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HOSPITAL COSTS AND UTILIZATION SOAR UNDER CHAPTER 23
Highlights and Recommendations from Forthcoming Report
Access & Affordability Monitoring Project
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Costs and utilization of Massachusetts hospitals skyrocketed in 1988 and 1989, the first two years under Chapter 23's hospital payment rules. The growth in hospital and other health care expenses burdens Massachusetts employers, government, and citizens, both insured and uninsured. It crowds out funding for other needs and makes this a less appealing state in which to live or do business.

Personal health care spending overall in Massachusetts is 25 percent higher per capita than the national average. For 1990, our personal health spending totaled about $18 billion, and the 25 percent excess was $3.5 billion.

We spend more of our health care dollars on hospitals than any other state. Thus, hospital costs are central. Even if other components of health care costs rise faster on a percentage basis, we face huge dollar increases for hospital care each year because hospital costs are the largest single component by far.

Massachusetts acute hospital expenses per capita were already the highest in the nation before 1988. Since then, the problem has worsened.

1. In the first two years of C.23, our hospitals greatly increased their spending, leaving them further above the U.S. average than they were under the previous legislation.

$$ By 1989, with total hospital expenses of $6.1 billion, and $1,043 per capita, we rose to 39.7 percent above the national average of $747. Our hospital expenses exceeded those of second-ranked New York by nearly 8 percent. (See Figure 1.) We would have saved over $440 million in 1989 if we had spent at New York's rate.

$$ Because our state's hospital costs are so high, even if future percentage increases here are held to the national rate, the gap between Massachusetts and the nation in **dollars** will continue to widen rapidly. And it is dollars that matter.

$$ We added $198 per person to our hospital expenses from 1987 to 1989, more than any other state, and 67 percent more than the average dollar increase for the U.S. (See Figure 2.)

$$ C.23 offered hospitals much higher payments for their care of already-insured patients, giving them over 10 times as much new money as the law has made available to improve protection for people who lack health insurance.

2. Soaring hospital utilization has apparently helped drive these cost increases.

$$ Both inpatient and outpatient volume here increased to new highs in 1989.

$$ Rates of admissions, surgery, and outpatient visits in Massachusetts hospitals, which already substantially exceeded national levels, all rose faster in 1989 than they had in recent years and rose faster here than in the country as a whole.

$$ While admission rates continued their national decline in 1989, they increased here for the first time in six years -- a striking reversal.

3. In 1989, our hospitals provided more services per state resident than the U.S. average:

$$ 52.4 percent more outpatient visits (non-emergency room) -- 700,000 more than they provided in 1988,

$$ 19.3 percent more surgical operations -- for the fastest rise of the eighties, and

$$ 8 percent more admissions -- the largest Massachusetts-U.S. gap of the decade.

$$ Our high utilization does not necessarily indicate inappropriate care, but the likelihood must be examined carefully, given the demonstrated ability of caregivers elsewhere to provide high-quality, appropriate care at lower rates of service and lower cost.

4. C.23's cost control plans have failed. The law linked hospital payment closely to volume, ostensibly to spur competition for patients and to close beds and hospitals. C.23 has disproportionately and retroactively overpaid those hospitals that have been adding patients. *C.23's rewards for increased volume may largely explain the 1989 surge in utilization.*

$$ C.23 increased the payments that hospitals gain for increasing admissions and outpatient visits. Now hospitals receive payment that far exceeds the actual added cost of serving more patients, so higher volumes have been very attractive financially to hospitals since 1988. And volume has soared.

$$ Numbers of hospital beds cannot account for our high costs, because our bed-to-population ratio is actually below the national average. If we continue to close hospitals, we will surely endanger access in many communities.

$$ Lower-cost hospitals appear to be the ones closing. Far from saving money, this means that their patients must then move elsewhere, to be treated at higher cost.

5. Our high costs cannot be justified by commonly-cited factors.

$$ A February 1991 AAMP report found that two-thirds of our 1989 excess hospital costs were not justified even after adjusting for age, out-of-state patients, research, training, outpatient/emergency room use, wages, profit margins, and case mix.

$$ That report also concludes that our excess costs are not buying us commensurate gains in our health status or our economic well-being.

$$ Some blame administrative expenses and regulation for high costs. The administrative burden of a patchwork multi-payor system exists in every state, however, and Massachusetts hospital costs were even farther above the nation's before Chapter 372 introduced comprehensive charge regulations in 1982.

6. Our hospital staffing levels are the nation's highest and a key element of our extraordinary costs.

$$ Massachusetts hospitals have 33.5 percent more full-time equivalent employees per capita than the U.S. average and over 5 percent more than in the next-ranked state.

$$ Total FTEs rose by nearly 7,000 from 1986 to 1989, despite hospital association claims of job cuts.

$$ Our high ratio of registered nurses per capita is a sign that this heavy staffing is largely for patient care, rather than for research.

$$ Our hospital workers appear not to be idle, but rather, to be providing an elaborate pattern and and great quantity of care.

The evidence strongly suggests that *our high costs reflect the intensity of treatment in our hospitals and heavy utilization of hospital services.* We must therefore look at the dominance of teaching hospitals here, the prevailing style of medical practice among our hospitals and physicians, and the payment rules that influence both.

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RECOMMENDATIONS

We must address the problems that this evidence reveals if we are to get more for our health spending. To contain Massachusetts hospital costs, necessary steps include:

** eliminating current incentives for hospitals to add admissions and outpatient visits. New hospital financing legislation should use volume-neutral payment methods.

** developing ambulatory care options that are more affordable and appropriate than hospital OPDs. Emergency room use, particularly by Medicaid patients, has received much attention, but the greater problem appears to be the rising reliance on hospitals for other, non-ER outpatient visits.

** containing hospital costs by capping them statewide and/or by hospital.

** gradually but steadily entitling all Massachusetts residents to care over the next four years or so.

** giving hospitals and physicians the tools to serve us all well -- and reasons to trust them to use those tools wisely.

If hospitals were obliged gradually to serve all citizens of the Commonwealth, while hospital payments were capped, hospitals would need to work with their physicians to identify effective patterns of care and to weed out unnecessary services. Secure, predictable, and volume-neutral payment methods for all caregivers would free them to make decisions for all patients considering only what care we need.

When we are spending so much on health care, it is crucial to seek ways not only to limit increases but to get more for the dollars we already spend, to make health care affordable for all patients and employers, and for government.

Better use can be made of the already vast health care spending in Massachusetts by **reallocating** it in several ways:

-- redistributing funds among hospitals to achieve greater fairness;

-- redistributing funds among patients, to provide the care that works to all;

-- redistributing funds from hospital services to physician and other primary care services, to give everyone a primary provider and direct entry to care.

At a time of concern about jobs, it is worth noting that health care employment will not be jeopardized by by cost containment if we redirect resources away from high-cost but low-payoff services for the already-insured in order to assure needed care for all of us.

For the estimated $20 billion that we are spending on health care in Massachusetts this year, we can make sure that everyone receives the care that works. We can also slow cost increases. But we must begin soon. Otherwise, as more hospitals face fiscal crises and more payors sharply cut insurance coverage, we will face the catastrophe of sudden adjustments, harming both access and quality of care.

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Note on methods: AAMP studies rely heavily on costs of hospital care as reported by the hospitals themselves to the American Hospital Association and published in the AHA's *Hospital Statistics.*

The national comparisons that this analysis uses actually understate how extraordinarily high hospital costs in Massachusetts are. The U.S. spends twice as much on health care and hospitals as other industrial democracies -- even though the others cover everyone and enjoy better health status. AAMP analyses use per capita comparisons to relate services provided and their costs to the people being served. Unlike comparisons of cost per admission or cost per day, they do not assume that current use rates are appropriate. Some argue that out-of-state patients invalidate per capita comparisons and explain much of our high costs. In fact, net admissions of patients from outside the state accounted for no more than 4.8 percent of admissions to our hospitals in 1987 -- and for less than 2.0 percent of Massachusetts hospital costs.

C.23 influenced costs for hospital fiscal year 1988 because, although the law passed in April 1988, its hospital payment provisions were retroactive to October 1987 and were largely known in advance of passage.

For more information, call the Access & Affordability Monitoring Project at (617) 638-5042. Authors of the reports are Alan Sager, Deborah Socolar, and Peter Hiam.

1989 HOSPITAL EXPENSES PER CAPITA

BY STATE

$ of hospital expenses/capita
(Thousands)

0 0.1 0.2 0.3 0.4 0.5 0.6 0.7 0.8 0.9 1 1.1

STATE

Idaho
Wyoming
South Carolina
Mississippi
Hawaii
New Mexico
Vermont
Utah
Washington
Alaska
Oklahoma
South Dakota
Kansas
Virginia
Arkansas
Colorado
North Carolina
Montana
Oregon
Kentucky
Texas
Wisconsin
Maryland
Nebraska
Arizona
New Hampshire
Nevada
Alabama
Iowa
Maine
Indiana
Georgia
Minnesota
Louisiana
California
West Virginia
UNITED STATES
New Jersey
Delaware
Rhode Island
North Dakota
Florida
Illinois
Tennessee
Michigan
Ohio
Connecticut
Missouri
Pennsylvania
New York
Massachusetts

RISE IN HOSPITAL EXPENSES/CAPITA 1987–9