Protecting Needed Hospital Capacity in Massachusetts

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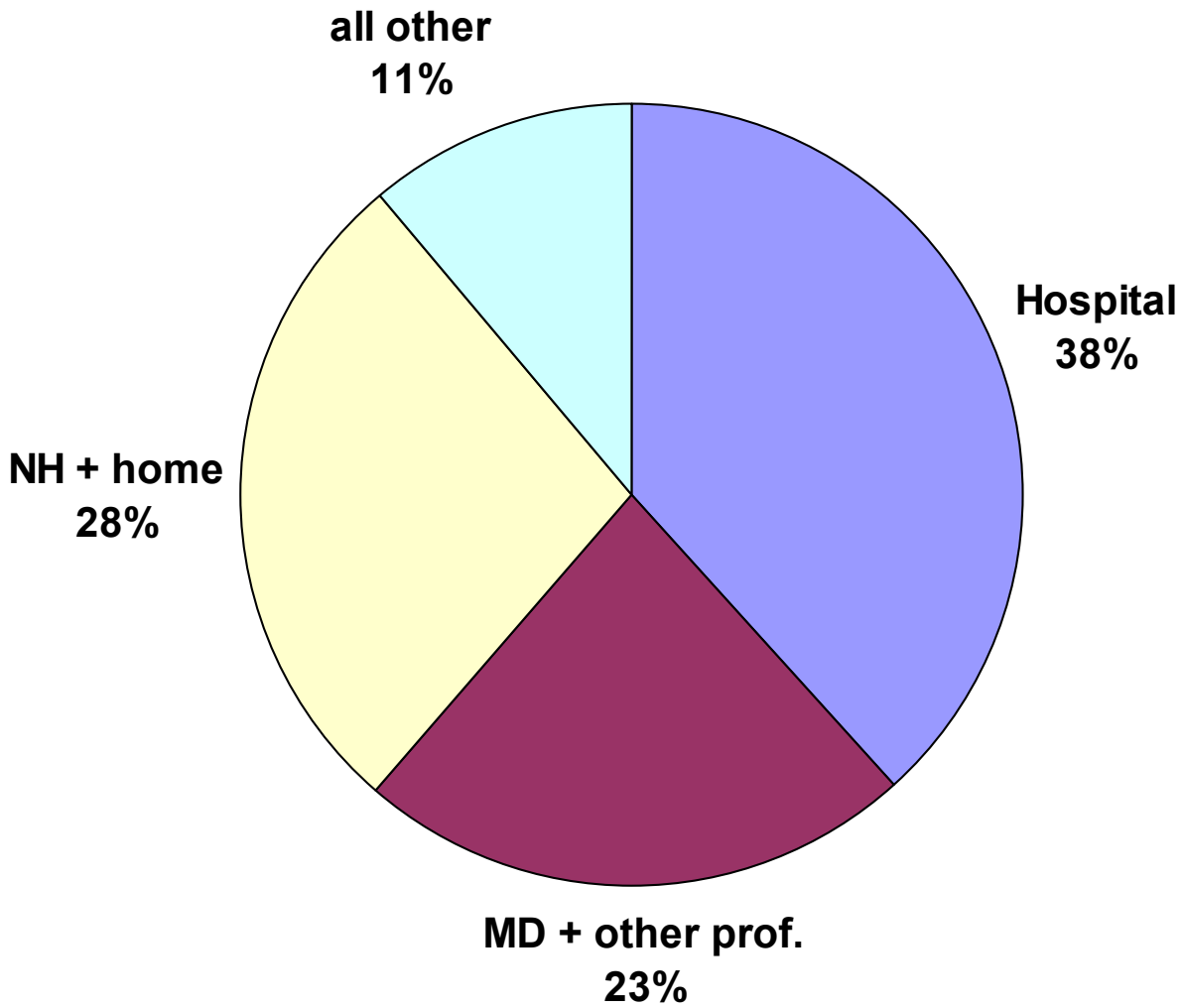
Themes

- Too few beds - too many - too few
- Bed adequacy and ER capacity problems are embedded in hospital problems, which are embedded in health financing problems
- Paradox of high spending but distress
- No market + no government = anarchy
- One hand for yourself and one for the ship
- Immediate + durable solutions
- Targeted relief to save each needed hospital

Context -- High Mass. Health Cost

- $80,000/minute * 525,000 minutes/year
- if spend at U.S. mean, save $9 billion (2002)
  - Massachusetts excess by sector
- premiums rise from $6,000 to $9,000
- family premium share rising much faster

ALLOCATION OF $6.9 BILLION IN EXCESS MASS. HEALTH SPENDING, ABOVE U.S. RATE, 1998



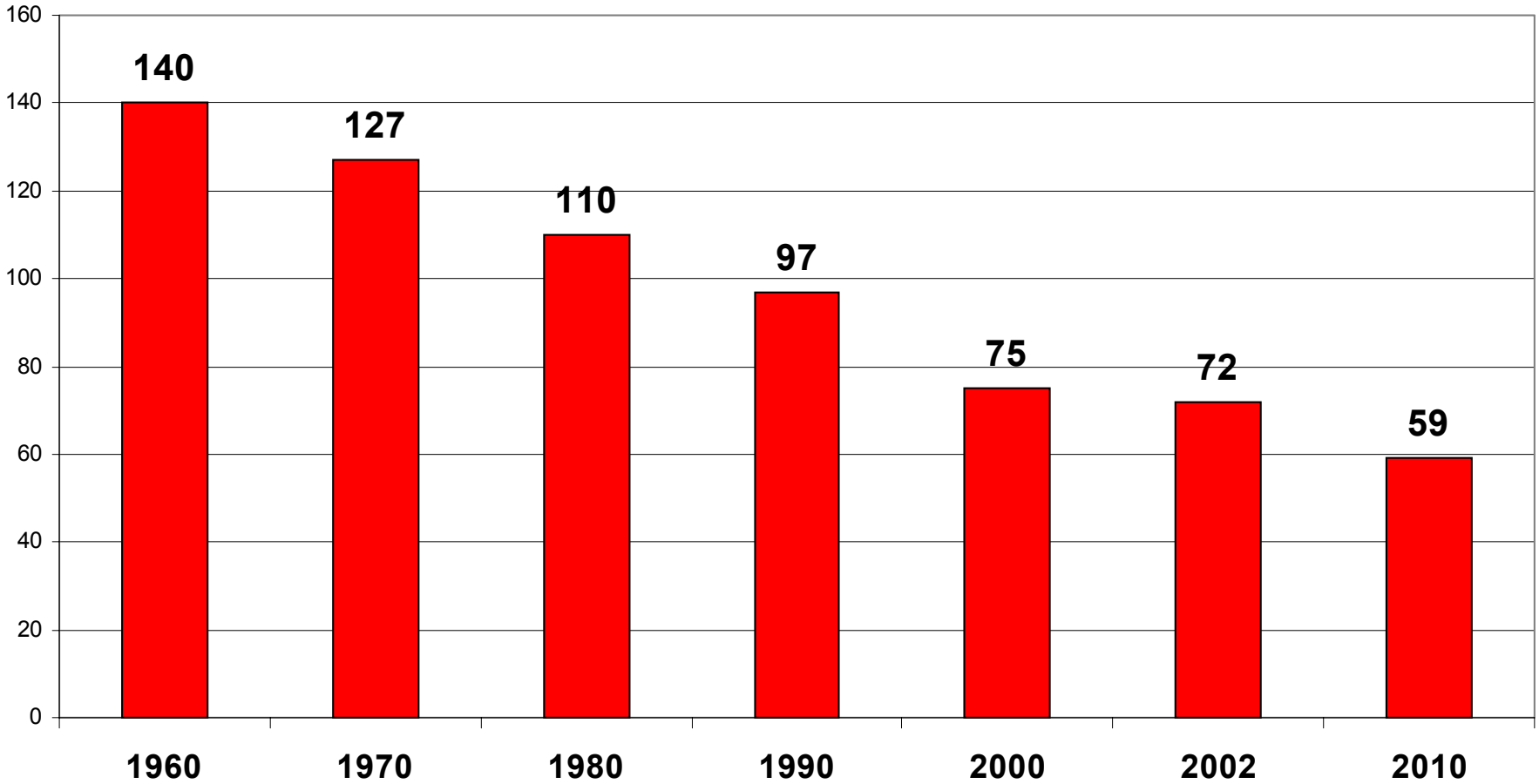
Problem: Caregiver Malconfiguration and Financial Distress

- Massive hospital closings and bed cuts
- Financial distress for many hospitals, nursing homes, and physicians
- Cost of bringing Mass. caregivers up to U.S. levels

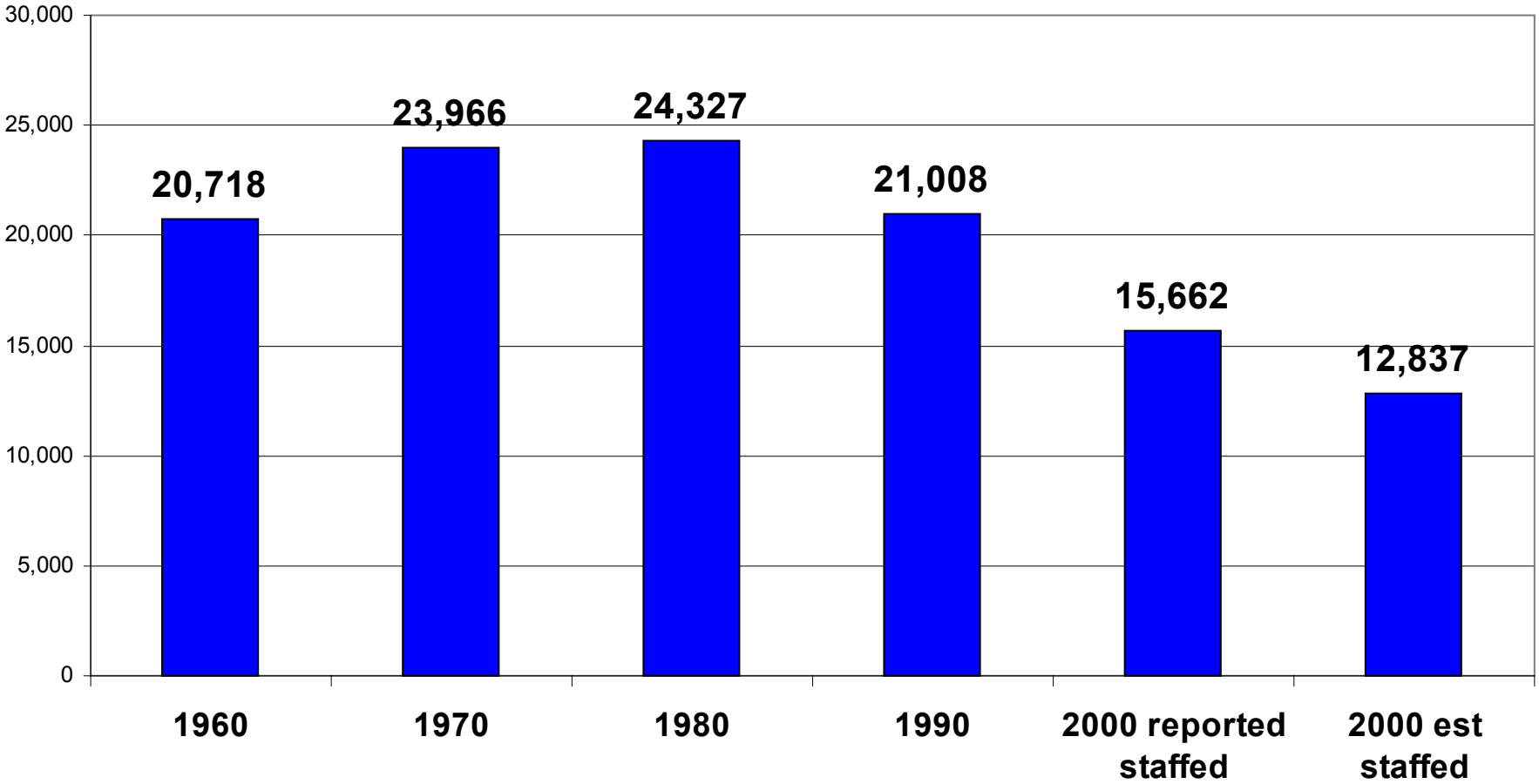
Do we face a crisis?

- Massachusetts has lost one-half of our hospitals since 1960
- And half of beds since 1980--shortage looms
- Most surviving hospitals are said to be losing money
- ER diversions and boarding are at levels widely considered to be unacceptable
- bad flu season = ambulances circle in the snow

MASSACHUSETTS ACUTE CARE HOSPITALS, 1960 - 2010



MASSACHUSETTS ACUTE HOSPITAL BEDS, 1960 - 2000



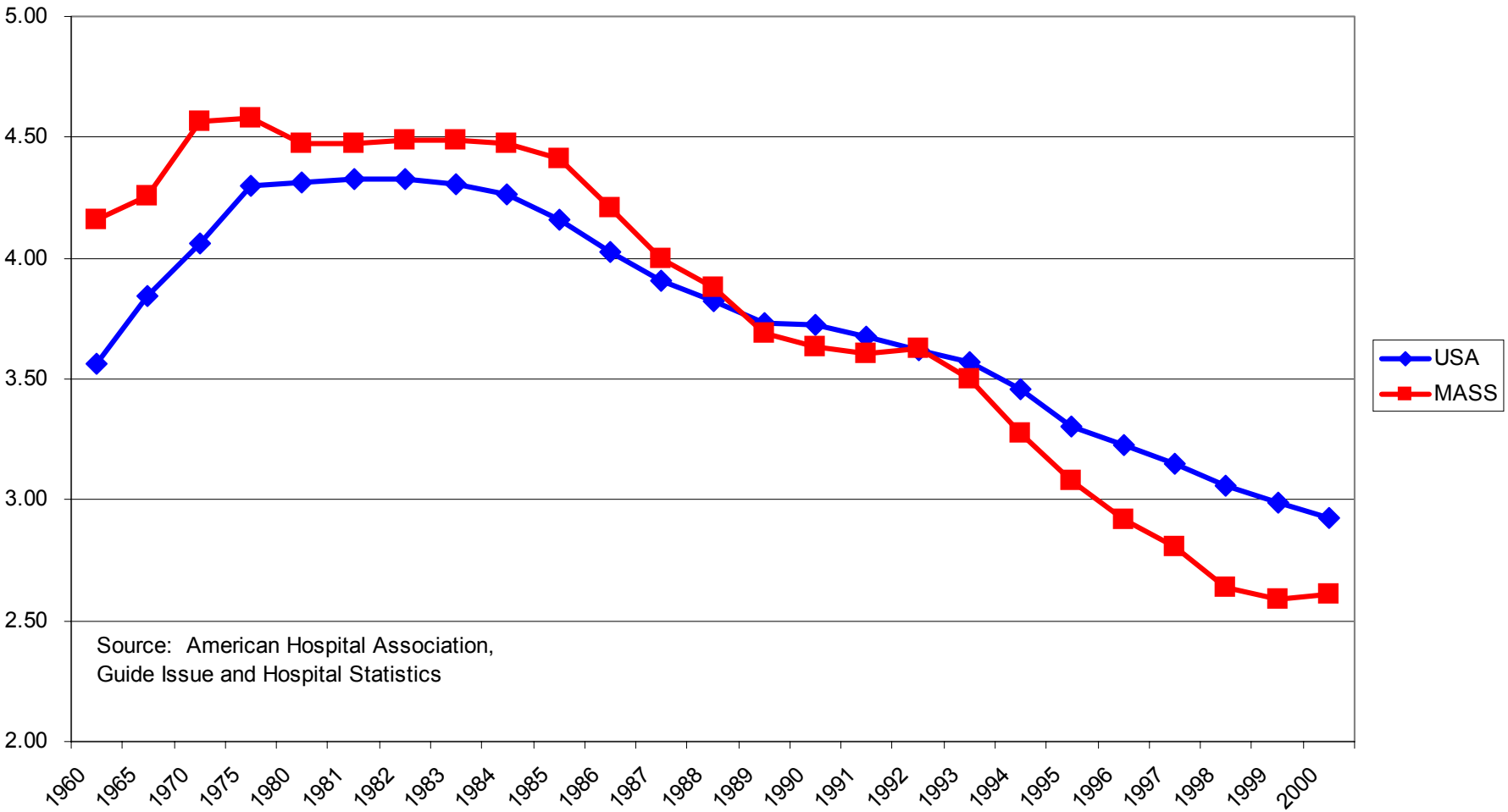
Paradox of high spending but financial distress

- Massachusetts hospital spending per person is highest in the world, but many individual hospitals lose money
  - Inadequate revenue or excessive cost?
- Nursing homes' problems
- Physicians' problems
- Patients'/employers' problems in paying soaring premiums

Do we face a hospital capacity crisis?

- Once we had too few beds
- Then we built more and had too many
- Unless something changes, we face an acute shortage of acute beds associated with
  - lack of physical capacity,
  - lack of right types of beds in right places,
  - lack of nurses to staff beds, or
  - lack of money to serve patients in them

REPORTED ACUTE BEDS PER 1,000 CITIZENS, U.S.A. AND MASSACHUSETTS, 1960-2000

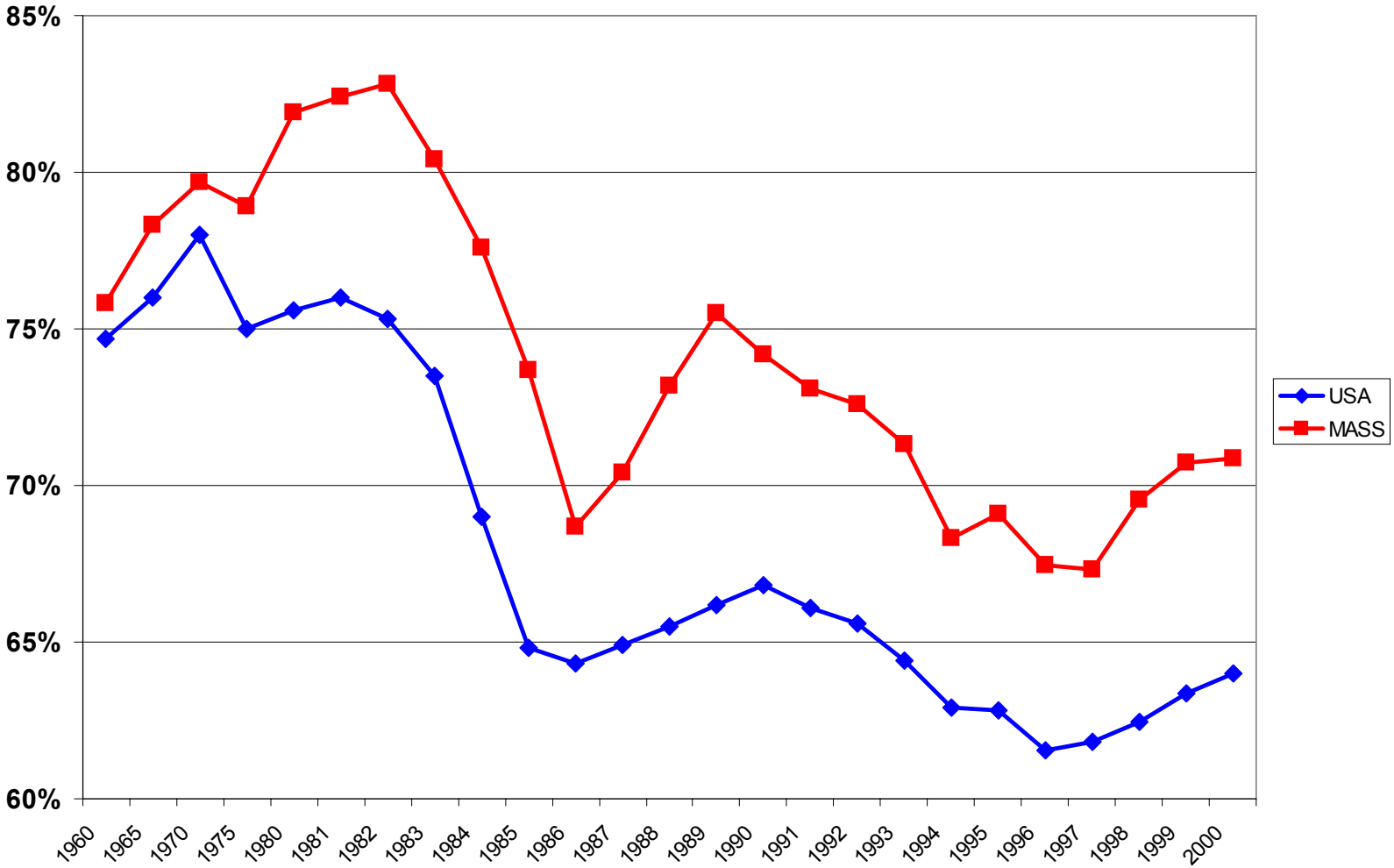


Closing hospitals and beds does not seem to save money

- Mass. hospital beds/person
  - 1988 = 1.5% above U.S. average
  - 2000 = 10.7 % below (26 hospitals closed)

- Mass. hospital cost/person
  - 1988 = 38.3% above U.S. average.
  - 2000 = 38.6 percent above

REPORTED HOSPITAL OCCUPANCY RATES, USA AND MASSACHUSETTS, 1960-2000



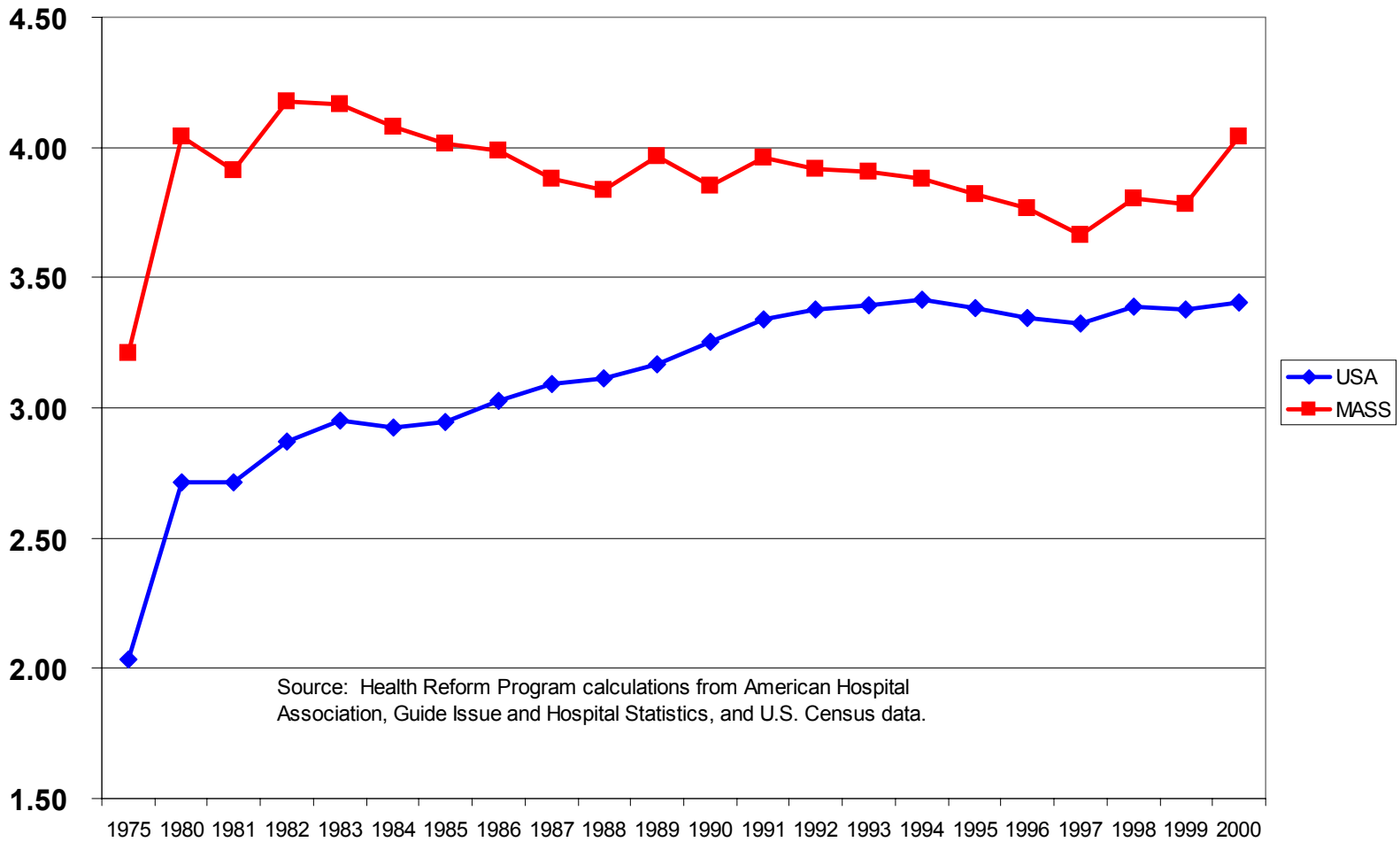
Hospital bed data are unreliable

- At one time, hospitals reported licensed beds
- Are now supposed to report beds "set up and staffed," but often still report licensed
- Some hospitals claim they staff only occupied beds, so they always run 100 % occupancy rate
- Legislature refuses to obtain reliable data

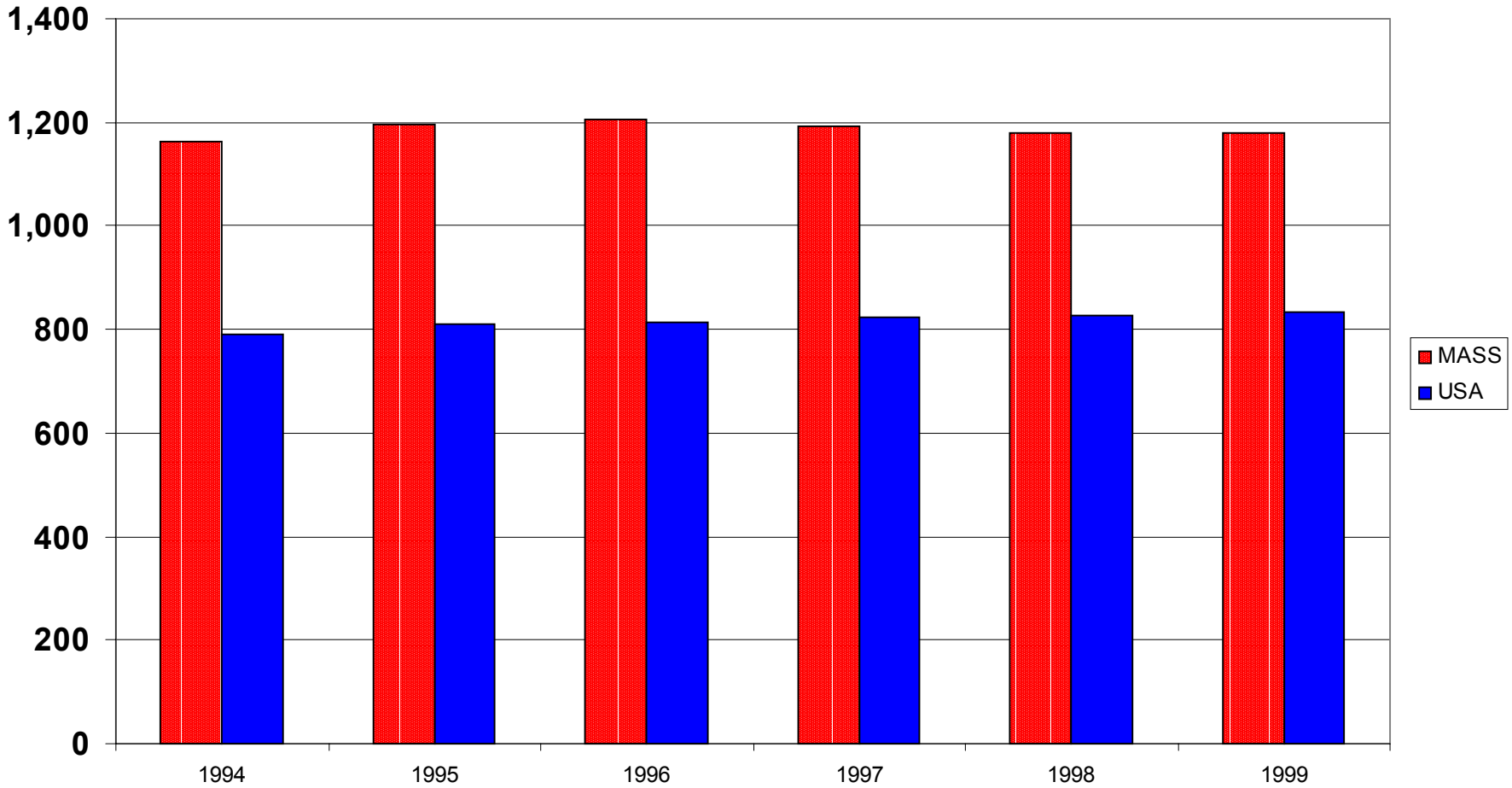
Why a shortage of nurses?

- Fluctuation between surplus and shortage
- Surplus deters new students
  - New students cover 2nd and 3rd shifts
- Shortage attracts, but training takes time
- Is pay adequate? Can hospitals afford more?
- Have working conditions changed?
  - Much greater share of high acuity patients
  - Less chance to help patients recover, to nurse
  - Tighter staffing ratios relative to need, no slack
- Still, Mass. 2nd in nation in total RNs/capita

HOSPITAL RNs PER 1,000 CITIZENS, USA AND MASSACHUSETTS, 1975 - 2000



TOTAL RNs PER 100,000 CITIZENS, USA AND MASSACHUSETTS, 1994 - 1999



Do our caregivers face a crisis?

- Our hospitals, nursing homes, and other caregivers entered the 2001 recession with dangerously low financial margins
- They chose not to/were not able to improve their margins during the prosperous 1990s
- During the recession, Medicare, Medicaid, and employers lack dollars
  - Hard to raise taxes during recession
  - Raising premiums could force loss of coverage

Estimated Cost of Bringing Mass.Caregivers up to U.S. Incomes/profits, 1999

• Hospitals	$	570,000,000
• Physicians	$	1,425,000,000
• Nursing homes	$	200,000,000
TOTAL	$	2,195,000,000

Problem: Access

- Mass. uninsured doubled 1987 - 1994
- Then fell with booming economy and surging Medicaid eligibility
- Expect many more uninsured people with rising premiums and sinking economy
- Health insurance premiums have risen 50 percent in four years, 1998-2002
- Workers' dollar payments for health insurance are up 24 %, 2001-2002

Causes: High Costs

- Caregivers and patients don't want the job of containing costs
- Much inpatient care in teaching hospitals
- Much outpatient care in hospitals
- Closing of lower-cost community hospitals
- Failure of HMOs and price competition (and hospital closings) to save money durably

Competition does not work

- More efficient hospitals likelier to close
- So are those in minority/lower-income areas
- Teaching hospitals likelier to remain open
- So are hospitals with more money in bank
  - "Survival of the fattest"?
- Public regulation could not close hospitals, but competition can't stop closing them

MHA boosted market and opposed protecting hospitals

- There have been "no untoward results either on patients or access to care" in wake of closings." The AG "already ensures the provision of needed services." (1995)
- Competition "has shown great promise in slowing the growth of health costs in Massachusetts." (1995)

The MHA vs. Mass. hospitals (more)

- Government action to identify and protect needed hospitals "is entirely inconsistent with the new direction of Massachusetts health policy...." (1997)
- "Hospital beds are an increasingly irrelevant measure of hospital care because so much of the medical care has moved to outpatient care." (1999)

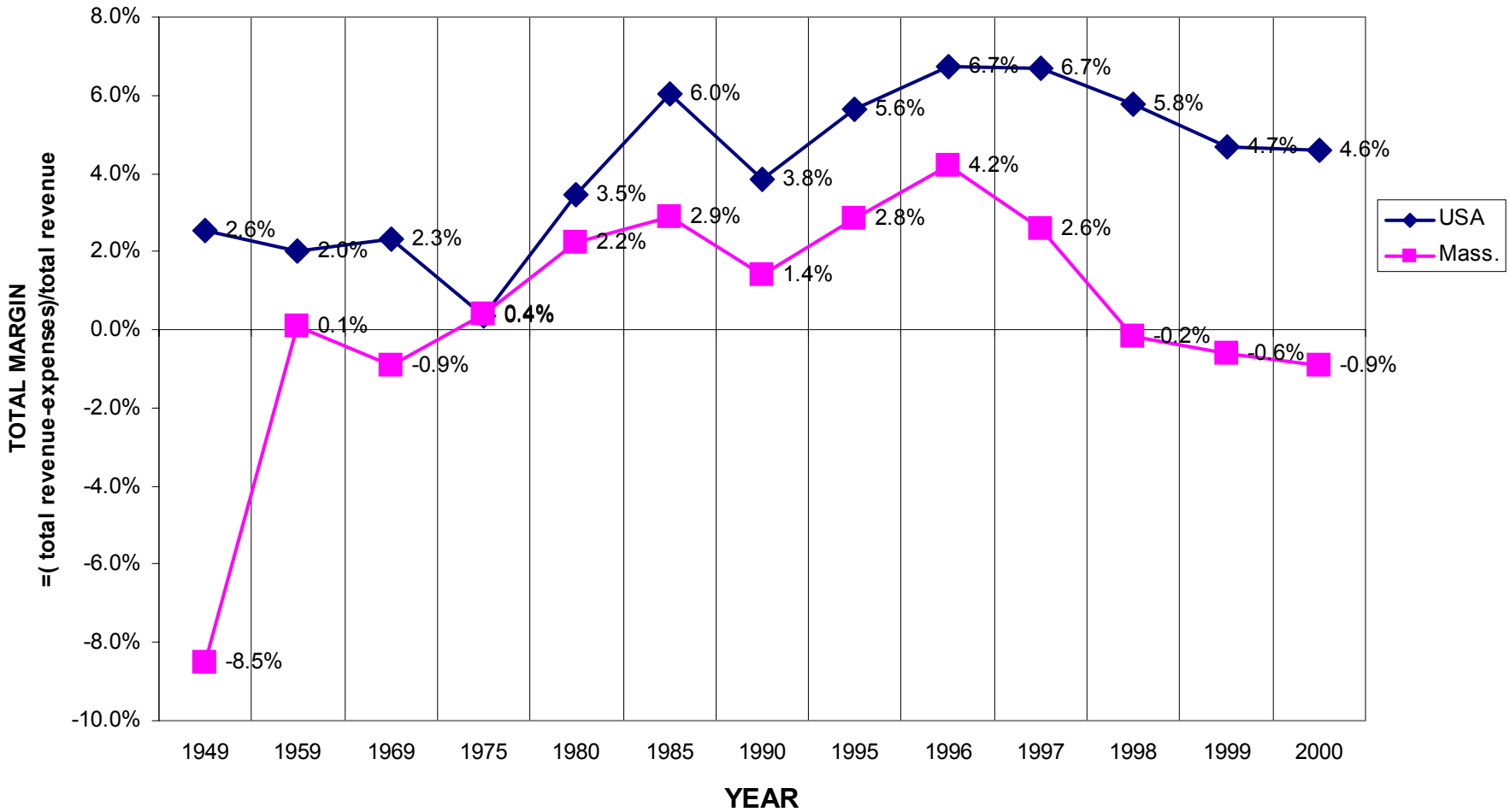
More Causes: High Costs

- Failure of hospital mergers to demonstrate savings (and mergers boost market power)
- Relatively elaborate and costly care pattern
  - --many teaching hospitals and specialists
  - --many physicians/capita
  - --legacy of Blue Shield balance billing ban

Why do Mass. hospitals have lowest financial margins in U.S.?

- Desire to do as much good as possible
- Mass. hospital spending (cost) rises faster than revenue in late-1990s. Why?
  - Low Medicaid rate hikes?
  - Suppressed Medicare revenue (BBA 97)
  - HMO tight-fistedness
  - Excessive cost increases?
  - High-cost hospitals admit more patients
  - Other factors we don't understand

ACUTE HOSPITAL TOTAL MARGINS, USA AND MASSACHUSETTS, 1949 - 2000



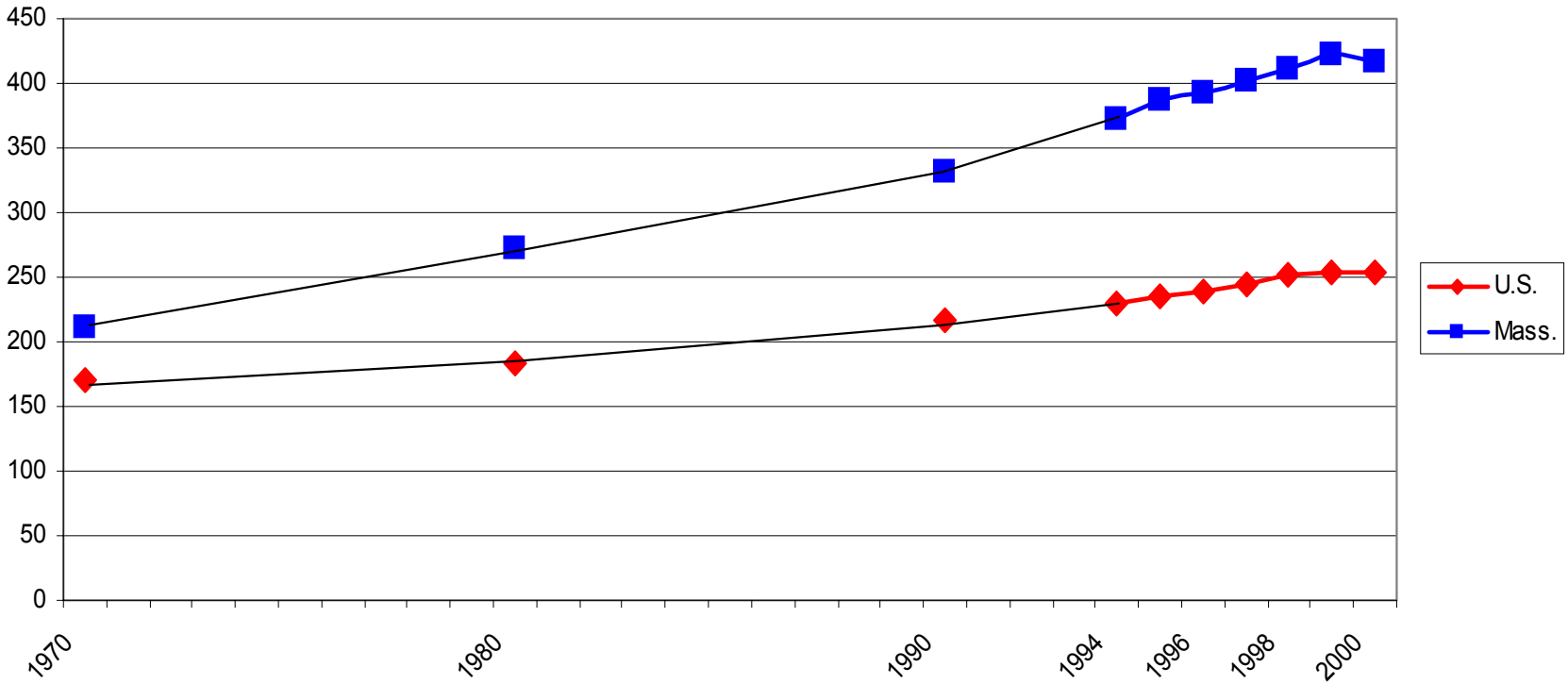
Changes in Hospital Expenses and Total Revenue, United States versus Massachusetts, 1996 - 1999

	percentage change in expenses	percentage change in total revenue
USA	14.1%	11.6%
Mass.	19.3%	13.6%
Mass. rise as % of U.S.	+36.9%	+17.2%

Causes of physician distress

- Highest physician/population ratio, but MDs uneven by specialty and geography
  - Patient shortage?
  - (Then, why is it so hard to get an appointment?)
- Weakening physician bargaining power in some parts of Massachusetts, especially in the face of merged hospitals and HMOs

MASSACHUSETTS AND U.S. PHYSICIANS PER 100,000 RESIDENTS, 1970 - 2000



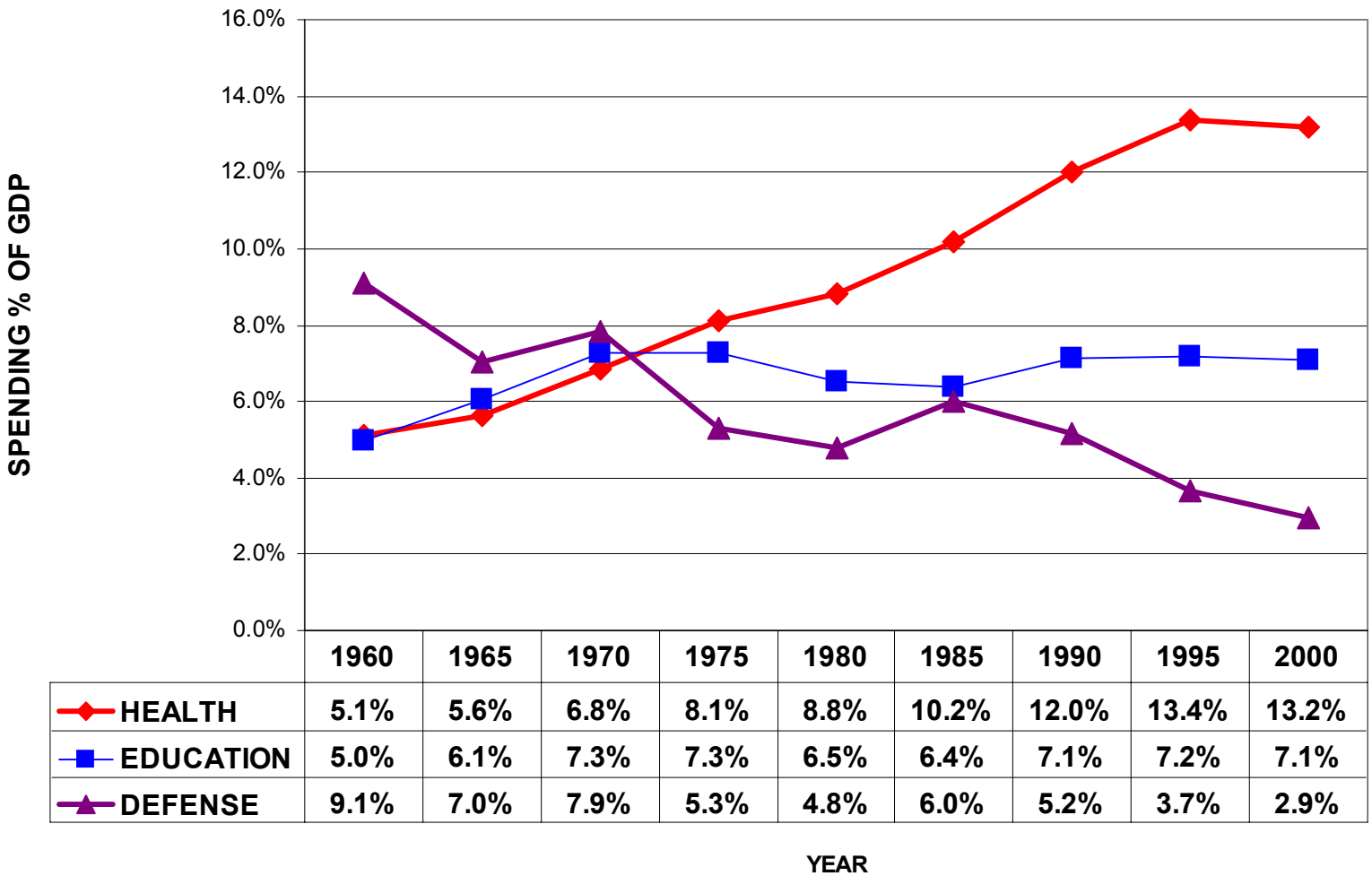
Bad Solutions: Muddle Through

- More money for business as usual (some caregivers say this)
- Less money for same (some employers)
  - Make someone else pay (shift costs to employees via higher co-pays)
  - Medical savings accounts
- Greater patient financial responsibility cuts use and so means less money for caregivers

Better Solutions

- Single payor to cut administrative waste, cover all, and buy time for long-term solutions
- Cost-reducing technologies
- ***$45 billion is enough*** to finance the care that works for everyone in this state who needs it, and more will be hard to get--where would more money come from?

HEALTH, EDUCATION, AND DEFENSE SPENDING, U.S., 1960 - 2000, AS PERCENT OF GDP



	1960	1965	1970	1975	1980	1985	1990	1995	2000
HEALTH	5.1%	5.6%	6.8%	8.1%	8.8%	10.2%	12.0%	13.4%	13.2%
EDUCATION	5.0%	6.1%	7.3%	7.3%	6.5%	6.4%	7.1%	7.2%	7.1%
DEFENSE	9.1%	7.0%	7.9%	5.3%	4.8%	6.0%	5.2%	3.7%	2.9%

A Few More Solutions

- Identify and stabilize all needed hospitals
- Tackle prescription drug prices
- Cost controls that physicians and patients can accept
- Affordable long-term care

  (hardest problem)

Identify and stabilize needed hospitals

- Having closed 1/2 of hospitals, assume that each surviving hospital is needed unless proven otherwise (shift burden of proof)
- DPH commissioner and AG have said we can't afford to lose another hospital
- If all else fails, look at a map

Immediate protection for each needed hospital

- To prevent a closing, governor declares public health emergency
- Legislature finally passes a hospital receivership law
- Adequate emergency financing: cash and technical assistance
- Trust fund, financed by hospital assessment
- Targeted Medicaid and free care pool relief

Targeted relief is vital

- Across-the-board Medicaid rate hikes mean that 1/2 of money goes to 20 most prosperous hospitals
- Which hospitals were helped by recent $60 million in pool relief?
- By contrast, governor cut $15 million for distressed hospitals to $5 million

The MHA should protect all needed hospitals--or change its name

- For 10 years, MHA has supported and even justified closing smaller and mid-sized hospitals, claiming Mass. had too many beds, and a market judged hospitals fairly
- MHA opposed hospital receivership law and now opposes targeted aid, claiming that only across-the-board hikes are fair
- But that allows vulnerable hospitals to close, forcing patients into costly survivors, at best

Durable protection

- Assure each needed hospital the revenue required to finance high-quality care, subject to efficient operation
- All payors pay same price for same care
- Flexible budget to cover actual costs, as volume rises and falls, without financial incentive to do too much
- Address ER and inpatient capacity problems

High-quality cost controls

- Physicians manage budgets
- They are financially neutral: fire wall between their revenue and all other dollars
- Physicians must manage money carefully, spend it all, and take care of everyone
- Spending capped by political agreement, not by competition among caregivers
- Competition by quality, not by price
- Flexible budgets protect hospitals