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Because Regulation to Assure Quality Will Continue

Because Business Favors a Competitive, Data-Supported System

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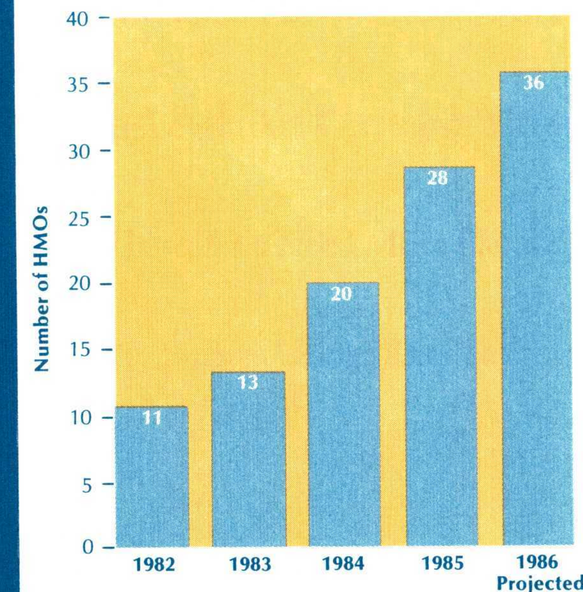
Wisconsin's business community believes that, as purchasers, they can better influence cost containment and quality issues through a competitive marketplace than through a Madison-based bureaucracy.

Business and industry also want consistent, understandable health care data that will provide the information they need to be intelligent purchasers of hospital care.

Because HMO Growth Increases Hospital Competition

Wisconsin HMOs



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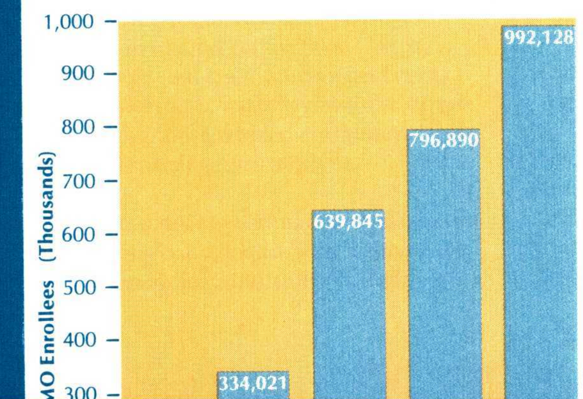
Wisconsin HMO Enrollment



GOVERNMENT SETTING
OF PRIVATE HOSPITAL CHARGES:

AN OBSOLETE CONCEPT
THAT SHOULD BE ABANDONED

I. The National Perspective

Increases in the cost of hospitalization have been a major concern in the United States since inflationary pressures began rising in the late 1960s.

Attempts to deal with the problem have taken a number of directions, including:

* Establishment of wage/price controls in the early 1970s under the Nixon Administration.

* Creation of utility-type hospital rate commissions by northeastern states in the middle 1970s.

* Continual modification of the hospital incentive/disincentive under the Medicare system.

* Development of a competitive climate that uses the marketplace to allocate health care resources.

Assessing these options, it was widely concluded that the Nixon approach of wage/price control not only was ineffective but also may have contributed to the inflationary spiral of the 1970s. State hospital rate setting, a concept felt to be workable in the mid 1970s, has also failed to achieve any support regarding its ability to lower the cost of health care without adversely affecting quality.

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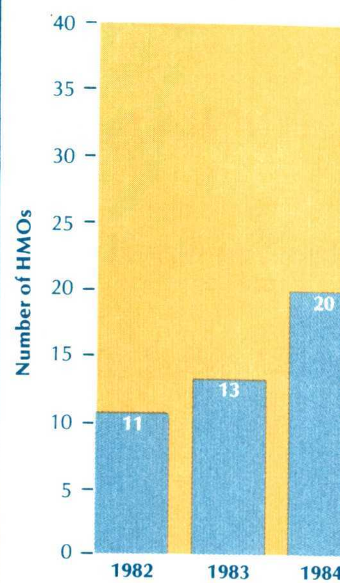

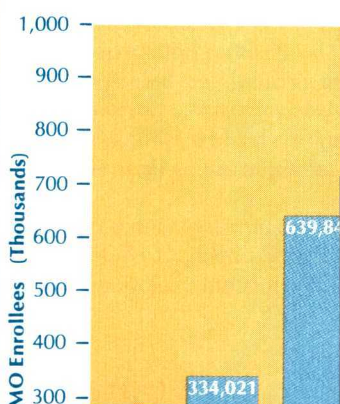

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This general lack of success has resulted in stagnation in the number of states that use the rate-setting option. Two states, Colorado and Illinois, recently abandoned private rate setting as being expensive, cumbersome and counterproductive in dealing with the hospital cost issue.

The only consistent success in lowering the rate of increase in health care costs has occurred during the last few years through a combination of a private market approach and use of a prospective payment system for Medicare patients.

Most dramatic among the shifts brought about by the private marketplace has been increased reliance on outpatient care as a convenient and cost effective alternative to the traditional inpatient options of the past. Reflecting patients' preference to be in a home environment rather than a hospital, lengths of stay have been reduced dramatically due to increased use of home care services.

Sunset the HRSC

Parallel to these developments has been a fundamental shift in the payment for government services under the Medicare program. The shift has replaced the former system of cost-based reimbursement with one that pre-determines payment for 467 separate diagnostic groups.

The combination of market forces for private patients and an innovative payment system for Medicare patients is widely credited with significantly reducing the inflationary cost increases of the late 1970s. Most health care experts believe this approach is more effective than a simplistic strategy that uses governmental controls for all aspects of a hospital's financial operation.

II. The Wisconsin Experience

Despite widespread national support for multiple approaches to cost containment, the Wisconsin legislature in 1983 adopted a system of rate regulation similar to that implemented mainly in the mid 1970s in the northeastern U.S. The legislature concluded that a governmental approach was preferable to market forces and that a public commission should be given broad statutory authority to decide what rates should be paid by private payors.

As a result, the Wisconsin Hospital Rate-Setting Commission (HRSC) was enacted into law on July 1, 1983. The HRSC has three full-time commissioners appointed by the Governor and is supported by a staff of 25 state employees. During its most recent fiscal year, the HRSC had a budget of $1.5 million--all of it assessed against hospitals and the private patients that use hospitals' services.

In 1985, the Wisconsin legislature again made the issue of rate setting a major policy discussion and questioned the decision two years earlier to focus on the regulatory approach widely used in the east. The Wisconsin Assembly expressed its clear preference to statutorily repeal the Commission, and similar sentiment existed with a majority of state senators. However, through extensive personal lobbying efforts, Governor Earl convinced the necessary number of state senators that the governmental approach to health care, as embodied in the Commission, should be preserved.

However, the legislature in 1985 made one important modification, and altered the date when the HRSC would automatically sunset (statutorily cease to exist) from 1989 to 1987. Legislative leaders supporting this change indicated that by 1987 the competitive influence in Wisconsin would be sufficiently strong to encourage abandoning the regulatory option and focusing on effective use of the marketplace.

Sunset the HRSC

III. Organization of the Wisconsin Hospital Rate-Setting Commission

Although ably administered, the HRSC has established its clear intent to assume increased decision making from hospital management, medical staffs and governing boards. Through a number of decisions affecting Wisconsin hospitals, the HRSC has shown its intent to:

1. Determine appropriate staffing levels for hospitals.

2. Interject itself into the establishment of overall compensation levels.

3. Place requirements on hospitals for the provision of uncompensated care and the necessary subsidy by other private patients.

4. Place requirements on how hospitals process their patient bills.

5. Question decisions of hospital management and governing boards in replacing clinical equipment and engaging in renovation.

6. Limit the ability of hospitals to accumulate financial reserves.

7. Question decisions made by other regulatory agencies under programs such as Certificate of Need (CON).

8. Force the dissipation of hospital reserves achieved through cost containment efforts in previous years.

9. Burden small hospitals which, in some cases, spent more on regulatory compliance than requested in their initial price increase.

10. Question whether mergers/consolidations should take place as hospitals downsize their capacity.

11. Limit the ability of hospitals to jointly purchase high technology equipment.

12. Limit the ability of religiously-sponsored hospitals to operate as part of a multi-state system.

The question of whether this type of decision making by three commissioners in Madison is appropriate, depends upon one's philosophy of where decisions can best be made.

> * Those who believe government bureaucracy can and should make decisions for local citizens throughout Wisconsin would support these activities by the Commission.

Sunset the HRSC

* Those who believe decisions can best be made at the local level feel this type of intervention by government is counter-productive and an example of why Wisconsin is increasingly viewed as an anti-business state.

Operation of the HRSC also has identified another problem: the inconsistency between the utility model embodied by the Commission and the competitive model embodied by the development of health maintenance organizations (HMOs).

Under the utility model, it is widely accepted that once rates are established, all users will adhere to the level of charges incorporated into a Commission order. This contrasts sharply with the reality of today's health care marketplace which increasingly involves private contracting by HMOs and individual purchasers, using the power they command in the marketplace.

Unless basic Commission philosophy changes, Wisconsin's regulatory environment will significantly reduce the ability of HMOs and other innovative, managed care programs to bring cost effective health care options to the Wisconsin consumer.

The final problem identified with the Commission approach pertains to the inequity of highly regulating one segment of the health care market while others are able to engage in various free-market activities.

This becomes particularly acute when the regulatory restrictions placed upon community hospitals are compared to the near total lack of regulation required for physicians, and particularly, major multi-specialty clinics. Without some degree of regulatory equity, the highly controlled community hospital will become an insignificant purveyor of acute beds in the free market economy of the future.

Sunset the HRSC

IV. Conclusion

Despite concern over many facets of the HRSC, few believe that public interests are best served by the total deregulation of health care. It is generally agreed:

* That regulation should continue to assure the quality of health care services offered.

* That some control should continue over hospitals' capital expenditures, particularly for new facilities and expansion of beds.

* That government can appropriately regulate the services it purchases for programs such as Medicare and Medicaid.

* That government should have a role in collecting and distributing data necessary for business and consumers to make prudent decisions.

It is widely concluded by Democrats and Republicans alike, however, that the degree of regulation involved in the Commission is costly for the consumer, a long-term threat to community hospitals and their ability to meet patient needs, and of questionable effectiveness in dealing with the issue of rising health care costs.

The latter point is perhaps the most important. A comparison of Wisconsin to the regulated states identifies the primary reason why the concept of private rate regulation has not grown in the United States.

* National data for 1984 (the last year before implementation of the HRSC) shows that despite many years of rate reductions, the cost of hospitalization in regulated states was 27 percent higher than the corresponding figure for Wisconsin.

* Figures for the first year of Commission operation (mid-1985 to mid-1986) shows that despite major claims of cost saving by the HRSC, hospital costs in Wisconsin increased at a rate comparable to both the national average and to the inflationary pressures felt by hospitals.

Given the national perspective emphasizing use of the marketplace versus governmental involvement, the questionable track record in regulated states, and Wisconsin's traditional desire to seek progressive approaches, the Wisconsin Hospital Rate-Setting Commission should be allowed to sunset on June 30, 1987.

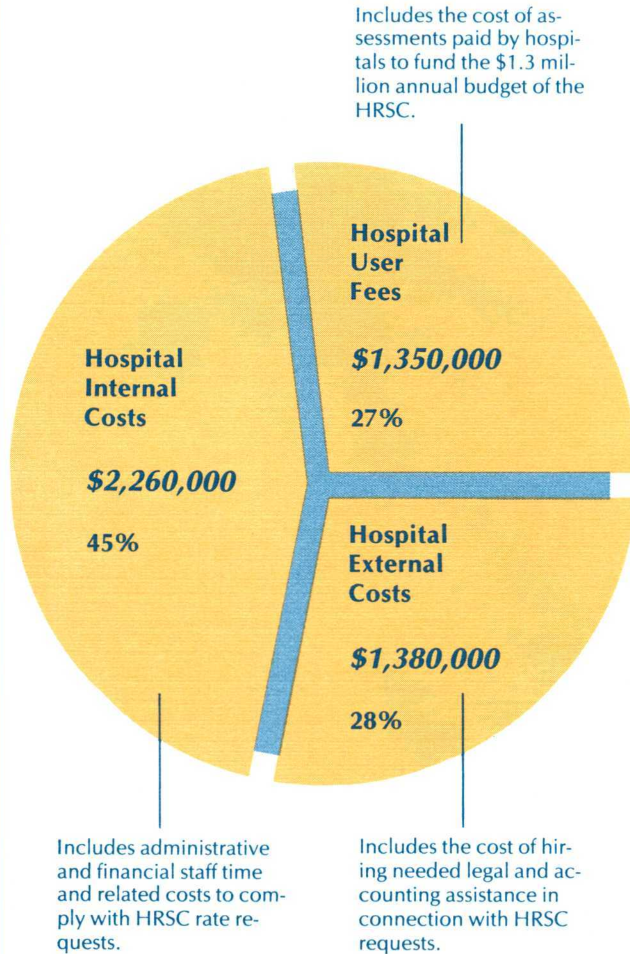
Summer, 1986

Sunset the HRSC

Because

Rate Setting is Expensive for Patients and Hospitals

Cost of HRSC Regulation: $4.99 Million



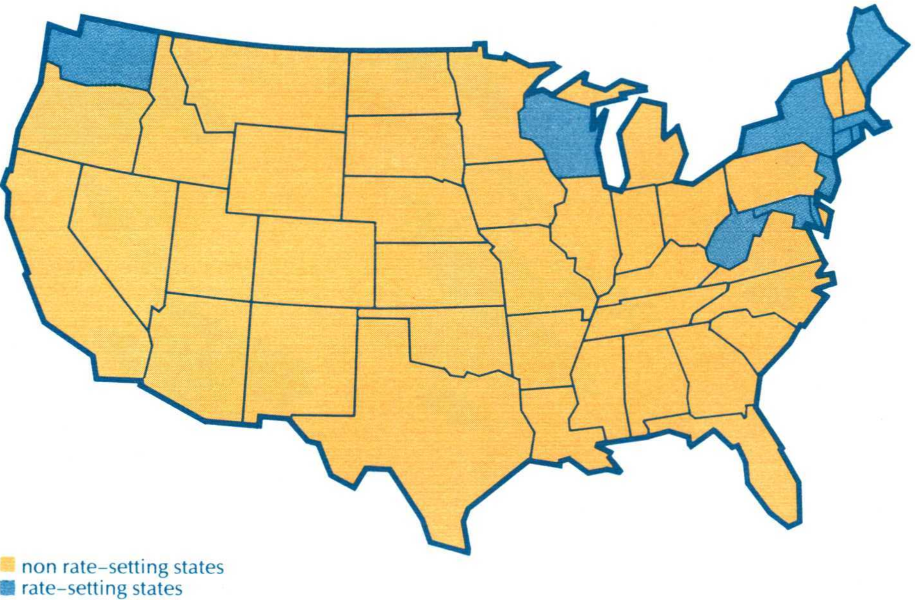
Key points

• The average cost for a Wisconsin hospital to undergo HRSC review is more than $21,000.

• Some hospitals have been forced to spend more money for the HRSC review than they received in their rate increase.

Sunset the HRSC

Being a Regulatory Island Doesn't Assure Cost Effectiveness



Typically in the U.S., the marketplace sets hospital prices. Besides Wisconsin, rate setting exists only in the northeast and the state of Washington.

Colorado and Illinois established rate commissions, but abandoned them in the early 1980s as being expensive and counterproductive.

Key point

• Despite a number of studies, there is still no concrete data to show that rate setting is an effective alternative to the competitive marketplace.

Because

Rate Setting Does Not Reduce Medicare Bills

Congress and the federal government—not the HRSC:

- Establish Medicare hospital charges.
- Set the Medicare Part A deductible.
- Determine coinsurance liability.

Here are the cost implications for an average Wisconsin hospital treating a Medicare patient for a fracture of the hip and pelvis:

$1,843	treatment of fracture and hospital stay	(payment set by federal government)
- 492	Medicare deductible	(determined by Congress and paid by Medicare recipient)
$1,351	portion of bill actually paid by Medicare	

Key point

- **Not one dollar** of the hospital payment **or** the Medicare deductible is determined or influenced by the HRSC.

Sunset the HRSC

Because

As Times Change, the Commission Becomes Irrelevant

The Commission has nothing to do with the 42 percent of hospital Medicare revenue set by the federal government.

The state duplicates its own efforts and sets the 7 percent of hospital revenue for Medicaid through a separate government program.

HMOs now cover almost 1 million Wisconsin residents whose rates are negotiated between hospitals and HMOs.

Business and labor increasingly are negotiating managed care programs that bypass the Commission.

Key point

- If present trends continue, by 1990 the Commission could be setting rates for less than 25 percent of Wisconsin's hospital patients.

Sunset the HRSC

Regulation to Assure Quality Will Continue

The *quality* of hospital services will still be *regulated* and *inspected* by the Department of Health and Social Services and *approved* by the Joint Commission on Accreditation of Hospitals.

The *quality* and proficiency of hospital personnel will still be *regulated* by the Department of Regulation and Licensing.

The *quality* and *safety* of radiology equipment and laboratories will still be *regulated* by the Department of Health and Social Services.

Hospital Building Code *compliance* will still be *overseen* by the Department of Industry, Labor and Human Relations.

The *capabilities* of hospital emergency rooms will still be *identified* and *publicized* by the Department of Health and Social Services.

The *quality* and *cost effectiveness* of care rendered to Medicare, Medicaid and many private patients will still be *reviewed* by the Wisconsin Peer Review Organization under state and federal contracts and by other private utilization and review organizations.

Capital expenditures for equipment and construction will still be *regulated* by the Department of Health and Social Services.

Key point

- This continuing regulation will assure consumers of a quality health care system without producing the negative effects and costs inherent in rate regulation.

Sunset the HRSC

Because

Business Favors a Competitive, Data–Supported System

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Business and industry also want consistent, understandable health care data that will provide the information they need to be intelligent purchasers of hospital care.

Key points

In addition to supporting a competitive hospital marketplace, business is actively working with hospitals to develop such a data system. It would feature:

- Aggregate information from every inpatient discharge in Wisconsin.
- Regular reports identifying costs by individual hospitals.
- Regular reports providing information on the experience of individual employers.
- Comparative information on a diagnosis basis.

Sunset the HRSC

Because

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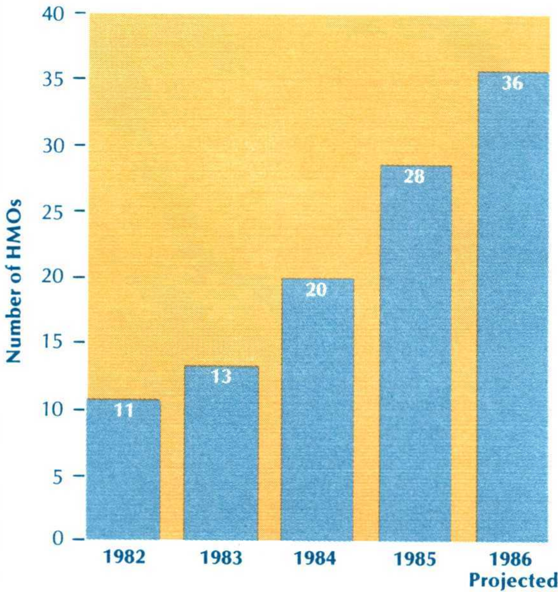

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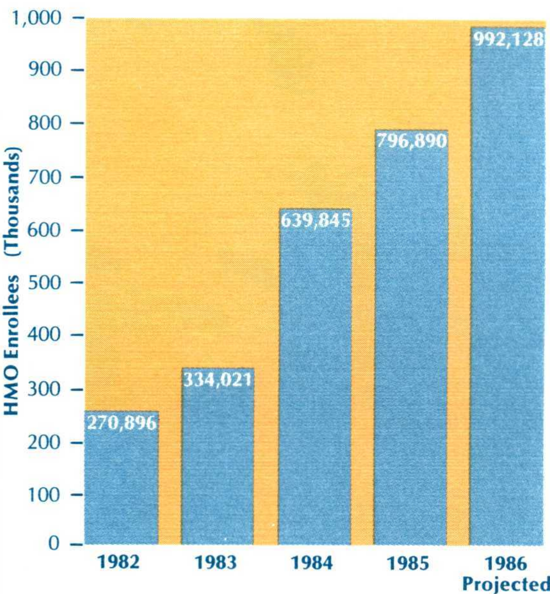


Key points

- The number of HMOs increased about 250 percent and HMO enrollment grew nearly 300 percent between 1982 and 1985.

- About 17 percent of Wisconsin's population was enrolled in HMOs at the end of 1985.

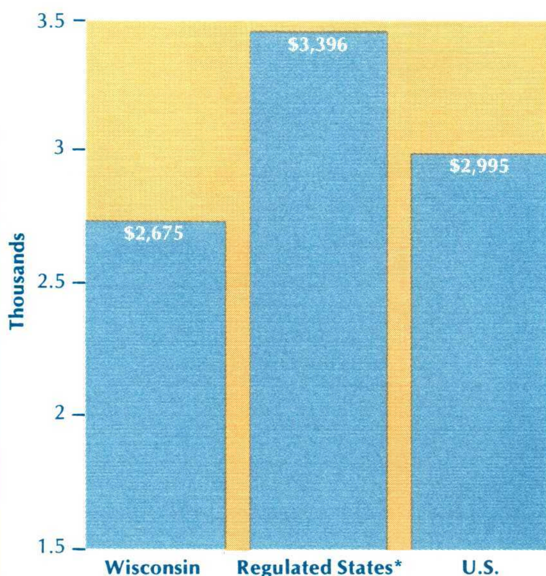
- During 1985, about 240,000 hospital inpatient days were provided to HMO enrollees.

- During 1985, Wisconsin hospitals had an overall use rate of about 870 inpatient days per 1,000 population; the average for Wisconsin HMOs was about 500 inpatient days per 1,000 population.

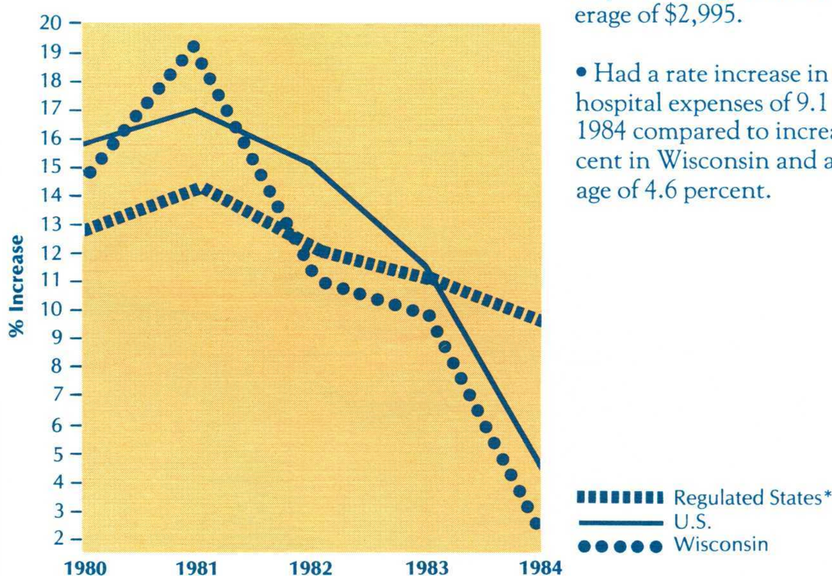
Sunset the HRSC

Rate Regulation Does Not Mean Lower Costs

Charge Per Admission, 1984



Annual Increase in General Hospital Expenses



Seven states—Connecticut, Maryland, Massachusetts, New Jersey, New York, Rhode Island, and Washington—have had mandatory rate setting since 1980. These states:

- Had an average cost–per–admission of $3,396 during 1984, 27 percent higher than Wisconsin's figure of $2,675 and 13 percent higher than the national average of $2,995.

- Had a rate increase in total general hospital expenses of 9.1 percent during 1984 compared to increases of 2.4 percent in Wisconsin and a national average of 4.6 percent.

* Does not include data from Maine or West Virginia where rate commissions were implemented in 1985.

Key points

- The rate of increase in hospital expenses from 1980 to 1984 was lower in Wisconsin than in the nation's regulated states.

- The seven regulated states have had consistently higher costs than Wisconsin, and, despite years of regulation, have not been able to close the cost gap.

Sunset the HHSC

Border Hospitals Face Unfair Competition

Key points

• Eighteen Wisconsin hospitals face major hospital competitors across the state border who have no rate-setting commissions to:

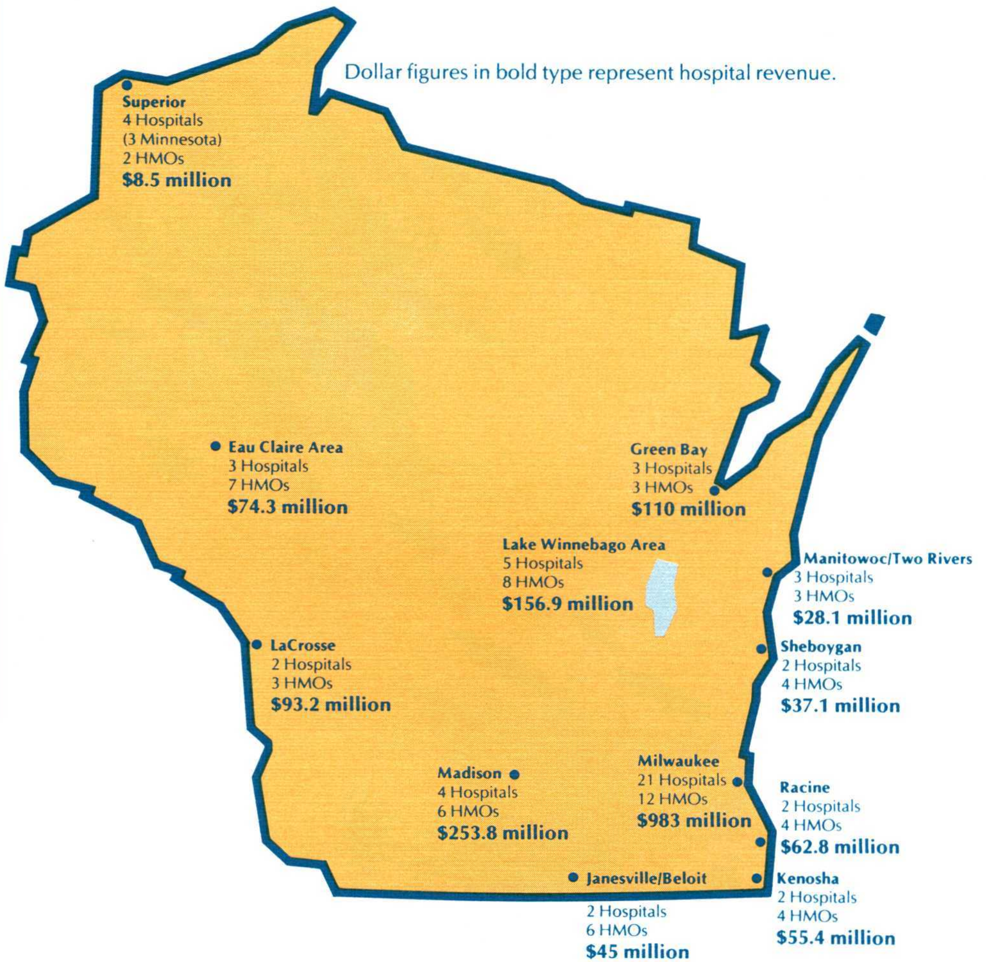
- set employee salaries
- determine employee staffing levels
- determine capital needs
- review the costs of marketing
- approve expenditures for equipment and services

• This competition is unfair and means lost growth opportunities for Wisconsin hospitals and for Wisconsin's economy.

Sunset the HRSC

Because

Price Competition Controls Most Hospital Revenue



Key points

• Urban areas: 76 percent of Wisconsin's total hospital revenue—$1.9 out of $2.4 billion—is in multi-hospital areas where price competition exists.

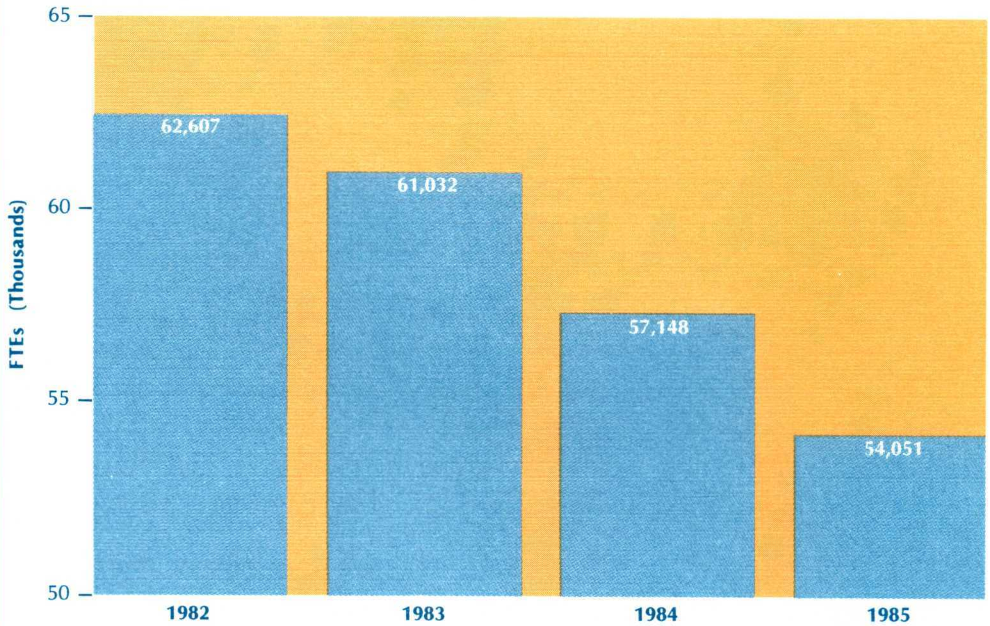
• Rural areas:

—are involved with 12 separate HMOs
—compete actively with nearby urban hospitals
—compete with neighboring small hospitals

Sunset the HHSC

Because

Staffing Levels Are Declining Without HRSC Intervention



Key points

• Largely due to the competitive climate, FTE levels in Wisconsin have decreased nearly 14 percent over the last three years; the national average is 3.8 percent.

• This decline occurred at a time when hospital inpatient cases were increasing in intensity and complexity.

• Wisconsin hospitals are responding to market pressures responsibly, as any businesslike organization would.

Sunset the HRSC

Because

Small Hospitals Need More Flexibility and Less Regulation

Over half of Wisconsin's 140 acute general hospitals have less than 100 beds and serve basically a rural area. Like any smaller business, comprehensive government regulation is more difficult for those hospitals that find it expensive to hire legal and accounting expertise.

Key points

Small and rural hospitals:

- Represent only 13 percent of Wisconsin's total hospital expenses.
- Have 46 percent of their rates set by Medicare and Medicaid, not the HRSC.
- Are closely integrated with their community and governed by more than 800 local trustees.
- Find the $13,100 yearly average cost of HRSC regulation a poor expenditure of scarce funds.
- Have found the HRSC's so-called "exemption from review" to be expensive and frequently unworkable.
- Require greater flexibility than large hospitals to cope with the changing marketplace.

Sunset the HRSC

Because

Quality Suffers Under Rate Setting

A slowing in the rate of increase in hospital expenditures provided by state rate-setting programs is being achieved at the expense of quality.

In Wisconsin, through May 30, 1986, the HRSC disallowed more than $5.3 million in capital requests of 12 hospitals—large and small, urban and rural. The net result is inability of these hospitals to purchase needed equipment and renovate their physical plant.

Further, a national study by William O. Cleverly, Ph.D., Ohio State University, of the financial condition of hospitals under state rate-setting programs, showed that:

- Hospitals in regulated states, on the average, are 17 percent older than those in non-regulated states.

- The overall measure of hospital financial viability is worse for hospitals in regulated than in non-regulated states.

In addition, growing evidence suggests that hospitals in regulated states encounter more difficulty in obtaining competitive financing for needed projects.

Key points

- Without adequate capital to update equipment and renovate facilities, the quality of hospital services is threatened.

- Without competitive financing, hospitals face higher costs when planning capital projects.

Sunset the HRSC