

Containing Health Spending— Focus on Hospital Costs

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Containing Health Spending—Focus on Hospital Costs

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Table of Contents

TABLE OF CONTENTS 1

EXECUTIVE SUMMARY 1

1. INTRODUCTION 2

2. INCREASES IN HEALTH CARE COSTS OUTPACE ECONOMIC GROWTH..... 2

3. KEY DRIVERS OF HOSPITAL COSTS 3

Technological Advancements..... 3

Health Care Worker Shortages..... 3

The Growing Number of Uninsured..... 4

Containing Cost Drivers for the Long Term 5

4. OPTIONS FOCUSING ON HEALTH CARE PROVIDERS 5

Efficiency Incentives 6

Health Care Market Regulation 8

5. OPTIONS FOCUSING ON HEALTH CARE CONSUMERS 10

Keep People Healthier..... 10

Expand Access to Insurance 13

CONCLUSION 14

GLOSSARY 15

Executive Summary

Rising health care costs have received a great deal of attention in recent years, as Medicaid continues to consume a larger share of state budgets and the number of uninsured Americans grows. State leaders have diligently searched for strategies that lower health care costs without adversely affecting access to or quality of care. Containing long-term costs is critical, especially considering the aging of the population and the unknown impact it will have on future health care costs.

What causes this continued increase in health care costs? While prescription drugs and medical malpractice insurance receive the most media attention, the biggest factor is hospital costs. In fact, at about 30 percent, hospital costs represent the largest portion of total national health care spending.¹

Several factors drive up the costs of and spending on hospital services. Cost drivers include:

- technological advancements, which lead to increased demand for services;
- health care worker shortages, which contribute to higher wages; and
- the growing number of uninsured, which restricts access to preventive care, leading to costly hospital admissions and emergency room visits for avoidable conditions.

To impact hospital costs and affect cost drivers state leaders should consider cost containment instead of cost shifting.² The following options for states are designed to contain costs for the long term by focusing on both health care providers and consumers.

Because technology and work force issues are the primary influences of rising hospital costs, states should consider measures that address both factors. Options targeting health care providers can focus on promoting efficiency, including:

- mandating public disclosure of quality and cost information;
- encouraging evidence-based and cost-effective medicine;
- considering tiered-provider plans that group providers in health plans based on cost; and
- making administrative changes to ease burdens on personnel resources.

Options targeting health care providers can also focus on regulatory changes, including:

- expanding certificate of need (CON) laws; and
- instituting an all-payer, rate-setting system.

States should consider policy options focused on health care consumers in addition to addressing issues concerning health care providers. Options targeting the population can focus on ways to improve health, including:

- supporting public health programs such as tobacco cessation and nutrition; and
- disease management, a set of interventions designed to improve the health of a group of individuals, especially those with chronic diseases.

Options targeting the population can also focus on guaranteeing every citizen access to insurance. Although states will have to spend money to increase access to insurance, caring for the uninsured is more expensive in the long run, so cost savings should eventually be realized. Options include:

- using reinsurance, which helps lower an insurance company's risk;
- creating a high-risk pool, which provides insurance for people rejected by other insurance plans due to risk; and
- expanding insurance options for low-income populations.

As state revenues decline and health care costs soar, state leaders are charged with the task of fixing the problem now while simultaneously implementing initiatives to contain costs in the long term. As these strategies show, states can take steps to control hospital spending, encourage quality care and promote good health. From managing access to technology to rewarding quality and efficiency, options exist that can limit cost growth without compromising care.

1. Introduction

State government encompasses a host of issues, programs and policies that compete for policy-makers' attention and scarce public funds. State officials routinely encounter acronyms, statistics and advocates, all vying for top billing on the policy agenda. In the midst of this commotion, it can be difficult to interpret which issues should take priority, let alone what policies effectively address those problems.

Rising health care costs have received a great deal of attention in recent years, as Medicaid continues to consume a larger share of state budgets and the number of uninsured Americans multiplies. Nationwide, health care accounts for more than 30 percent of state budgets.³ Nearly 22 percent of state expenditures are for Medicaid alone, on par with elementary education, traditionally the largest category of state spending.⁴ In an era of budget deficits, increased spending on health care translates into decreased spending on other government programs and services.

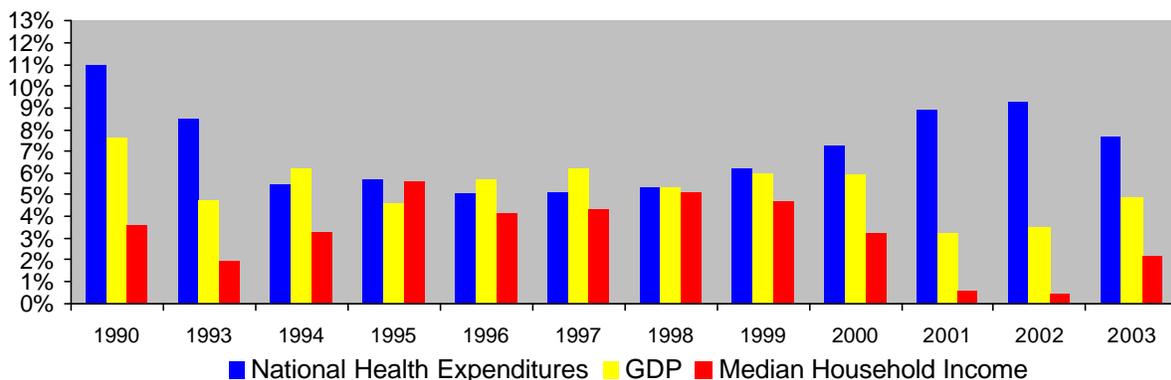
While prescription drugs and medical malpractice insurance receive the most media attention, the major cause of rising health care costs is often overlooked—hospital costs. Prescription drugs account for about 11 percent of spending on health care, whereas inpatient hospital care accounts for about 30 percent.⁵ Moreover, experts anticipate Medicare and Medicaid hospital spending will accelerate drastically in the coming years.⁶

This *TrendsAlert* is designed to help state policy-makers understand this key factor in rising health care costs and to offer concrete solutions based on successful state experiences.

2. Increases in Health Care Costs Outpace Economic Growth

As state revenues have plummeted in recent years, health care costs have increased drastically. State leaders are searching for strategies to contain health care costs without adversely affecting access to or quality of care. Reports note that national health spending has slowed recently, increasing 7.7 percent in 2003 compared to 9.3 percent growth in 2002.⁷ However, increases in health spending continue to outpace economic growth and wages,⁸ as shown in Figure 2.1.

Figure 2.1 Annual Percent Change in National Health Expenditures, Gross Domestic Product and Median Household Income, 1990 to 2003

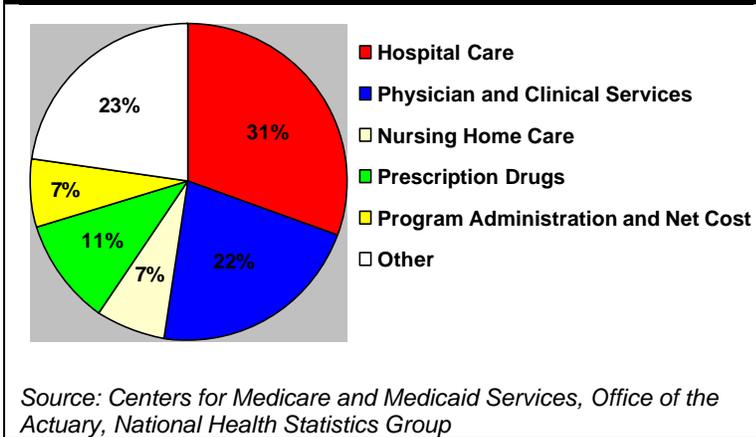


Source: U.S. Department of Commerce, Bureau of Economic Analysis; and U.S. Bureau of the Census, Current Population Survey, Social and Economic Supplements.

What is causing this continued increase in health care costs? A common misconception is that medical malpractice issues or prescription drugs are solely to blame. Hospital costs, however, represent the largest portion of total national health care spending.⁹ Figure 2.2 depicts the most recent data on how national health dollars are spent, showing that 31 percent of national health dollars are spent on hospital care, compared to only 11 percent on prescription drugs. Although prescription drugs have been growing at a faster rate, hospital costs are such a large percentage that even small increases can have larger

effects on total health spending.¹⁰ In order to reduce health care cost's impact on state budgets for the long term, policy-makers must address rising hospital costs now.

Figure 2.2 National Health Expenditures, 2003



Between 2001 and 2003, total spending for hospital services—including both inpatient and outpatient services—rose nearly 16 percent from \$446.4 billion to almost \$516 billion.¹¹ Analysts predict that if states do nothing to contain hospital costs, spending could increase by as much as 4.8 percent annually over the next five to 10 years.¹² Economic forecasters predict that real GDP will grow only 3.3 percent annually over the next 10 years,¹³ meaning that increases in hospital costs and total health spending will continue to outpace economic growth.

3. Key Drivers of Hospital Costs

There are several factors driving up the costs of and spending on hospital services. These include:

- technological advancements, which lead to increased demand for services;
- health care worker shortages, which contribute to higher wages and higher costs; and
- the increasing number of uninsured people, which restricts access to preventive care, leading to costly hospital admissions and emergency room visits for avoidable conditions.

Technological Advancements

The key, long-term driver of hospital costs is advancements in medical technology, including new or improved pharmaceuticals, equipment and procedures. New technologies make it possible to diagnose more patients for treatment and make standard procedures safer and less invasive.¹⁴ This creates an increased demand for services, resulting in a greater need for providers to consider the costs versus benefits of utilization.

In the late 1990s, technology was responsible for up to 40 percent of the increases in health care spending.¹⁵ Even during the period of huge growth in hospital costs between 1980 and 1989, the single factor considered most important to these cost increases was advancements in new medical technology.¹⁶

The U.S. General Accountability Office points out that while new technologies increase quality of care and the quality of life for many patients, they cost more and result in higher input prices, including the labor, materials and equipment needed.¹⁷ In addition, competition among providers to attract physicians and patients creates an incentive for hospitals to be high-tech regardless of cost-effectiveness. This results in unnecessary duplication of costly services, which drives up health care costs.

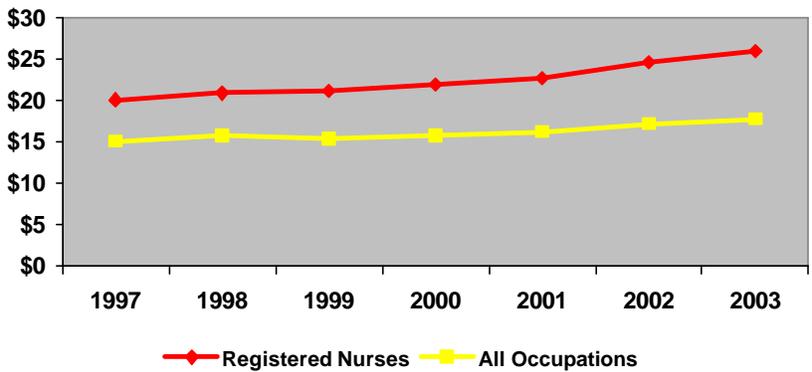
Health Care Worker Shortages

Rising wages caused by health care worker shortages are another major cost driver. Work force costs account for 50¹⁸ to 65¹⁹ percent of hospital operating expenses and can have a profound effect on inpatient hospital costs. Worker shortages drive up costs by forcing hospitals to raise wages to attract medical professionals. Payroll expenses account for 80 percent of direct inpatient costs, and direct costs related to nursing staff alone comprise 44 percent of these costs.

Payroll for health care workers has increased more than 8 percent annually for the last few years.²⁰ This impact is substantial considering that a 1 percent increase in hospital and physician office wage levels translates into a 2 percent or higher increase in inpatient hospital costs.²¹

Figure 3.1 shows how the mean hourly wage of registered nurses compares to the national average. In 2003 alone, the mean hourly wage in the United States for all occupations rose 3.3 percent, whereas the mean hourly earning for registered nurses rose 5.7 percent.²²

Figure 3.1 Mean Hourly Wage of Registered Nurses Compared to All Occupations, 1997 to 2003



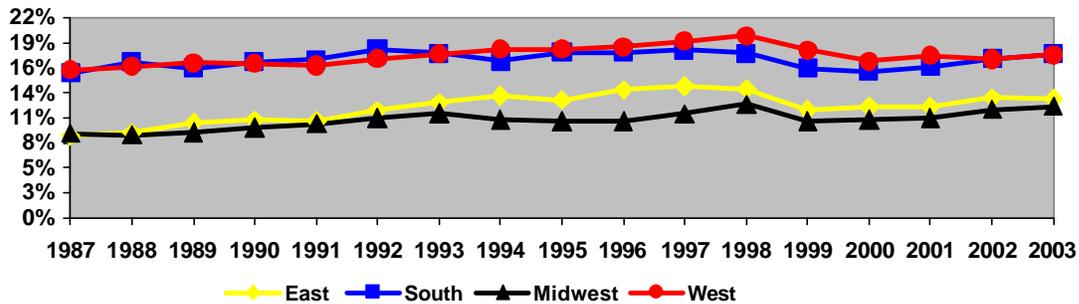
Source: U.S. Department of Labor, Bureau of Labor Statistics, National Compensation Survey 1997 to 2003

The aging of the population contributes to worker shortages in the health care field, especially in nursing. The majority of health care workers in the United States are baby boomers, born between 1946 and 1964. In fact, a recent CSG *TrendsAlert* reports that approximately 25 percent of the public health work force is currently eligible for retirement, and 30 percent will be eligible in 2006.²³ This is especially important considering it is coming at the same time that demand for health care is rising as the aging population requires more health services.

The Growing Number of Uninsured

The slowing of the economy also has a dramatic effect on hospital costs. Over the last three years, job losses and employer cutbacks in benefits have caused health insurance enrollment to decline by almost 1 percent.²⁴ The U.S. Census Bureau estimates that the number of uninsured increased from 43.6 million in 2002 to 45 million in 2003, which is almost 16 percent of the U.S. population under age 65.²⁵ Figure 3.2 shows the annual percent of uninsured between 1987 and 2003 by CSG region.

Figure 3.2 Percent of Population Without Health Insurance, by Region, 1987 to 2003

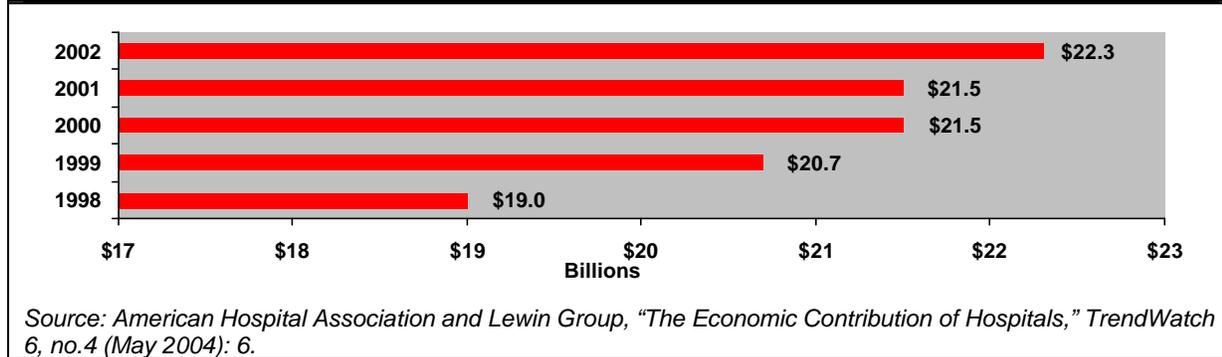


Source: U.S. Census Bureau, Current Population Survey, 1988 to 2004 Annual Social and Economic Supplements.

The percentage of people without health insurance varies by state, but few states have seen uninsured populations decrease. According to the U.S. Census Bureau, only two states have seen the percentage of their uninsured populations decline over the past four years.²⁶

The uninsured are less likely to seek preventive care, leading to costly hospital admissions and emergency room visits for avoidable conditions, thus increasing hospital costs.²⁷ Hospitals absorb many of the costs related to the care of the uninsured. In Wyoming, for example, hospitals were not reimbursed for about 50 percent of the \$10.6 million in inpatient and outpatient trauma care costs for fiscal year 2004 alone.²⁸ Figure 3.3 displays the total annual costs of uncompensated care to hospitals, including charity and other care for which payment was not received.²⁹

Figure 3.3 Total Costs to Hospitals for Uncompensated Care, 1998 to 2002



Containing Cost Drivers for the Long Term

The methods used to contain costs during the last economic slowdown in the early 1990s did not successfully alter long-term cost trends.³⁰ Managed care decreased hospital costs through the 1990s primarily by reducing the length of inpatient admissions and placing limits on provider payments.³¹ However, by 2000, due to growing discontent by consumers and providers, insurers scaled back their cost containment efforts.³² Combined with other hospital cost drivers, this caused costs to return to levels seen in the early 1990s.

Recent efforts to contain hospital costs that focus solely on cost shifting—particularly to consumers—will not successfully reduce health care spending because they fail to address the main drivers of rising costs. In fact, increases in cost sharing may raise the number of uninsured and discourage preventive care for those unable to afford the additional costs.³³

To impact hospital costs and effect cost drivers state leaders should focus on cost containment instead of cost shifting.³⁴ The following options for states strive to contain costs in the long-term by focusing on health care providers and consumers.

4. Options Focusing on Health Care Providers

Because technology and work force issues are the primary influences on rising hospital costs, states should consider measures to address both factors. Furthermore, adopting more than one policy allows states to tackle rising hospital costs more effectively than focusing on a single option.

Table 4.1 Hospital Cost Containment Options Focusing on Providers

Policy Option	Pro	Con
Efficiency Incentives		
<i>Public disclosure of quality and cost information</i>	Enables informed decisions	Requires provider and consumer participation
<i>Evidence-based and cost-effective medicine</i>	Increases quality of care	Providers may be reluctant
<i>Tiered health plans</i>	Encourages cost-effective care	Ineffective if quality not considered
<i>Administrative changes</i>	Lowers cost of labor	Security of information and quality of care must be considered carefully

Table 4.1 (continued) Hospital Cost Containment Options Focusing on Providers

Policy Option	Pro	Con
Health Care Market Regulation		
<i>Certificate of need</i>	Prevents unnecessary duplication of services	May stifle competition among providers
<i>Rate setting</i>	Spreads cost of indigent care across all payers	Complex system to set up

Efficiency Incentives

In addition to technology and capital costs, policy-makers should consider options that promote efficiency. These options encourage both providers and consumers to make informed choices before implementing any course of treatment. Efficiency can be promoted by:

- mandating public disclosure of quality and cost information;
- encouraging quality and evidence-based medicine that evaluates safety, effectiveness and cost;
- considering tiered-provider health plans that group providers based on cost; and
- administrative changes designed to contain personnel costs.

Public Disclosure of Quality and Cost Information

Governments can encourage improvements in quality and efficiency by requiring health care providers to publicize quality and cost information for total care over the course of an illness or a specified time period.³⁵ This information can help build “best practices” for use by hospitals and individual health care providers.³⁶

A public-private partnership called the Hospital Quality Alliance recently launched a Web site (<http://www.hospitalcompare.hhs.gov/>) for consumers that will report hospital quality data for heart attack, heart failure and pneumonia.³⁷ The site helps improve quality of care by providing the public with useful and easy to understand information about hospital quality, and standard quality measures and data collection methods.³⁸

Transparency in pricing encourages consumers to make informed choices about the cost of care and persuades providers to consider their rates. Maine’s Dirigo Health Reform Act recognizes this need by requiring providers to publicize prices for the most common services purchased, inpatient or outpatient.³⁹ California and Arizona also require that hospitals make fees available to the public.⁴⁰

Evidence-based and Cost-effective Medicine

States aspiring to promote efficiency can encourage evidence-based and cost-effective medicine. When using evidence-based medicine, providers consider effectiveness, safety and costs when diagnosing and treating a condition.⁴¹ While these practices will increase quality of care, provider and payer support is essential. Oregon, for example, promotes evidence-based medicine by evaluating the effectiveness of several prescription drugs and making the findings available to the public on a Web site.⁴²

Cost-effective medicine includes appropriate use of technology. Under the current system, providers often rely on attracting patients through the high-tech services they offer with no incentive to use economical alternatives, even when clinically warranted.⁴³ During this period of limiting provider payments, states must keep in mind that providers use technologies, such as MRI, to earn revenue.⁴⁴ To alleviate reluctance, states can institute incentive programs encouraging providers to evaluate a course of treatment’s clinical effectiveness and cost before it is used.⁴⁵

Tiered Health Plans

Rewards can be established to encourage providers to promote quality and efficiency.⁴⁶ Desired outcomes can be rewarded through financial incentives. One way to do this is through tiered fee-schedules.

Tiered plans suppress hospital costs in the same manner as they do for pharmaceuticals. Hospitals and providers are grouped based on cost, and co-pays vary based on tier with the least expensive providers commanding the lowest co-pays.⁴⁷ Individuals may select the tier when service is needed (tiered providers), or upon coverage enrollment (tiered premium).⁴⁸ Encouraging consumers to use hospitals in less expensive tiers contains costs, and providers are persuaded to improve efficiency in exchange for placement in a lower tier.⁴⁹

Private health plans have been using the tiered approach since 2002. Critics say these plans are not adequate because they fail to account for quality of care and the range of services provided.⁵² Some private insurers have responded to this criticism by including measures of quality and patient experience to determine appropriate tiers for hospitals.⁵³ In addition, the Medicare Payment Advisory Committee recently recommended to Congress that Medicare vary pay to providers based on quality of care.⁵⁴

Minnesota's Tiered Approach for State Employee Health Insurance

Minnesota has successfully used a tiered structure for its state employee health insurance since early 2002. Providers are categorized into four tiers based on cost.⁵⁰ Since implementation, Minnesota's annual increase in employee insurance costs has declined. Providers are encouraged to offer discounts to state employees in order to be moved to a more favorable tier.⁵¹

In order for tiering to effectively contain costs without financially burdening patients, detailed information must be available to assist consumers in making informed decisions.⁵⁵ While some health plans provide quality data and other decision-making tools to patients, the information systems required for successful implementation are still in the early stages of development.⁵⁶

Administrative Changes

Because labor accounts for a large portion of direct hospital costs, controlling increases means finding methods to contain labor costs without harming wages or quality of care. This can be accomplished by simplifying administrative processes and considering more flexible scopes of practice to relieve pressure the current complex system puts on personnel resources.

Florida's Response to Critical Nursing Shortages

In 2001, in response to nursing shortages across the state, the Florida Legislature established the Florida Center for Nursing to create a statewide strategic plan for nursing manpower, bring together key stakeholders and promote a positive image of nursing. The legislation also provided additional funding for nurse recruitment and education.

Initially, money from state general funds provided backing for the center, but the funds must be renegotiated each year. Nurses can voluntarily offer financial support for the center when renewing their licenses. In 2004, the center issued its statewide strategic plan that provides accurate forecasts of nursing supply and demand, evaluates the nursing educational system capacity and goals, and disseminates strategies for recruitment and retention. For more information, go to:

<http://www.flcenterfornursing.org/>

Providers face a maze of requirements from state and federal government agencies and private insurance companies.^{57,58} Each form or process required by a regulator or payer requires time and personnel. In some instances, reporting requirements, regulations and other information could be simplified, or a common form or process could be arranged among different payers and regulators.

In addition, implementing information technology systems creates administrative efficiencies. In 2003, new rules under the Health Insurance Portability and Accountability Act (HIPAA) took effect that set national standards for the exchange of electronic information in health care. The goal of these new standards is to reduce the administrative burden by allowing secure, electronic transactions to occur across all portions of the health care system.

States can further reduce costs by encouraging more flexible scopes of practice in health care professions. In some instances, certain duties performed by higher-cost workers can be shifted to lower cost workers without compromising care. Professional licensing regulations and turf battles among various health care professions, however, may prevent utilization of lower cost workers by hospitals and other health care entities. Some professionals argue that when lower cost workers provide certain services—like prescribing medications—the benefit of advanced education is lost, and quality of care may be compromised.

States can combat this by creating coordinating structures among agencies that regulate health professionals. Coordinating councils or umbrella agencies can ensure that scope of practice determinations are based on scientific research regarding cost-effectiveness and quality of patient care, not on the preferences of one professional group versus another. Some analysts have also encouraged states to move away from licensing individual health professions and instead provide interdisciplinary or institutional licensure and regulation.⁵⁹

The current worker shortage offers policy-makers an excellent opportunity to examine worker productivity and scope of practice. A close examination of who is doing what may reveal opportunities to increase efficiencies by broadening responsibilities for professionals at all levels of care. Job redesign, reducing paperwork and encouraging implementation of health information technologies are all elements of addressing the demand for workers.

Health Care Market Regulation

When addressing technology's role in rising costs, policy-makers need to manage the effect of technology on hospital prices without discouraging innovation or restricting patient access to quality care. No long-term cost containment plan will be complete without addressing access to medical technology, which can be done through regulation of the health care market.⁶⁰ Options targeting health care providers that focus on regulation include:

- certificate of need (CON) laws, which require providers to get approval for technology investment; and
- rate-setting, which controls the price of hospital services, offsetting any effect of technology.

Certificate of Need

In an attempt to control spending on technology, many states have had CON laws in place since 1974. These programs intend to limit duplication of costly technology and services and keep spending in check by requiring providers to obtain approval before investing in new technology, construction or services.⁶⁴ Currently, 36 states and the District of Columbia have CON laws, but the specific services reviewed vary and some laws are not fully enforced. States can re-examine CON provisions by expanding coverage and modernizing the review process.

For CON to contain costs, clear standards must exist for approval and denial of applications based on avoiding unnecessary duplication that would result in higher costs.⁶⁵ New technology will continuously develop, and CON can be a proactive tool to review capital expenditures to identify areas of need.⁶⁶

Proponents suggest CON has a “chilling effect” in that big-ticket investments are discouraged,⁶⁷ and funds not spent on new technology and capital can finance uncompensated care.⁶⁸

Researchers studying Florida's CON program found that regulators used the program as an incentive for the provision of indigent care.⁶⁹ They found that providers with high levels of indigent care had applications approved 79 percent of the time compared to 49 percent for providers offering low levels

Maine's Expansion of its Certificate of Need Program

Recognizing the usefulness of CON, Maine recently changed its program as part of the Dirigo Health Reform Act.⁶¹ In addition to hospitals, the act expanded CON to cover ambulatory surgery centers and physician's offices and requires review based on function and cost.⁶² The act also establishes the Commission to Study Maine's Hospitals, a nine-member board that will examine Maine's hospitals and make recommendations to the Legislature on how best to move forward. The commission will look at a wide variety of issues, including financing, reimbursements, assets, technology and staffing.⁶³

of indigent care.⁷⁰ As a result, researchers suggest hospitals have less incentive to provide indigent care under deregulation.⁷¹

Health care providers, on the other hand, have long opposed CON laws because technology, such as MRI, can be a source of income during this time of limiting provider payments.⁷² Opponents of CON claim that these laws are not effective at containing costs⁷³ and may stifle competition, giving established institutions an advantage.⁷⁴

Research is inconclusive regarding the impact of CON on patient outcomes. One major study evaluated the outcomes of more than 900,000 Medicare beneficiaries undergoing coronary artery bypass graft surgery between 1994 and 1999 in states with and without CON legislation.⁷⁵ Researchers found that mortality rates in states without CON laws were higher than in states with them.⁷⁶ After adjusting mortality for risk, researchers found that the figure was 22 percent higher in the states with no CON for open-heart surgery.⁷⁷ Although researchers cannot establish a firm causal link, there is a relationship between CON and patient outcomes for this particular surgery.

The Federal Trade Commission and the U.S. Department of Justice recently recommended that states consider eliminating CON programs because their negative effect on competition outweighs any cost benefit.⁷⁸ The American Health Planning Association argues, however, that CON can be useful in providing cost and quality information, encouraging competition and assisting regional planning and geographic distribution of health care services.⁷⁹

Rate Setting

States can limit technology's effect on hospital costs by controlling the prices of hospital services. A rate-setting system allows regulators—typically through a commission much like public utilities—to set the price hospitals can charge by imposing a limit on hospital revenues.⁸⁰ Rate-setting programs vary in terms of whether provider participation is mandatory or voluntary; whether the overseeing body is regulatory or advisory; which payers are included; and which services are regulated.⁸¹ The programs with the most success at influencing pricing have required mandatory participation of all providers and all payers, including out-of-pocket, HMOs, Medicare and Medicaid (all-payer systems); and are flexible and able to respond to a rapidly changing environment.⁸²

Maryland's All-Payer Rate-Setting System

Maryland is the sole state with a rate-setting program. In the mid-1970s, Maryland faced costs per admission that exceeded the national average by 25 percent.⁸³ In the mid-1990s, after 20 years of price regulation, the state's costs were 11 percent below the national average.⁸⁴ Due to its all-payer system, Maryland is the only state that can guarantee residents will receive care in any hospital, regardless of their ability to pay.⁸⁵ Part of the success in Maryland's system is flexibility in the enabling legislation, allowing agency staff to develop the program and the ability to limit negotiated discounts.^{86,87} For more information, go to:

http://hospitalguide.mhcc.state.md.us/Resources/md_regulatory_system_hosp_oversight.htm

Historically, rate-setting has successfully contained hospital costs and costs per admission.⁸⁸

Throughout the 1970s and 1980s, the states that instituted all-payer systems, including Maryland, New York and Washington, found their hospital costs rising more slowly than those without such a system.⁸⁹

Several states regulated hospital pricing in the past, but today only Maryland maintains a rate-setting program. Specific incidents in the health care industry—such as the growth of Health Maintenance Organizations (HMOs)—contributed to the decline of these regulatory programs. When HMOs grew rapidly in the 1990s, state rate-setting programs faced the decision of whether to require HMOs to pay state-regulated prices or to allow them to negotiate rates with providers.⁹⁰ Rather than include HMOs in the rate-setting system, many

states chose deregulation.⁹¹ Maryland overcame this issue by limiting negotiated discounts for HMOs to 4 percent.⁹² Complex laws and regulations created another problem with rate-setting programs in many states.⁹³ Maryland avoided this by building flexibility into its enabling statute.⁹⁴

Cost containment is just one benefit of hospital price regulation through an all-payer system. Because of high numbers of uninsured patients, hospitals and states are burdened by uncompensated care. Price regulation makes it possible to spread the burden of caring for indigent patients evenly among payers, ensuring access to care and equity in pricing.⁹⁵ It is important to note that hospital charges do not always reflect the actual cost of care.⁹⁶ Rates for identical services vary between hospitals and depend on who is paying the bill.⁹⁷ For instance, while insurers secure negotiated rates for their patients, the uninsured pay full price for all services—from an aspirin to an x-ray.⁹⁸ An all-payer system eliminates this disparity.

Because health care is not a typical economic good or service, proponents of regulation contend that the private market is not appropriate for health care.⁹⁹ Hospital services are different due to limited information and choice, significant consequences based on treatment decisions and the need for health care professionals to assist in decision-making.¹⁰⁰ Supporters also argue that the past shows hospital costs grow more slowly when government structures the framework for pricing.¹⁰¹

A major argument against regulation of the health care market, through CON or rate-setting, is that price competition and market forces result in lower prices, higher quality and better technology.¹⁰² Moreover, limiting market competition may restrict patient access to health care services, and the benefits of scientific advancement could diminish.¹⁰³

5. Options Focusing on Health Care Consumers

In addition to considering policy options focused on providers, states also need to address issues concerning health care consumers. To contain costs for the long term, states must evaluate options targeting the population, particularly methods to improve health and provide every citizen access to insurance.

Table 5.1 Hospital Cost Containment Options Focusing on Consumers

Policy Option	Pro	Con
Keep People Healthier		
<i>Public health support</i>	Proactive investment that keeps people healthy	Difficult to quantify
<i>Disease management</i>	Reduces long-term costs	Requires provider support
Expand Access to Insurance		
<i>Reinsurance</i>	The insured are less costly in the long run	Costly to establish initially
<i>High-risk pools</i>	Encourages preventive care	May require reallocation of funds
<i>Insurance options for low-income populations</i>	Maximizes federal matching dollars	May require federal government approval

Keep People Healthier

Many factors that lead to the use of expensive health care services are preventable, making state policies and programs focused on improving citizens' health vital. Despite evidence that population-based investments save money, the current health care system is organized to react when an individual gets sick instead of proactively keeping entire populations healthier. Options to improve health include:

- promoting public health programs such as tobacco cessation and nutrition; and
- disease management, a set of interventions designed to improve the health of a group of individuals, especially those with chronic diseases.

Although these options for improving health are crucial to reduce long-term costs, the impact of these programs can be hard to quantify for certain populations, such as fee-for-service Medicaid enrollees. In addition, cost savings are not always immediate and can take years—if not decades—to fully surface.

Public Health

Currently, 95 percent of state funding for health finances services for individuals instead of programs that could serve an entire population, such as preventing diseases and promoting healthy behavior.¹⁰⁴ This is important because improvements in health status result more often from population-based public health initiatives.¹⁰⁵

The Centers for Disease Control and Prevention recently reported that approximately half of all deaths in 2000 were attributable to a few, mostly preventable, factors. Tobacco use, poor diet and physical inactivity accounted for one-third of all deaths.¹⁰⁶ In light of such statistics, states seeking to improve public health may want to include initiatives for tobacco cessation, access to nutritional foods and increased physical activity.

Researchers estimate that smoking cessation can reduce the anticipated medical costs for a smoker \$47 the first year and \$853 during the next seven years due to the reduced risk of heart attack or stroke.¹⁰⁷ Some states have addressed tobacco use by conducting media campaigns, increasing taxes on cigarettes to discourage use and city-wide or state-wide bans on smoking in public places.¹⁰⁸ Massachusetts' Tobacco Control Program reduced smoking during pregnancy from 25 percent in 1990 to 13 percent in 1996.¹⁰⁹ The Massachusetts Association of Health Boards recently reported, however, that budget cuts to the Tobacco Control Program increased the number of illegal sales to minors to twice the national average.¹¹⁰ The rate of sales jumped from 9.3 percent in 2002 to 29 percent in 2003.¹¹¹

Delaware enacted a smoking ban in late 2002 and has since seen the rates of smoking in the state drop, particularly among adults age 18 to 24. In 2003, 26.7 percent of young adults in Delaware smoked compared to 36 percent in 2002.¹¹² Mississippi reduced smoking among public middle school students by 48 percent and public high school students by 29 percent by using tobacco settlement funds to establish prevention programs.¹¹³ California also reports significant savings related to its prevention programs, which began in the early 1990s.¹¹⁴

States must also work to combat another key health threat: obesity. Approximately 65 percent of the U.S. population is overweight or obese, costing the health care system more than \$117 billion per year in direct and indirect medical costs.¹¹⁶ Expenses to individual states are significant; between 1998 and 2000, for example, obesity cost Wyoming \$23 million and New York \$3.5 billion in Medicaid expenditures.¹¹⁷

Obesity is costly because it leads to other chronic illnesses, such as diabetes and hypertension, and even death. Indirect costs include the value of income lost due to low productivity, absenteeism, and future income lost due to premature death.¹¹⁸ The American Cancer Society reports that the 90,000 annual cancer deaths related to obesity could be prevented if those individuals maintained a normal body weight.¹¹⁹ Another project examined data from the Framingham Heart Study—a longitudinal study of adults spanning 50 years.¹²⁰ Researchers examined 40 years of data for study participants age 30 to 49 at baseline. They found that overweight non-smokers decreased their life expectancy by three years; and six and seven years for obese men and women, respectively.¹²¹ If these trends persist, obesity will become the number one killer in America.

Despite the high costs and adverse health effects of obesity, most states have not adequately addressed the nutrition and physical activity needs of their residents. According to the Trust for America's Health, as of late 2004 only four states—California, Hawaii, Texas and West Virginia—had set nutritional standards for vending machines and other non-school lunch foods sold in schools.¹²² Additionally, few states have made comprehensive statewide efforts to increase physical activity.¹²³

Arkansas Study of the Effects of Obesity

In 1999, the state Senate asked the Arkansas Department of Health to study the impact of obesity and the related costs. The study and subsequent report led to increased staff and financial resources for obesity-related issues and legislation requiring physical education and body mass index (BMI) measurements for children in public schools.¹¹⁵

Disease Management

Disease management can present states with an opportunity to decrease hospital costs by improving health without adversely affecting access to or quality of care. Disease management “is essentially a coordinated, proactive, disease-specific approach to patient care that seeks to produce the best clinical outcomes in the most cost-effective manner.”¹²⁴ While programs can vary in structure, the ultimate goal of disease management is to improve the health and quality of care of chronic illness sufferers and reduce costs by managing chronic diseases long-term.¹²⁵

Disease management programs identify and enroll high-risk patients who have incurred or may incur high costs related to their illnesses; give these patients tools to manage their condition and change risky behaviors; provide evidence-based protocols for care to health care professionals; and coordinate the patient’s care, including rigorous follow-up and feedback.¹²⁶

Almost half the U.S. population—125 million people—suffers from at least one chronic condition.¹²⁷ These illnesses—such as asthma, diabetes and congestive heart failure—are responsible for seven out of every 10 deaths in the United States¹²⁸ and account for more than 75 cents of every dollar spent on health care in this country.¹²⁹ Many of these costs result from expensive hospitalizations and emergency care and could be prevented through proper monitoring of the condition.¹³⁰ In fact, people with chronic illnesses account for 76 percent of all hospital admissions, 88 percent of all drug prescriptions and 72 percent of all physician visits.¹³¹

Despite the high costs related to chronic illnesses, the existing health care system manages acute episodes instead of providing patients and health care professionals the tools to prevent these emergencies by managing chronic illnesses effectively.¹³² Due to ineffective care coordination, the current infrastructure has not effectively managed chronic illnesses. This leads to conflicting medical advice, possible drug interactions, the absence of evidence-based protocols for treating chronic illnesses and lack of follow-up to monitor patient’s self-care and changes in their health condition.¹³³

Washington’s Disease Management for Medicaid Fee-for-Service Enrollees

In 2002, Washington contracted with disease management organizations to offer programs for chronic heart failure, diabetes, asthma and end-stage renal disease. In a six-month period, patients showed significant improvement in indicators related to health improvement for 16 out of 19 measures. Preliminary outcomes report significant increases in patient self-management. In late 2003, the Disease Management Association of America recognized Washington’s Medicaid disease management program as the best program in the country.¹³⁴ According to McKesson Health Solutions, working well with the state Medicaid staff and involving stakeholders in the community have been the keys to success in Washington.¹³⁵

About half the states are experimenting with disease management.¹³⁶ For example, in 2003, Mississippi contracted with McKesson Health Solutions, a disease management organization, to provide services to statewide Medicaid enrollees diagnosed with asthma, diabetes and hypertension. Preliminary outcomes from a small sample of asthma patients demonstrate that hospital costs fell 96 percent and emergency room visits declined 58 percent.¹³⁷

Research indicates disease management’s greatest benefit is improved health, resulting in decreased morbidity and mortality, increased patient satisfaction and reduced health care costs.¹³⁸

Despite these potential advantages, however, disease management programs have been

criticized due to insufficient program evaluation, inattention to comorbidities (having two or more diagnosable conditions at the same time), inadequate physician involvement and limited evidence that disease management increases patients’ self-management skills.¹³⁹

Preliminary evidence indicates that disease management can save states money. McKesson Health Solutions evaluated the financial outcomes of its asthma disease management program for the Medicaid population. Hospitalizations decreased 50 percent and emergency department visits decreased 28 percent for participants between November 1998 and April 1999.¹⁴⁰ These reductions led to an estimated 131 percent return on investment.¹⁴¹

However, not all studies have found cost savings. A 2001 review by the Florida Legislature's Office of Program Policy Analysis and Government Accountability criticized the disease management program, noting that the agency spent \$24.1 million on implementing the initiative, but did not produce analysis demonstrating that actual savings met original projections.¹⁴²

Disease management is one method of managing chronic illnesses and dealing with the special needs of people with long-term conditions and the costs of those needs. It is one emerging response to the high health care costs related to chronic illness, the fragmented nature of chronic illness care, and the fact that care for chronic illnesses often does not follow evidence-based guidelines.¹⁴³

Expand Access to Insurance

Between 2002 and 2003, the percentage of people in the United States covered by employer-sponsored health insurance dropped from 61.3 percent to 60.4 percent.¹⁴⁴ When considering long-term changes in hospital and health care cost trends, it is important for states to ensure all citizens have access to some form of insurance. Options include:

- using reinsurance, which helps lower an insurance company's risk;
- creating a high-risk pool, which provides insurance for people rejected by other insurance plans due to risk; and
- expanding insurance options for low-income populations.

While each option for expanding insurance access reduces the number of uninsured, cost savings may not be immediately realized. In fact, states will have to spend money to increase access to insurance. Because caring for the uninsured is more expensive in the long run, cost savings should be realized.

Reinsurance

Several states use reinsurance to keep premiums low and to support the health care insurance market. Reinsurance—insurance for insurers—helps lower an insurance company's risk of claims in excess of the amount paid in premiums. Lower risk means a company can set premiums that reflect typical costs to care for a plan member without anticipating paying for those few who will cost significantly more because of accident, illness or disease.

Arizona's program, Healthcare Group of Arizona, aims to increase the number of small businesses offering employer-sponsored health care coverage (currently only 28 percent) by making plans less expensive. The state contracts with managed care organizations (MCOs) that then sell coverage to eligible small businesses. The state reinsures the MCOs for claims over \$100,000 to protect them from the risk of high-cost medical cases and to assure financial stability. The state appropriates funds to pay for the program, which currently covers 11,200 individuals.¹⁴⁷

The Healthy New York program reinsures participating HMOs by covering 90 percent of claims between \$5,000 and \$75,000 per member per year. The program targets small businesses with low-wage workers and individuals with lower incomes, and currently insures 40,000 people. Like Arizona, New York pays for this program through state appropriation.¹⁴⁸

Maine's Low-Cost Health Plan for Business and Individuals

Maine will offer a health plan to businesses and individuals aiming to reduce the financial burden for qualified employers and low-income enrollees by sharing the costs of coverage.¹⁴⁵ Benefits of this health plan include disease management and the distribution of quality information.¹⁴⁶ This plan covers low-risk individuals as well as those who would traditionally be covered in a high-risk pool. For more information go to: <http://dirigohealth.maine.gov/>.

High-Risk Insurance Pools

Currently, 34 states have high-risk pools covering approximately 172,000 people.¹⁴⁹ While state programs vary, a person can generally qualify for a program if an insurance company has rejected him or her because of high risk or due to a specific health condition. Premiums for high-risk plans are higher than market average, and states sometimes cap enrollment and/or lifetime benefits.

Some states look at these plans more favorably because the 2002 Trade Adjustment Act made money available to states for establishing high-risk insurance pools to cover some of the losses associated with these plans. While the plans cover only a small group of individuals—1 to 2 percent of the population—they are a critical source of coverage for this population. High-risk pools will initially cost states because insurance is extended to costly people, such as AIDS patients and the chronically ill. The positive impacts are that high-risk individuals have access to health care at a lower cost and health insurers can keep costs down.¹⁵⁰ Health coverage also makes these people more likely to seek preventive care, lowering costs in the long run.

Insurance Options for Low-Income Populations

Medicaid cuts result in fewer federal matching dollars and increases in hospital and health care costs.¹⁵¹ During a time when many states are making cuts to their public insurance programs, some states are seeking to insure more individuals by expanding these programs or finding different ways to extend health coverage to low-income populations.

New Mexico, for example, got a federal government waiver to use money from the state's Children's Health Insurance Program for partial funding of its State Coverage Initiative program. The state wants to create an affordable insurance product for employers who don't currently offer coverage. Premiums will be financed through a combination of employer, employee, state and federal contributions.¹⁵²

Also through a waiver, Maryland offers PrimaryCare, a program for adults with chronic illnesses who are not eligible for Medicaid but participate in the state's pharmacy assistance program. Services covered include office visits, diabetes treatment and maintenance drugs.¹⁵³

Rhode Island has implemented RItE Share, a premium assistance program for families eligible for the state's Medicaid program but who also have access to approved employer-sponsor health plans. Instead of enrolling these families in Medicaid, the state instead pays the employee portion of the premium. Because premium assistance costs half what full coverage in Medicaid would cost, the state estimates that for every 1,000 full-year RItE Share enrollees, it saves \$1 million.¹⁵⁴

Conclusion

While hospital costs are the most expensive line item in health care, prescription drugs often take the limelight in formulating a policy response. As state revenues decline and health care costs soar, state leaders must fix the problem now while simultaneously implementing initiatives that will contain costs long-term. States can take steps to control hospital spending, encourage quality and promote good health. From managing access to technology to rewarding quality, options exist that can limit spending without compromising care.

Glossary

Baby Boomers – Americans born between the years 1946 and 1964.

Chronic Illness – A chronic illness is any health condition that requires ongoing care for more than a year and may limit a person's activities. Some of the most common examples of chronic illnesses include asthma, arthritis, Alzheimer's disease, cancer, depression, diabetes, heart disease, stroke, and HIV/AIDS.

Cost Shifting – Cost shifting is used to describe mechanisms including rising insurance premiums and co-pays that increase out-of-pocket expenses of health care consumers. It is a way to lower costs by reducing utilization of health care based on the premise that having to pay more to access services encourages people to do so less often.

Disease Management – Disease management is a set of interventions designed to improve the health of a group of individuals, especially those with chronic illnesses. This is accomplished by identifying and enrolling high-risk patients who have or may incur high costs related to their illnesses, give them the tools to manage their condition and change risky behaviors, provide evidence-based protocols for care to health care professionals, and coordinate the patient's care including rigorous follow-up and feedback.¹⁵⁵

Fee-for-Service (FFS) – Payments to providers are based on the specific services rendered and are made each time he or she provides a different service.¹⁵⁶ In Medicaid, this group is not covered under an HMO that contracts to provide services to the Medicaid population.

Health Insurance Portability and Accountability Act (HIPAA) – This bill, passed by Congress in 1996, established minimum standards for access, portability and renewability of coverage for all health plans. Provisions of the bill include guaranteed issue and renewability, limits on waiting periods for preexisting conditions, nondiscrimination based on health status and portability of coverage.¹⁵⁷

Managed Care – This system of health care involves a limited network of providers and cost controls through capping provider payments.

Population-based Health Care – This strategy involves implementing health care initiatives after assessing the needs of a specific population in order to improve the health of that population.¹⁵⁸ Health care delivery is done on an individual basis but within the context of the overall population and with the goal of improving the health of the entire group.¹⁵⁹ A population can include an entire community, as is the case with public health initiatives; a panel of enrollees, as in managed care; or to groups of people with similar demographics, conditions or health status.¹⁶⁰

Utilization Management – Used in managed care systems to monitor the use of, or evaluate the medical appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities.¹⁶¹

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