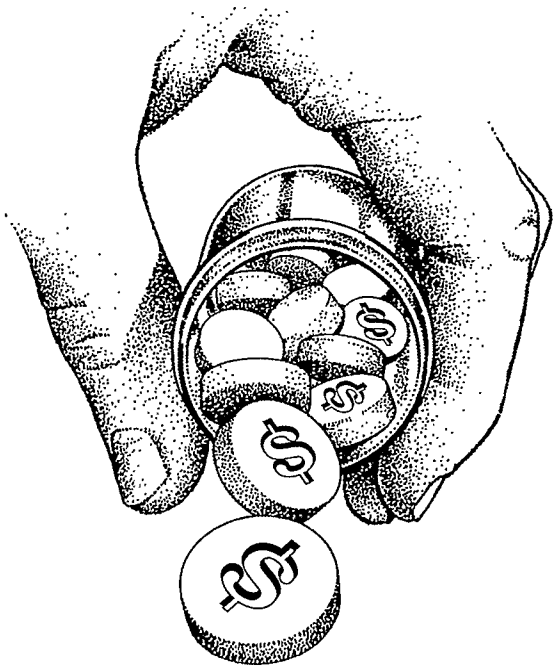

Health Care Cost Containment: Does Anything Work?

by Nina Yeager and Jack Betts

North Carolinians shelled out an estimated $12.3 billion in total health care expenditures in 1990, and that huge sum is projected to soar to $32 billion by 2000. The rapid increase in health care facilities and equipment is part of the reason, and so is the cost of certain medical procedures. What drives the high cost of health care? And what can be done to come to grips with these sky-rocketing costs? What devices have other states used to try to put a lid on cost increases and still provide adequate levels of care to their citizens?

Think of national health care costs as a line on a piece of graph paper. And compare that line to a few other graphic cost lines. The personal income line: steadily up, more than 7 percent per year from 1983–1990. The corporate profit line: moderate growth over the same period, up by an average of about 4.8 percent. The government revenue line: average growth of 9.75 percent. The consumer price index: generally up, an average of 4.7 percent.

And then there's the health care line—up, up, up: From 1980 through 1990, up every year, for a whopping average of 10.4 percent. That makes the growth in health care costs soar over other increases and off the edge of the page.

State policymakers and health care officials are wringing their hands about how to rein in health care costs—and about the impact of efforts to control costs on the delivery of care. This is what one foundation has to say: "Health care costs in the United States have risen dramatically, far outpacing economic growth, general inflation, and families' incomes. These spiraling health costs are creating an emergency—a crisis of affordability for consumers, government, labor, and business. Families are paying more in premiums, deductibles, and copayments while often seeing their benefits shrink. Employers faced with double-digit premium increases now find that health care costs [are equal to nearly] 94 percent of net profits. Rising costs have also resulted in a growing number of Americans without adequate health coverage, or none at all."[1]

Too dramatic a description? Consider the rate of spending from all sources—public and private—on health care in the United States. Not that long ago—1980 to be precise—we were spending about $230 billion annually on health care—a tidy sum. In 1990, we managed to spend nearly triple that amount—about $606 billion. By 2000, Families USA Foundation projects, the total tab will have more than doubled again—to a projected $1.5 trillion, give or take a few score billion dollars. "The cost of health care is out of control and beyond control," says Glenn Wilson, professor of social medicine at the UNC–Chapel Hill School of Medicine.

Unfortunately, the 1991 health-care price hike of 11.8 percent is not unusual, and Families USA Foundation predicts that costs won't moderate over the next decade. The group says that without fundamental reforms in our health care system, per capita spending on health care will consume 15 percent of the nation's gross national product by 2000.

The news is no better for North Carolinians than for the rest of the country. Total health care spending in North Carolina rose 137 percent between 1980 and 1990 and will more than double by the year 2000, from an estimated $12.3 billion in 1990 to a projected $32.2 billion in 2000 (see Table 2, page 52). In one year alone, hospital bills in North Carolina rose by nearly 18 percent.[2]

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The strain of rising health care costs on state government was evident during legislative budget deliberations for the 1991–93 biennium. In the midst of a $1.2 billion budget shortfall, the State Employees Health Plan needed $75.2 million in state appropriations to meet the cost of health care for state employees and retirees. Meanwhile, the state's Medicaid Plan needed $113.3 million in new money to cover *current* operating expenses—an increase of 25 percent over the previous year.

Government is not the only third-party payer complaining. In a 1990 survey conducted by *Business and Health* magazine, nine of 10 top executives in firms averaging 3,500 employees listed rising health insurance premiums as the health care issue of greatest concern. On average, premiums for employees in the companies surveyed rose 20 percent in 1990.

The picture is even worse for small business owners, some of whom complain premiums have jumped more than 150 percent since 1984.[3] Leaders of organized labor, like their management coun-

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terparts, see the escalating cost of health care premiums for employees as the most critical and potentially disruptive element in employee relations today.

These rate increases bring up a central question, says Blue Cross and Blue Shield of North Carolina economist Sandra Greene. "How much more can we expand the health care system and still afford to pay the bill?" she asks. Greene says North Carolina is engaging in a "medical arms race" that makes health care increasingly costly—at least in part because there are so many high-cost medical facilities and high-tech services and devices available.[4] Greene says a national Blue Cross and Blue Shield study—not released to the public—found that many costly procedures were performed more frequently on Blue Cross and Blue Shield of North Carolina subscribers than among BCBS subscribers in 15 other states studied, puncturing the myth that we are a medically underserved state.[5] "We have to conclude from this that our subscribers are receiving large amounts of medical care in this state," notes Greene, who asks whether all this care really is necessary.

Figures from the N.C. Medical Database Commission point out clearly how the costs of certain medical procedures have increased in a short period. The commission noted that the average cost of a heart transplant increased from $88,496 in 1988-89 to $139,773 in 1989-90, a 57.9 percent increase (see Table 3, page 55, for more). The cost of a cardiac valve procedure was up 16 percent, from $47,846 to $55,494; and the cost for a coronary bypass was up from $29,417 to $33,643—a 14.4 percent increase.[6]

The North Carolina Hospital Association is equally concerned about these high costs. In a recently-adopted policy statement, the association points out that in one year alone (1988), the average cost of hospitalization in North Carolina jumped from $4,400 to $5,008, according to figures from the database commission.[7] One reason for that huge increase is "cost-shifting," the association says—covering the unpaid bills of indigents by shifting their costs to paying customers. That can amount to a third of bills, and may hit the 50 percent mark by 1994 (see Figure 1, page 54).

Higher costs do not mean that more Americans have access to health care. On the contrary, the number of uninsured Americans rose from 25 million in 1980 to an estimated 37 million in 1989.[8] At least one person in eight has trouble getting access to health care of any kind. The ranks of the medically indigent are likely to swell as employers stop offering health insurance benefits entirely. It is clear that until we get control of rising costs for those who are already insured, there's little hope for expanding coverage to growing numbers of medically indigent citizens.

There are those who see runaway health care costs as potentially apocalyptic—threatening the very viability of the nation itself. Former Colorado Gov. Richard Lamm calls rising health care costs an "economic cancer" that threatens the nation's competitive edge in the international marketplace. He has become a proponent of rationing health care. "We're denying polio and flu shots to kids for exotic things like Barney Clark's artificial heart," says Lamm.[9]

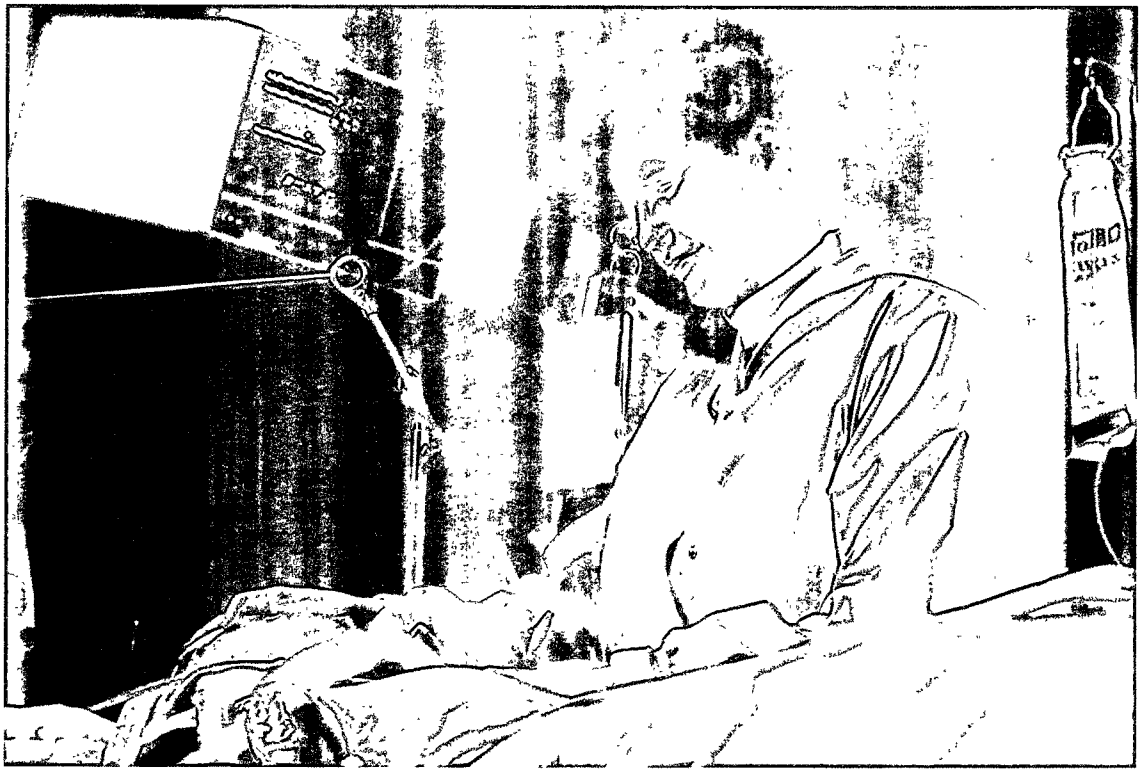
Table 1. Rate of Growth in Selected Costs of Living, 1980-1990

Energy:	1.9 percent
Apparel:	3.6 percent
Transportation:	4.5 percent
Rate of Inflation (CPI):	**4.7 percent**
Food and Drink:	5.2 percent
Entertainment:	5.8 percent
Housing:	5.9 percent
Medical Care:	**10.4 percent**

Source: Dan M. Bechter, "Consumer Prices," Cross Sections, *Federal Reserve Bank of Richmond, Spring 1991, p. 12.*

What Factors Drive Up Health Care Costs?

Although there is little agreement about what to do to cure the cost problem, there is some agreement among experts about what factors are driving costs. Those factors include 1) high technology, 2) demographic changes, 3) the American psyche, 4) mental health coverage, 5) health care



Wake Medical Center

wages, 6) physician fees, 7) malpractice costs, 8) administrative costs, 9) marketing, 10) growth of outpatient care, 11) cost shifting, and 12) price insensitivity.

1. *High Technology:* Powerful medical technologies such as life-saving artificial organs, advanced wonder drugs, experimental cancer treatments, advanced diagnostic devices, and new infertility treatments are major factors in the cost equation. Advances in high-technology medicine may contribute more than 50 percent to annual cost inflation for health care, economists estimate.[10] Ironically, researchers and health care officials alike expected that high technology would be a powerful cost-*cutting* force. In addition, medical success itself often adds to the health care tab (see sidebar on page 105 for more). For example, recent advances in neonatal care enable premature babies weighing under a pound to survive at a cost ranging from $200,000 to $1 million. Unfortunately, about 30 percent of the premature babies who survive have handicaps which require additional health care spending.

What's worse, not all technologies actually improve care or are even necessary. A Rand Corporation study of Medicare records for 300,000 patients found that more than one-third of three major procedures—coronary angiography, upper gastrointestinal endoscopy, and opening carotid arteries—were unnecessary or of questionable benefit.[11] Other studies have concluded that as much as 20 percent or $100 billion of the money spent on health care is wasted.[12]

2. *Demographic Changes:* High-tech medicine combined with an aging population is a potent force that will drive health care costs in the years ahead. On average, 85 percent of an individual's health care expenses accumulate in the last two

North Carolina is engaging in a "medical arms race" that makes health care increasingly costly—at least in part because there are so many high-cost medical facilities and high-tech services and devices available.

Table 2. Spending on Health Care, All Sources, by State

State	Estimated Per Capita Spending 1990	Rank	Total Spending in 1990 (billions)	Estimated Per Capita Spending 2000	Total Estimated Spending in 2000 (billions)
Alabama	$2,286	26	$ 9.5	$5,201	$22.7
Alaska	2,367	21	1.2	5,390	3.2
Arizona	2,211	30	8.1	5,031	23.3
Arkansas	1,944	42	4.7	4,423	11.1
California	2,894	2	84.7	6,584	223.6
Colorado	2,415	20	8.0	5,496	18.8
Connecticut	2,699	6	8.8	6,136	20.9
Delaware	2,268	27	1.5	5,160	4.1
Florida	2,427	19	31.4	5,520	90.1
Georgia	2,072	38	13.7	4,714	37.7
Hawaii	2,469	15	2.8	5,619	7.6
Idaho	1,726	49	1.7	3,926	3.9
Illinois	2,619	8	30.6	5,953	69.8
Indiana	2,201	31	12.4	5,004	28.5
Iowa	2,351	22	6.6	5,343	13.6
Kansas	2,548	11	6.4	5,792	14.7
Kentucky	1,875	43	7.0	4,266	15.7
Louisiana	2,185	33	9.5	4,972	20.6
Maine	2,175	34	2.7	4,945	6.6
Maryland	2,436	18	11.6	5,541	31.1
Massachusetts	3,031	1	17.9	6,890	42.4
Michigan	2,569	9	23.9	5,840	54.7
Minnesota	2,480	14	10.9	5,641	25.8
Mississippi	1,751	48	4.6	3,984	11.0
Missouri	2,568	10	13.4	5,837	31.9
Montana	2,059	39	1.6	4,686	3.5
Nebraska	2,452	16	3.9	5,576	8.6
Nevada	2,757	4	3.1	6,272	8.8
New Hampshire	1,981	40	2.3	4,505	6.4
New Jersey	2,224	29	17.4	5,056	42.4
New Mexico	1,792	45	2.7	4,078	7.1
New York	2,818	3	50.4	6,408	115.1
North Carolina	**1,833**	**44**	**12.3**	**4,170**	**32.2**
North Dakota	2,661	7	1.7	6,051	3.6
Ohio	2,493	13	27.2	5,667	61.9
Oklahoma	2,139	35	6.8	4,867	14.2
Oregon	2,312	24	6.5	5,260	15.3
Pennsylvania	2,536	12	30.5	5,763	69.6
Rhode Island	2,707	5	2.7	6,153	6.4
South Carolina	1,689	50	6.0	3,842	15.2
South Dakota	2,322	23	1.6	5,278	3.7
Tennessee	2,262	28	11.3	5,145	27.9
Texas	2,192	32	37.4	4,987	88.9
Utah	1,784	46	3.1	4,062	7.5
Vermont	1,956	41	1.1	4,448	2.7
Virginia	2,076	37	12.9	4,724	34.4
Washington	2,311	25	11.1	5,258	27.3
West Virginia	2,088	36	3.8	4,752	7.8
Wisconsin	2,449	17	11.9	5,567	26.9
Wyoming	1,756	47	0.8	3,996	1.6
United States	**$2,425**		**$605.9**	**$5,515**	**$1,476.5**

Source: State Policy Reports; *Vol. 9, Issue 1, p. 18; and LEWIN/ICF Health & Sciences International Co. for the Families U.S.A. Foundation and Citizen Action, Washington, D.C.*

A hospital bed is a parked taxi with the meter running.

— GROUCHO MARX

years of life.[13] This is true regardless of age, since accidents and illnesses occur throughout lifetime and may require large expenditures whenever they occur. Still, the elderly do account for large portions of health care costs. "Today, those over 65 account for about 11 percent of the population and consume 35 percent of all health care dollars," *BusinessWeek* magazine reports. "By 2040, those over 65 will account for 20 percent of the population and will use an even greater proportion of health care expenditure, since many medical technologies are aimed at prolonging their lives."

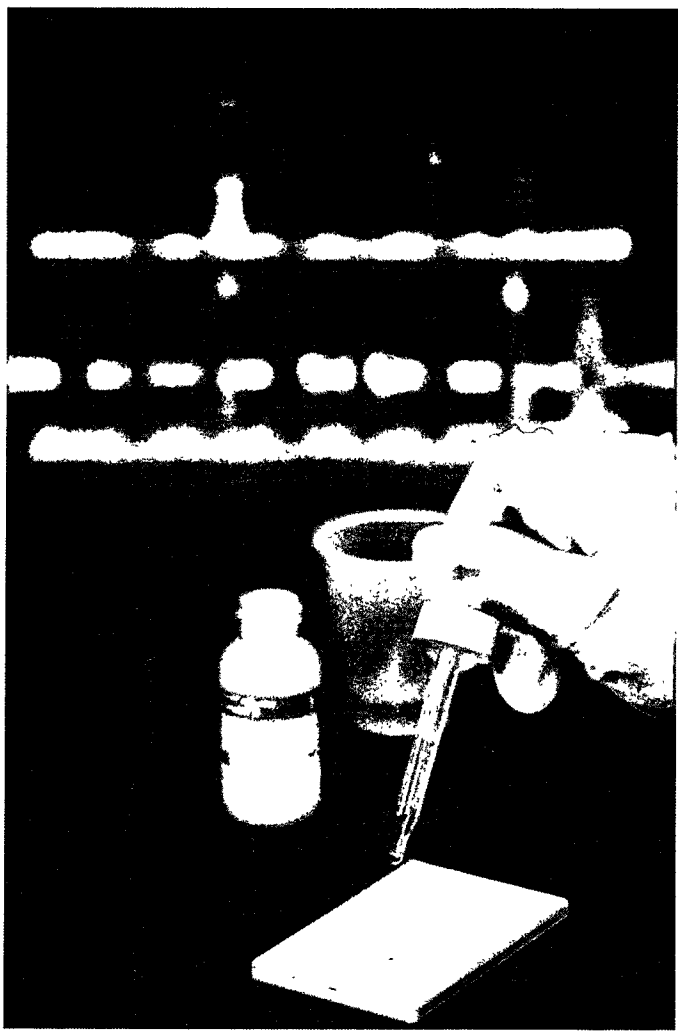
3. *The American Psyche:* Most American citizens believe that alongside life, liberty and the pursuit of happiness is the right to the best and newest in American medicine (see article on page 109 for more). A 1987 Harris Poll found that nine out of every 10 Americans believe that everyone deserves care "as good as a millionaire gets"[14]

4. *Mental Health Coverage:* Depression, substance abuse, and stress-related health problems rank among the top 10 health problems in the work force. Once inaccessible to the average employee, expanded medical coverage for these problems now accounts for about 10 percent of employer medical plans.[15]

5. *Health Care Worker Wages:* From 1977 to 1987, wages in most industries failed to keep pace with inflation, but health care workers did better, outpacing employees in the rest of the economy by 6.8 percent per year compared to 5.5 percent for other workers. Economists consider these wage increases a significant factor in the rapid rise of health care costs. Recent improvements in wages for nurses, who provide the bulk of patient care but who have been in short supply until recently, are likely to continue in order to keep health care facilities operating and viable.

6. *Physician Fees:* The overall rise in physician incomes has played its part in the rising cost of health care. The net income of physicians grew 8.1 percent per year compared to 5.5 percent for other workers from 1977–1987. In 1987, the typical income for a physician was $116,000, but the median income for specialty physicians was nearly three times that amount.[16] Rising incomes are *not* related to increased productivity. On the contrary, physicians are seeing 8 percent fewer patients per week than 10 years ago despite—or because of—an increase of 44 percent in the number of physicians over the same period.

7. *Malpractice and Defensive Medicine:* When physicians order tests or other services in order to protect against charges of malpractice—rather than because they believe those services to be of value to their patients—they are practicing *defensive medicine.* Extensive record-keeping and



Karen Tam

unnecessary patient testing reduce physician productivity and increase costs. Some studies indicate that up to 25 percent of doctors' procedures are done for defensive reasons.[17]

8. *Benefit Administration:* Physicians and hospitals face a bewildering array of insurance plans which require substantial numbers of clerical personnel to handle the large volume of paperwork. The greatest growth in health care employment has been in the offices of physicians and surgeons, where employment has been increasing at an average rate of 7.6 percent annually.

9. *Health Care Marketing:* Increased competition among providers for paying consumers of health care has meant marketing, advertising, new computer systems, management consulting, and the like. These additional costs are not likely to result in an increase in the quality or quantity of health care delivered, but they do increase the overall cost of delivering care.

10. *Growth of Outpatient Settings:* In hope of reducing overnight hospital stays for routine treatment, medical insurers and employers encouraged the use of a variety of programs to increase outpatient care in doctors' offices and clinics. The result is that today, those outpatient settings contain laboratory, diagnostic, and surgical equipment that once was available in hospitals only. This proliferation of equipment, combined with advances in surgical techniques, has reduced *inpatient* hospital care.

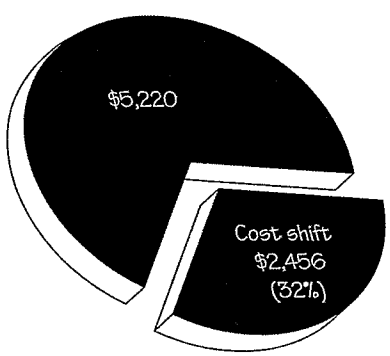
That's the good news. The bad news is that the cost of health care has continued to rise, particularly costs for *outpatient care.* In 1988, outpatient costs rose 25 percent. One reason for the rise in costs may be third-party payers' failure to control utilization of outpatient care. Outpatient services generate numerous bills, as opposed to a single itemized bill for a hospital stay, and that makes it difficult to track total costs for a specific procedure. From 1985 to 1990, outpatient billings have risen from 20 percent of total health care costs to 50 percent.[18]

Blue Cross and Blue Shield of North Carolina estimates that in 1991 the average hospital admission will cost $7,676; of that, cost-shifting accounts for $2,456—32 percent of the total.

11. *Cost Shifting:* Charges that can't be collected from third-party payers or from patients who can't pay for their care are shifted to paying patients and their insurance carriers. As payers tighten payment policies and the ranks of the medically indigent rise, the size of the cost shift to paying patients snowballs. How much does it amount to? Blue Cross and Blue Shield of North Carolina estimates that in 1991 the average hospital admission will cost $7,676; of that, cost-shifting accounts for $2,456—*32 percent of the total.*[19]

12. *Price Insensitivity:* Although the experts may disagree on the relative importance of each of the cost components, there is a consensus that the core of the cost problem is price insensitivity for patients who consume the services, physicians who order the services, and insurers who process payments for services. Consumers of care pay a relatively small portion of the cost of their care and have little incentive and little information to shop for low-cost health services. The doctor who orders the care has no financial incentive to use cost-effective services and suffers no consequences for ordering unnecessary procedures. The insurer simply passes the cost back to the employer or the consumer. No one feels the financial impact of the decisions and choices they make.

Figure 1. 1991 Average Hospital Stay Cost



Total Average Cost: $7,676

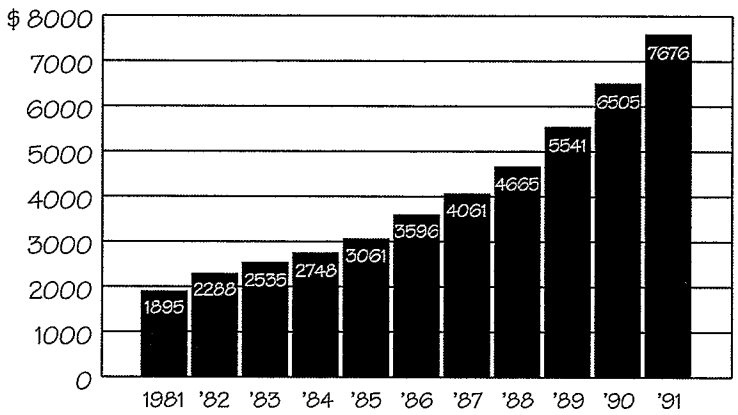
Source: Blue Cross and Blue Shield of North Carolina

Table 3. Most Expensive Medical Procedures in North Carolina, 1988–1990

Medical Case	October 88–September 89	October 89–September 90	Percent Change
Heart Transplant	$88,496	$139,773	+ 57.9%
Respiratory System Diagnosis with Tracheostomy	78,099	88,293	+ 13.1%
Extensive Burns with Operating Room	70,544	65,466	- 7.2%
Cardiac Valve Procedure with Pump without Catheter	47,846	55,494	+ 16.0%
Kidney Transplant	38,089	42,769	+ 12.3%
Other Cardiothoracic or Vascular Procedures with Pump	39,352	41,700	+ 6.0%
Cardiac Valve Procedure with Pump with Cardiac Catheter	37,962	40,244	+ 6.0%
Craniotomy for Trauma	28,781	35,292	+ 22.6%
Coronary Bypass with Cardiac Catheter	29,417	33,643	+ 14.4%
Extreme Immaturity/ Respiratory Distress Neonate	21,908	33,542	+ 53.1%

Source: N.C. Medical Database Commission

Figure 2. Average Hospital Charge per Admission, in Dollars



Source: Blue Cross and Blue Shield of North Carolina

Cost Containment Strategies

Efforts to gain control of health care costs have been underway since the 1970s. Generally, efforts have focused either on making consumers more aware of costs, or tightening controls on costs that insurers and other third-party payers, like the government, will pay for health care. These efforts fall within five categories: A) increasing the consumer's share of costs, B) increasing third-party payer control, C) creating incentives for efficiency, D) encouraging competition among health care providers, and E) controlling the supply of services and facilities through Certificate of Need programs.

An additional category—strengthening and expanding prevention programs to improve health and reduce demand—ought to be on every state's agenda, argues Ron Levine, a physician and the State Health Director. "The public health perspective, that is, prevention as a strategy to contain health care cost, is conspicuously absent," notes Levine, but programs adopted in North Carolina and five other states, including Virginia, may pay benefits in cost containment efforts.[20]

A. *Increase the Consumer's Share of the Cost.* The first approach has been to change the behavior of consumers by requiring them to pay a larger portion of the cost of their care. Obviously, larger employee deductibles (the amount of health care costs employees must pay before insurance payments kick in) and higher co-payments (fixed portions of health care costs that employees must pay on certain procedures) reduce costs for employers. The State Employees Health Plan, for example, saved $37 million by raising co-payments and deductibles for state employee health insurance. The increased co-payments and deductibles will cost state workers an average of $756 annually in coverage for their family health insurance in the coming year. But this approach poses some risks as well. Shifting costs to enrollees may deter them from obtaining care in the early stages of health problems, perhaps leading to a need for more expensive care later. The lower the employee's income, the greater the risk. In addition, once treatment is sought, increased deductibles and co-payments have little impact on a provider's medical decisions.

B. *Increase Third-Party Payer Control.* The second approach seeks to limit demand for health care by discouraging providers—doctors, facilities, insurers and other payers—from providing unnecessary or costly care through what euphemistically are called "utilization controls." These include *pre-admission certification,* which means patients must be approved for elective medical procedures prior to admission; *concurrent review* for inpatient stays, which means medical committees must review individual cases to determine if

patients should continue to stay in the hospital after a certain period; requiring *second opinions* from at least one more doctor before approval for elective surgery; and the like.

Utilization controls have become a standard feature of health insurance programs. Today, Medicare, state Medicaid programs, and more than 72 percent of employer-sponsored health plans make use of utilization controls. Despite their widespread use, there has been little systematic study of these mechanisms, and the evidence that they actually reduce spending is limited.[21]

C. *Create Incentives for Efficiency.* A third approach to cost control is to induce providers to make cost-saving changes by providing incentives for greater efficiency. An example of this approach is Medicare's DRG system—an acronym for *Diagnostic Related Groups*—which pays hospitals a fixed payment per case based on the patient's diagnosis. That keeps the government's costs down. And if the hospital can provide the service for less than the amount government will reimburse the hospital, the hospital can keep the difference.

Critics of this system claim that tightening the belt in one area tends to cause costs to balloon in another area. Hospital charges the DRG system fails to pay are shifted to other third-party payers, or to the taxpayer. For this reason, savings for one payer may not translate into system-wide savings.

D. *Encourage Provider Competition.* A fourth approach to cutting health care costs is to encourage consumers to choose among competing health plans. This approach assumes that consumers will pick the best health care value for their dollar just as they do when buying any other commodity. The validity of this assumption may be the key to the success or failure of this approach. There are two key programs competing in this arena—a) Health Maintenance Organizations (HMOs) and b) Preferred Provider Organizations (PPOs).

a. *Health Maintenance Organizations* represent a major effort to introduce a market orientation to the health care field.[22] HMOs provide a fixed package of health services for a fixed price that is independent of the use of the service. HMOs emphasize preventive visits in the hope of avoiding more costly treatment in the future. Services usually include ambulatory care and inpatient hospital services. Because the HMO assumes financial risk or gain in the delivery of the services, the HMO has a financial incentive to reduce unnecessary procedures and make the most of cost-saving practices. With HMOs, costs for health care are capped for the employer or insurer by contract. Consumers pay a relatively small fee, if any, for a service within the package. However, services outside the HMO package are paid for by the consumer only.

Nationwide, the number of HMOs has more than doubled over the past decade. Over the same period, enrollment has more than tripled, serving nearly 15 percent of the nation's population. Ten HMOs have been licensed in North Carolina since their introduction in 1984. By 1989, a total of 266,199 persons—more than 4 percent of the state's population—were enrolled in HMOs statewide. Most (71 percent) of the state's HMO participants live in the five largest metropolitan counties (Mecklenburg, Guilford, Wake, Forsyth, and Durham).[23]

b. *Preferred Provider Organizations* are also growing, having trebled in number since 1984, and serving more than 26 million persons nationally by 1991. Preferred Provider Organizations can take a variety of forms. Unlike HMOs, they take none of the risk for providing care, but act as brokers to negotiate contracts among employers, doctors, and patients.

PPOs can be organized by physicians or hospitals or a combination of both providers. Insurance companies, employers, and third-party administrators also establish PPOs. Some common elements apply to most. The broker negotiates an agreed-upon discount from the providers' normal fee schedule. Preferred providers may be physicians, pharmacies, hospitals and others. Discounts typically vary from as little as 5 percent to as much as 30 percent off the cost of conventional services.

Employers and insurers give consumers incentives to use the preferred provider, but patients are not restricted to PPO providers for health care. For example, the employer may be willing to pay the full cost of care from a physician on the preferred provider list but require employees to pay co-payments for services from other physicians. In this way, the insurer or employer basically sets a cap on the payment for a given service.

E. *Limit Supply of Services and Facilities.* Federal legislation enacted in 1974 created the Certificate of Need process, which was designed to control health care costs by limiting facilities and services. Costly new facilities and services could be offered only after issuance of a formal Certificate of Need—with a formal finding that the service or facility was needed to meet health care needs (for more, see page 60).

What Are Other States Doing?

Beyond these four broad system-wide strategies for controlling costs, various state governments have attempted to impose mechanisms to come to grips with rising costs—or at least to gauge how fast and how high costs are rising. In July 1991, the N.C. Center for Public Policy Research conducted a telephone survey of each of the 50 states' chief health planning agencies in an effort to learn what steps the states were taking in health care cost control. The results are summarized in Table 4.

State efforts fall into three categories—1) health data collection, 2) Certificate of Need approval processes, and 3) rate-setting commissions. Together, these three activities symbolize the overall attitude states share towards government regulation of the private health care system.

As Table 4 indicates, a few states create a highly regulatory environment in which private hospitals must operate, most of them in the northeast. The remainder prefer free competition, leaving little room for government regulation and involvement in health care cost containment.

North Carolina is among those states with relatively little government regulation in controlling health care costs. The state does collect data on hospital discharges, but so far does not collect the sort of financial data that other states use as a comparative basis to make decisions about cost containment and to inform consumers. North Carolina also has a Certificate of Need program, but has not seriously considered a rate-making commission.

1. *Health Data Collection Systems:* In the age of rising health care costs, more and more

Table 4: State Data Systems and Regulatory Approaches

State	(1) States with Data Collection Systems		(2) States with Certificate of Need Laws Requiring Approval for Health Care Facilities	(3) States with Mandatory Rate-Setting Mechanisms for Hospitals
	A. Hospital Financial Data	B. Hospital Discharge Data		
Alabama	N	N	Y	N
Alaska	Y	N	Y	Y
Arizona	Y	Y	N	N
Arkansas	N*	N	Partial	N
California	Y	Y	N	N
Colorado	Y	Y	N	N
Connecticut	Y	Y	Y	Y
Delaware	N**	Y	Y	N
Florida	Y	Y	Y	Y
Georgia	Y	Y	Y	N
Hawaii	N	N	Y	N
Idaho	N	N	N	N
Illinois	Y	Y	Y	N
Indiana	N	N	Partial	N
Iowa	N	Y	Y	N
Kansas	N	N	N	N
Kentucky	N	N	Y	N
Louisiana	N	N	Partial	N
Maine	Y	Y	Y	Y
Maryland	Y	Y	Y	Y

State	(1) States with Data Collection Systems		(2) States with Certificate of Need Laws Requiring Approval for Health Care Facilities	(3) States with Mandatory Rate-Setting Mechanisms for Hospitals
	A. Hospital Financial Data	B. Hospital Discharge Data		
Massachusetts	Y	Y	Y	Y
Michigan	N***	N	Y	N
Minnesota	Y	N	N	N
Mississippi	N	N	Y	N
Missouri	N	N	Y	N
Montana	N	N	Partial	N
Nebraska	N	N	Y	N
Nevada	Y	Y	Y	N
New Hampshire	Y	Y	Y	N
New Jersey	Y	Y	Y	Y
New Mexico	N	Limited	N	N
New York	Y	Y	Y	Y
North Carolina	**N**	**Y**	**Y**	**N**
North Dakota	N	Y	Y	N
Ohio	N	Y	Y	N
Oklahoma	N	N	Partial	N
Oregon	Y	Y	Y	N
Pennsylvania	Y	Y	Y	N
Rhode Island	Y	Y	Y	Y
South Carolina	N	Y	Y	N
South Dakota	Limited	N	N	N
Tennessee	Y	Y	Y	N
Texas	Y	N	N	N
Utah	N	N	N	N
Vermont	Y	Y	Y	N
Virginia	Y	N	Partial	Y
Washington	Y	Y	Y	Y
West Virginia	Y	Y	Y	Y
Wisconsin	Y	Y	Partial	Y
Wyoming	Y	N	N	N
Total	Y: 28 N: 22	Y: 29 N: 21	Y: 39 N: 11	Y: 13 N: 37

* Arkansas: Legislation has been approved for data collecting.
** Delaware: In the process of developing a data collection system.
*** Michigan: Financial data collected by an independent agency.

Partial: States with a partial CON process are included in total of 39. The term "partial" is used to indicate states which have a CON that does not apply to all health care facilities, hospitals and nursing homes. Rather, the CON process only applies to particular facilities, for example, just hospitals and not nursing homes, or only to long term care beds and other specialty beds.

Sources: N.C. Center for Public Policy Research Telephone Survey of Public Health Departments and Health Planning Agencies in all 50 states.

Chart Prepared by Center Intern Ellen Breslin

states are engaging in *financial* and *discharge* data collection. Financial data include information on hospital charges and other medical service costs, while discharge data include extensive information on hospital use and occupancy. Of the 50 states, 35 have adopted health data collection systems in an effort to contain health care costs. Of these, 29 collect discharge information only, and 28 collect financial information only. Only 22 states collect *both* discharge and financial data. State officials clearly see the existence of a health data collection system as one of the less intrusive measures a state might impose.

In North Carolina, the General Assembly established the Medical Database Commission in 1985 out of concern for the state's increasing health care costs.[24] The commission collects discharge data, and is authorized by statute to collect financial data as well. The commission does collect some cost information, such as average charges for diagnoses, but dissemination of that information is limited.[25]

North Carolina is among those states with relatively little government regulation in controlling health care costs.

Janis Curtis, director of the N.C. Medical Database Commission, says the discharge information is essential to making sound policy decisions and in directing the state health care resources to the problems. "The more we are faced with limited resources, the more we need to use data to make our decisions," notes Curtis.

In general, state discharge data bases consist of information pertaining to every inpatient stay in a non-federal hospital. In 1991–92, the commission expects to develop an outpatient data base of information and in the future expects to develop a financial data base.

2. *The Certificate of Need Process.* Many states try to control the *supply* of care available to patients, usually through a Certificate of Need (CON) process that limits facilities and equipment. The view that medical utilization was driven by the very existence of an excess supply of medical resources led to the CON approach in the 1970s. First established in 1964 in the state of New York, health planning and Certificate of Need programs were eventually mandated for all states by Congress in 1974 in the Health Planning and Resources Development Act.[26] At last count, 39 of the 50 states, including North Carolina, have some type of Certificate of Need process. The federal requirement was eventually repealed in 1986, and so was federal support for state health planning programs and the CON process.

Nationwide, health planning and Certificate of Need programs have had mixed outcomes. In North Carolina, as in the nation, CON's biggest success has been in limiting the growth of nursing home beds. Because the heavily state-funded Medicaid programs (one-third of the costs are borne by the state and local governments) are the chief source of payment for nursing home care, the CON process is a major factor in Medicaid cost containment. Bob Fitzgerald, assistant director of the Department of Human Resources' Division of Facility Services, says the process has also provided for "more equitable distribution of health care resources across the state, particularly in the areas of nursing care for the elderly and the developmentally disabled."

Inappropriately applied, however, CON may reduce choices without affecting costs for medical care. For example, the CON process has been used to limit the availability of kidney dialysis services in the state. However, since Medicare pays a set fee for Medicare recipients of the service, limited availability of dialysis stations has no effect on the costs, but does limit patient choice and drive up the value of the provider's facilities. Lee Hoffman, director of the Certificate of Need section, says that in the last three years, the state has granted all the CONs applied for by existing dialysis providers, but has not approved CONs for new providers.

3. *The Rate-Setting Process.* Rate-setting is common in industrialized countries such as Canada and West Germany. Uniform rate-setting systems generally set rates by establishing a total budget for a hospital during the year, or by establishing a rate for total treatment of a case. In isolation, this approach does not necessarily halt spiraling costs. In a study of states with rate-setting systems during the period 1976 to 1986, actual per capita savings were found to be marginal because the rate-setting states failed to take steps to simultaneously reduce inpatient admissions.[27]

Only 13 states have set up mandatory rate-setting commissions, as Table 4 indicates. Most of these states are located in the Northeast. The closest to North Carolina are Virginia, West Vir-

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ginia, Maryland, and Florida. North Carolina does not have a rate-setting process, nor does it collect the type of information required to set rates. If the state decided to enact such a process, the Medical Database Commission would have to begin collecting financial data from the hospitals.

Clearly, the Center's survey indicates that among its peers, North Carolina is doing more than a few states in an attempt to cope with health care costs, but far less than other states that have gone in for more government involvement. There are those who suggest North Carolina should seriously consider hospital rate-setting. Leigh H. Hammond, a former North Carolina Utilities Commissioner and now director of the N.C. Association of Retired Government Employees, told a legislative committee in 1991 that a rate-setting procedure similar to the utility commission's would help control costs. That, said Hammond, would ensure that "an extensive examination of their costs of doing business" would be considered and that rates would be accurately set.[28] But N.C. legislators traditionally have been cool to the notion of government rate-setting in health care, and few expect the proposal to head the legislative agenda in the near future.

Future Prospects

What's to be done? In an era of tighter state revenues and increasing demands for spending on education, environment, infrastructure, and a host of other public issues, how do policymakers plan to tackle health care costs?

The nation's governors have recently adopted plans to deal with costs by advocating a three-part strategy: 1) pushing for more managed health care systems (see description of "utilization controls," pages 56-57, for more), deregulating health care providers, and making prices and quality information more available to consumers; 2) developing a new system of health-care payers (such as a national health care system) and providing private health insurance for unemployed citizens not eligible for Medicaid; and 3) creating a uniform electronic billing system to reduce administrative overhead for providers and for consumers.[29] But beyond this broad strategy, what specific steps might state policymakers consider in coming years?

The list of potential targets includes, but is not limited to:

1. *Tighter Physician Payments.* New limits on physician reimbursements are one of the likelier strategies in coping with rising costs. The Medicare program is exploring modifications to its reimbursement system for visits to doctors that resemble the DRG payment system for hospitals.

2. *Increased Out-of-Pocket Costs for Patients.* Consumers of medical care can expect rising out-of-pocket expenses for health care as well. Business executives indicate that shifting increased costs to consumers will be their primary strategy for containing costs. To support their position, they point to a Rand Corporation study of health cost management which found that participants required to pay a $500 deductible cut usage by 25 percent, compared with those who paid no deductible; and those who paid a $1,000 deductible cut usage by 39 percent. After five years of tracking the health status of 8,000 people in the study, no significant health differences were found between

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groups that used the most health services and those that used the least.[30] Some North Carolina companies, like Nucor of Charlotte, are using much higher employee contributions to control costs.[31]

3. *Restraining System Growth.* Efforts to hold down the supply of health care resources may be strengthened and renewed. Limits on growth in the number of physicians and limits on expansion of medical care facilities and equipment can be expected in the future. But limiting the number of physicians could cause big problems in rural areas of North Carolina where health care costs may be one problem, but a lack of physicians is an even greater concern. In these areas, lack of facilities and professionals is a continuing problem (see article on rural health, pages 67–92, for more).

4. *Increased Pressure for National Health Insurance.* Farther out on the horizon, a growing number of business leaders have begun joining the ranks of advocates for national health insurance. While there hardly is unanimity on the subject, it is clear that many business leaders believe that some sort of national health care program should be created to provide a minimum, uniform measure of care. Some 30 percent of polled executives favor a government-sponsored program, 45 percent oppose such a program, and 25 percent take neither position. But of that same group, a whopping 77 percent believe that national health insurance will be instituted within the next five to 10 years.[32]

Some experts believe that business and industry have simply run out of time to make the alternatives to national health insurance work. Businessmen are not the only segment of society calling for national health insurance. In May 1991, the conservative American Medical Association added its voice to the call for universal health insurance, which would use public and private funding sources. Unfortunately, the AMA had few suggestions about how to restrain costs under the current system. But U.S. Sen. George Mitchell (D-Maine), the Senate majority leader, has proposed one such plan with cost control provisions in it (see page 15 for more on this plan).

5. *Assessing High-Tech Medical Procedures.* In the long run, some experts believe that successful cost containment strategies will inevitably focus on weighing the costs and benefits of technology. For that reason, there is growing interest in technology assessment that balances the cost of a procedure against its safety and effectiveness.

For example, Duke University medical economist David Eddy touched off a storm in 1989 when he suggested that annual mammograms may not be worthwhile because high false-positive rates

(incorrect diagnoses of breast cancers) would cost about $1 billion dollars annually. Eddy believes that health care policymakers need to examine the pros and cons of a procedure and give priority to practices that bring the most benefit for the resources they consume.

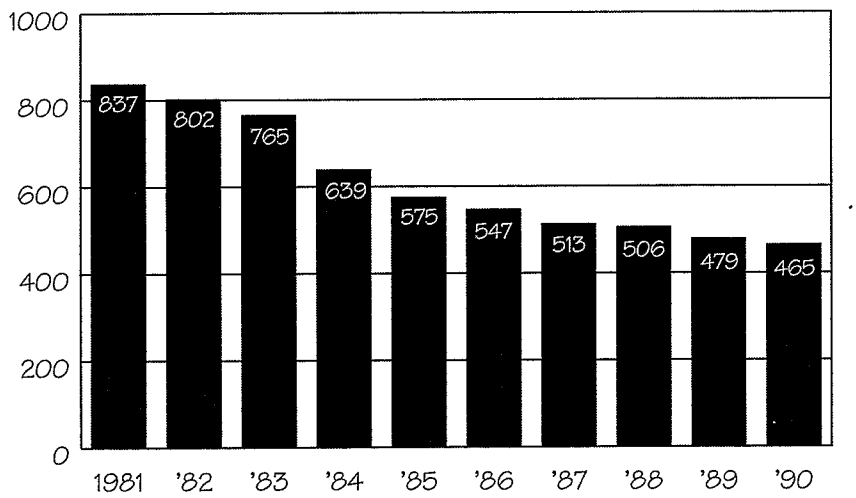
To some extent, the health care industry is already using medical evidence to evaluate safety and effectiveness and then promote or discourage certain procedures or techniques through their reimbursement policies. For example, evidence that modified mastectomies were just as effective to treat breast cancer prompted Blue Cross and Blue Shield in some states, though not North Carolina, to withdraw reimbursements for more radical procedures.

6. *Rationing Health Care.* One new antidote to soaring costs is rationing. This is among the most controversial of proposals, because it would limit health care resources for some patients in order to serve others—the notion of the highest public good for the greatest number. Rationing could (a) limit care to the elderly because many treatments offer little hope of sustained improvement, (b) provide less care to patients whose behavior brings on the illness (such as smoking or drinking heavily), (c) provide unlimited access to preventive care such as prenatal care and immunizations but limit high-tech care for the very ill, or (d) provide palliative care only to the terminally ill and use the remaining resources for prevention and treatment. Rationing formalizes what some critics say we already have—rationing care, in effect, based on a person's ability to pay.

Efforts to ration care on some other basis are underway. The state of Oregon may become the first state in the nation to implement rationing and make its health care priorities explicit. In 1987, the Oregon legislature voted to stop spending Medicaid money on costly organ transplants and to divert funds to preventive care for the poor. Since that time, Oregon has been struggling to rank treatments in order of importance and the state's most recent set of priorities is fraught with controversy. But the very fact that such an effort is underway is an indicator of the state of alarm about health care.

7. *Cutting Benefits and Eligibility for Medicaid.* The Medicaid program (paid for in North Carolina with federal, state and local funds, though other states do not require a local contribution) is always a likely target for state budget cost-cutting. In recent years, federally mandated coverage for some of the uninsured population, in addition to

Figure 3. Average Hospital Days per 1,000 Population



Source: Blue Cross and Blue Shield of North Carolina

While most policymakers can easily identify cost containment strategies and tactics, the real difficulty lies in putting those devices into place so they will have an impact.

medical inflation, has sent program costs skyrocketing. In 1991 alone, after cutting the proposed Medicaid budget by 17 percent, the N.C. General Assembly had to come up with $113 million to meet continuing costs. State policymakers, concerned about the poor and the ill and reluctant to shift costs to other payers, have avoided wholesale cuts in optional services and beneficiaries. For one thing, reductions in eligibles increases the number of uninsured, which contributes to cost-shifting, further increasing costs. In an era of limited state revenues, the struggle to fund the Medicaid program intensifies the pressure for some sort of national health insurance.

8. *Cutting State Employee Benefits, Raising Employee Contributions, and Raising Co-payments and Deductibles.* The N.C. General Assembly increased spending on state employee health plans by $75 million in 1991—another whopping increase despite decreased benefits. Deductibles were raised 67 percent and co-payments were doubled. Spending on state worker and teacher health care plans has risen rapidly in recent years, and legislators say privately these programs may get increased scrutiny in future years.

From Here, Where?

While most policymakers can easily identify cost containment strategies and tactics, the real difficulty lies in putting those devices into place so they will have an impact. Once any of these devices takes effect, the citizenry will be affected in various ways—some will get greater coverage, some less; most patients will pay more, and some will pay a lot more.

In 1990, the National Governors' Association took note of this difficulty in health care reform, identifying six key realities about health care, financing, and coverage:

1) the public doesn't really favor the kinds of hard choices we need to make to reduce health spending;

2) Americans say they support health care cost solutions as long as they don't lead to dramatic changes in their own coverage;

3) the public still isn't sure whether it wants the country to have a mostly public or mostly private universal health care system;

4) Americans are willing to pay only a modest tax increase for a universal health plan;

5) the public is ambivalent about using the welfare system to provide medical care for the poor; and

6) although the public says it wants the federal government to *create* a national health care system, it doesn't have confidence in the government's ability to *operate* it properly.

Cost containment concerns obviously are on Americans' minds these days. *The **Polling** Report,* a newsletter reporting various polling data, said recently that 91 percent of Americans "believe we face a national health care crisis" and that 85 percent believes the health care system should be reformed. One in every four said they could not afford adequate health care in the past year; a majority of workers said they paid more for health plans than they did in 1989, and many said the prospect of losing their health insurance prevented them from changing jobs.[33]

How can legislators and other policymakers cope with these public attitudes on the one hand, and health care needs and cost containment problems on the other hand? No one seems to know for sure. State Sen. Russell Walker (D-Randolph), a leading legislative advocate for improved health care, says the legislature has not yet considered the cost containment question because it was dealing first with questions of access. "At this point," says Walker, "there is no answer to it. It is a state problem and a national problem, and we are going to have to have a solution."

Some proposals may develop from a task force of the N.C. Institute of Medicine, which is exploring ways to improve access to care for the uninsured and underinsured. "Affordable care, and access to care, are the two big questions we face, and this report is being scheduled with the short session in mind," says Walker. "My feeling is that there is at least going to be an attempt to look at it" when the 1992 General Assembly reconvenes to consider changes in the state budget.

No one is publicly proposing such features as rate-setting or Oregon-style rationing of services.

"If the problem got a lot worse very quickly, we might have to deal with it more drastically," adds Senate President Pro Tempore Henson Barnes (D-Wayne), "but we hope in the meantime that it will improve." Barnes said the legislature devoted considerable time to cost-containment proposals in the past three sessions, and was not satisfied with the approaches taken by other states. Future strategies might include providing a set sum for health insurance that state workers and teachers could use to purchase insurance, but there are problems with such a plan, said Barnes. For another approach, the state might set a cap on how large an increase it will fund for state employees' health insurance, "but what that does is just limit coverage," notes Barnes.

Privately, some legislators are talking among themselves of beefing up the Certificate of Need Program, of requiring employers to provide more coverage, and of making consumers pay more of their health care costs. The N.C. Hospital Association has gone on record as calling for a new general tax to pay for indigent care, but after raising taxes during the 1991 legislature, many lawmakers may be hesitant to support another tax increase.

"Nothing has really jelled yet," says Walker. "We're just going to have to wait and see." Adds Barnes, "We're pretty much in the position of a person up to his neck in a swamp full of alligators. It's hard to discuss proposals for draining the swamp until you get out of that situation."

FOOTNOTES

[1] "Emergency! Rising Health Costs in America, 1980-1990-2000," A Families USA Foundation Report in cooperation with Citizen Action, Washington, D.C., October 1990, p. 1.

[2] "Semi-Annual Hospital Inpatient Data Statewide Trend Report," N.C. Medical Database Commission, June 18, 1991, p. 1.

[3] "The 1990 National Executive Poll on Health Care Costs and Benefits," *Business and Health,* April 1990, p. 26.

[4] Sandra B. Greene, paper presented to Duke Symposium, March 21, 1990, pp. 3–4.

[5] Sandra B. Greene, "The Economics of Improved Access to Health Care: A Focus on North Carolina," Carolinas Medical Center Spring Symposium, Charlotte, N.C. April 30, 1991.

[6] "State and County Profiles of Hospital Patient Utilization, Oct. 1, 1989–Sept. 30, 1990," Report Number H901201, N.C. Medical Database Commission, p. 26.

[7] "Health Care Costs," A Position Paper of the North Carolina Hospital Association, Summer 1991, page 1 of 4 unnumbered pages.

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[9] Joan O'C. Hamilton, "High-Tech Health Care: Who Will Pay?" *BusinessWeek,* Feb. 6, 1989, p. 78.

[10] *Ibid.,* p. 74.

[11] M.R. Chassin *et al.,* "Does Inappropriate Use Explain Geographic Variations in the Use of Health Care Services?", The Rand Corporation, *Journal of the American Medical Association,* Vol. 258, No. 18, Nov. 13, 1987, p. 2535.

[12] Hamilton, p. 76.

[13] Hamilton, p. 77.

[14] Humphrey Taylor, *Making Difficult Health Care Decisions, Vol. 1—The National Survey,* Study # 874003, Louis Harris and Associates, Inc., June 1987, p. 31.

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[16] *Ibid.,* p. 24.

[17] Victor Fuchs, The Health Sector's Share of the Gross National Product," *Science* magazine, Vol. 247, No. 4942, Feb. 2, 1990, p. 537.

[18] Ellen Paris, "Got a moment? How about some knee surgery?" *Forbes,* July 10, 1990, p. 58.

[19] Sandra B. Greene, "North Carolina Health Care Trends," April 1991, Exhibit 11.

[20] For more on prevention as a cost containment stratagem, see Karen Davis *et al.,* "Paying for Preventive Care: Moving the Debate Forward," *American Journal of Preventive Medicine,* Vol. 6, No. 4, 1990, pp. 1–32; Report of the Legislative Research Commission on Preventative Medicine, N.C. General Assembly, Dec. 12, 1986; and "Statewide Health Promotion Program Report to the Human Resources Subcommittees of the House and Senate Appropriations Committees," N.C. Department of Human Resources, March 15, 1989.

[21] Mark Merlis, *CRS Report for Congress: Controlling Health Care Costs,* Congressional Research Service, The Library of Congress, Jan. 26, 1990, pp. 6–7.

[22] For more on HMOs, see J. Kolimaga, ed., "Health Cost Management Handbook, Strategies for Employers," N.C. Foundation for Alternative Health Programs, Inc., 1984, pp. 19–28.

Also see Robert Conn, "Health Maintenance Organizations Arrive in North Carolina," *North Carolina Insight,* Vol. 7, No. 3, pp. 58–70.

[23] The Status of Health Maintenance Organizations in North Carolina, compiled by the N.C. Foundation for Alternative Health Programs, Inc. for the N.C. Department of Insurance, April 1989.

[24] G.S. 131E–10. The commission was scheduled to expire July 1, 1991, but its life was extended in Chapter 689 of the 1991 Session Laws.

[25] For more on health care costs, see generally Marianne M. Kersey *et al.,* "Comparing The Performance of For-Profit and Not-For-Profit Hospitals In North Carolina," N.C. Center for Public Policy Research, 1989, pp. 81–118.

[26] P.L. 93–641. According to "State Health Planning Report," State Issues Forum, July 1989, p. 1, 39 states including North Carolina continue to operate CON programs.

[27] C.J. Schieber and J.P. Poullier, "International Health Care Trends, 1987," *Health Affairs,* Vol. 8, No. 3, Fall 1989, pp. 169–177.

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[31] For more on this subject, see Susan Shackelford, "Making It Hurt," *Business North Carolina,* July 1991, p. 16.

[32] *Business and Health,* p. 26

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