given "central comprehensive responsibility" for the development and administration of the state's policy with respect to (1) health planning, (2) hospital and related health care services, and (3) facilities providing those services.

The act provides for:

1. Licensing of health care facilities;
2. Certificate of need;
3. Uniform System of cost accounting;
4. Uniform reporting;
5. Preparation of annual long range plans; and
6. Prospective rate setting by the Commissioner of Insurance with the approval of the Commissioner of Health.

The act further provides for the establishment of a Health Care Administration Board, with eleven members, six of whom currently have some provider connections or background.

In Appendix E of the report, we have included a comprehensive report on the New Jersey experience, which was prepared for Blue Cross by Anne R. Somers.

F. New York

In early 1969, the New York State legislature passed the Hospital Cost Control Law, which froze medicaid rates for the remainder of the year. Later, after the 1969 fiscal year had ended, that provision was declared unconstitutional. The law also declared

"that it is essential that an effective cost control program be established which will both enable and motivate hospitals to reduce their spiralling costs," and directed the Commissioner of Health to "determine and certify to the Superintendent of Insurance and the State Director of the Budget that the proposed rate schedules (Medicaid and Blue Cross rates) for payments to hospitals and providers of health-related services are reasonably related to the costs of efficient production of such service."

Following hearings and a workshop conducted by the Health Department and the Hospital Review and Planning Council during the summer of 1969, an interim formula was promulgated in November for the first half year, starting in January 1, 1970. The current method of setting prospective rates is based on each hospital's submission of prior year's costs and service data on a Uniform Financial Report (UFR) to the Health Department. A standard cost allocation procedure produces the cost of inpatient service (routine daily care and ancillary), the cost of outpatient clinics, emergency service and private ambulatory.

Since hospitals are grouped by location, number of patient days, and number of residency programs, a weighted average of the routine component of each group's per diem cost can be calculated. If a hospital exceeds the group average per diem cost by 10% or more, its costs are reduced accordingly in calculating the prospective rate. A fixed prospective rate is calculated for each unit of service (inpatient day, outpatient visit, emergency room visit) using a factor which reflects inflation, but makes no allowance for any increases in

III. CONCLUSIONS AND RECOMMENDATIONS

We have attempted to briefly describe in this report the major activities that have taken place across the country in the field of holding down the "spiralling costs of health care" through state o federal government regulation of health care providers. As we mentioned earlier, government's involvement can take the form of (1) providing incentives, or (2) restraining costs through direct controls. We greatly favor the first approach where it is at all feasible and two parts of our proposed package of health care legislation lean more towards this market-oriented approach - the HMO Bill and the Physician's Assistant Bill. However, based on the evidence of the success of state hospital rate regulation in New York State and the apparent success of the Economic Stabilization Program in the health care field over the past two years, we can only conclude that some form of regulation of hospital rates is the only way to effectively hold down the costs.

Clark Havighurst, writing in the Virginia Law Review of October 1, 1973, discusses "the ultimate health policy choice between health planning -- cum - regulation and a more market-oriented system which relies primarily on decentralized decisions by providers, consumers, and insurers." But no matter how much we might favor the free market approach over the public utility concept, it becomes more and more evident that hospitals do not really exist in a "market" as we know it in business. Patients tend to accept whatever the price might be and they have little ability to discern quality differences between hospitals. In fact, their physician usually selects the hospital for them, and the bill is paid by a third-party insurer or government agency in most cases.

The prepayment for health care under an HMO type of agreement is the first step towards introducing a market economy into the field of health care. Unfortunately, however, there are monumental tasks to be completed before this becomes widespread or before other "market" techniques take hold.

In the meantime, to protect our citizens from the inequities inherent in an uncontrolled inflation in health care costs, some form of regulation should be instituted. At the same time we are proposing that other forms of incentives be provided to develop a more market-oriented health care system where consumers can make choices on the basis of price and quality.

Recommendations:

We recommend that the Majority prepare a set of separate bills, aimed at providing solutions to specific problem areas. We believe that this approach will allow necessary discussion to begin quickly on separate issues and hopefully, the most critical bills can be passed by the Legislature as quickly as possible. Each of the bills, however, fit into the overall strategy of developing methods to control rises in hospital costs and encouraging new methods of delivering health care in a more effective manner.

We recommend the submission and passage of the following set of bills:

1. *To control the inflation in health care costs without reducing the quality of care being delivered:*

   (a) *The Physician's Assistant Bill (H.B. 1468, 1469)*

   By allowing for the licensing of Physician Assistants, doctors

should be freed from providing minor medical procedures to concentrate on more critical treatment procedures.

(b) The Certificate of Need and Licensure Bill (H.B. 1710)

Certificate of Need legislation can help to insure that hospital facilities are constructed in a rational manner so that communities are not faced with the expense of maintaining excess capacity because of overbuilding and duplication of services.

(c) A Revised HMO Bill (H.B. 1919)

The new bill encourages the formation of new HMO's, on both a non-profit and profit making basis. As discussed earlier, the HMO approach probably offers the best hope for reducing the overall cost of medical care in the long run.

(d) The Hospital Rate Regulation Bill (H.B. 2018)

This bill includes provisions for both prospective rate setting, which provides management incentives to hospitals, and incentive reimbursement rewards, which provides financial incentives to improving the effectiveness of hospitals.

2. To correct the situation in hospitals, whereby medicaid patients tend to be served on an inpatient (more costly) basis, rather than on an outpatient basis (lease costly), the Majority should submit a bill allowing for the reimbursement of reasonable outpatient costs per visit for medicaid recipients. This could probably be submitted in the form of an amendment to H.B. 609.

There could be an initial increase in costs to the Medicaid program because of this amendment, however there is good reason to believe that it would reduce the use of inpatient facilities for these same patients.

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