Impact on Hospital Costs Through The Tax Equity and Fiscal Responsibility Act of 1982

by

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ABSTRACT: The Tax Equity and Fiscal Responsibility Act of 1982 was inacted to curb hospital spending through reducing reimbursement from Medicare and Medicaid. By design, the legislation will lower the federal share of expenditures for hospital care. Whether total hospital costs are affected by this act is the central question explored in this research paper. Questions concerning the impact of TEFRA reach as far as the goals and objectives of national policy dealing with health care.

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PREFACE

Today's health care cost problem is a major public policy concern. The complexity is at times overwhelming. This is because health care policy is highly interdependent and goes beyond the boundaries of strict issues of health care for the United States. Structuring a health care policy requires an interdisciplinary approach. The correcting of uncontrolled health care costs requires a proper methodology with systematic and critical study. There is no one right answer or conclusion. However, procedures are necessary to pose the right questions in order to get the best answer, given all the possible alternatives. A proper framework of policy design improves our ability to resolve public problems. It appears that the Reagan Administration has developed policy action through TEFRA in order to deal with the policy issue of uncontrolled rising health care costs. The purpose of this action is to produce policy change,but the concerns, causes, and consequences of this action will be difficult to forecast. It is very difficult to separate out the multiple intervening variables that impact on health care costs, because of the different actors present in the process. If change occurs, it is not because of analysis alone, but much depends on the environment in which options are available. A major question is who is accountable? When you are dealing with questions of cost versus benefit, you must consider the question of finite resources. It is not realistic to consider starting over again in designing a new health care system, you must evaluate from within the system. The critical issue is how will the policy be structured. Quite often, analysis deals with errors of the third type (E111)-solving the wrong problem.

It will be fairly easy to monitor the performance of the new policies under TEFRA because of the specific forms necessary for reimbursement. However, it will be difficult to answer the question; What difference does it make? The evaluation of any public policy has as its main feature, certain values placed on it. Judgments regarding the value of the policy attempt to determine the worth or social utility of the policy. Information gathered concerning inadequate policy performance contributes to the restructuring of the policy problem in question. This then leads to new or revised policy alternatives.

It is very important to attempt to consider and make explicit informal as well as formal goals and objectives of all the stakeholders. Formally announced goals and objectives of policy makers and administrators are but one source of values. The recipients as well as the whole public sector must have input in order to evaluate the impact of policy change. The decisions made must link information about policy outcomes with the values of multiple stakeholders, in order to measure the appropriate worth or value of policies. For example, part of the evaluation process should include a user-survey analysis where information is collected about the evaluability of a policy from the intended users and other stakeholders.

Often, the process of policy analysis is unclear especially in dealing with the nature and scope of the problem to be investigated. Different stakeholders, while agreeing on the existence of a problematic situation, frequently disagree about the nature of policy problems and their solutions. For this reason, methods of problem structuring are central for public policy analysis.

A major task is to determine what policy makers and other stakeholders really want to accomplish, "ultimate goals", as Quade observes,

> may be easy to state but more immediate objectives that lead toward them are harder to determine.... It is easy for an analyst to accept a client's view of what is wanted without further discussion and then to set about searching for feasible alternatives and gathering data without giving a thought as to whether the stated objective, if attained, will contribute to solving the problem under attack.

A policy change such as TEFRA, whose impact is widespread, brings up many questions that should be answered. William Dunn's book, Public Policy Analysis, describes important questions that deal with any public policy problem. These questions are pertinent to the health care cost problem. These questions are: What actual or potential courses of action are the objects of conflict or disagreement among stakeholders? In what different ways may the problem be defined? What is the scope and severity of the problem? How is the problem likely to change in future months or years? What goals and objectives should be pursued to solve the problem? How can the degree of success in achieving objectives be measured? What activities are now under way to resolve the problem? What new or adapted policy alternatives should be considered as ways to resolve the problem? Which alternatives

are preferable given certain goals and objectives? This procedure essentially becomes a prospective investigation that begins with historical information about post policy actions, outcomes, and performance, and ends with as much information as possible about the nature of policy problems, alternatives, and actions to be taken in the future.

INTRODUCTION

The Tax Equity and Fiscal Responsibility Act (TEFRA), enacted by the Reagan Administration, in the fall of 1982, is designed to curb hospital spending through reducing reimbursement from Medicare and Medicaid. The estimated federal budget savings from provisions in the Act that affect hospital costs will save the federal government $3.95 billion by year 1985. In 1975, hospital expenditures totaled more than $55 billion, or 40 percent of the total expenditures for health care.[1] Hospital expenditures constitute the largest single health care expenditure category and are rising at a rate of 15 percent per year. Hospitals are considered the most expensive setting on a per unit basis.[2]

Historical national policy on health has been one that supported efforts by all stakeholders to insure financial resources and availability of services to all citizens. A change in policy by the current Administration has not taken into account all the mitigating variables that influence the health care system and its cost structure.

The purpose of this study is to test my hypothesis that there will be no significant reduction in the overall rate of growth in hospital service costs even with the enactment of TEFRA legislation. Costs may shift around within the industry, but overall hospital cost increases will notabate because too many stakeholders participate in the system to permit one component to determine a unilateral course of action.

The methodology to test my hypothesis will involve breaking down a hospital's departmental cost structure, and comparing these costs to two separate population groups. Two separate time periods will be utilized in the comparison. The data gathered will be analyzed to determine whether or not TEFRA made an impact on overall hospital service costs.

HOSPITAL COST MODEL

The first thing that must be considered is to look at the components of hospital costs and the reasons for their rapid growth. There are common unit cost measures used to assess hospital cost trends. One is the hospital semiprivate room charge index which is calculated as a component of the CPI. Another is the adjusted-expense-per-patient-day figure which is simply calculated by taking total expenses of hospitals divided by the total number of inpatient days provided. Another commonly used cost unit is expenses per admission. All three cost measures have shown increases over time.[3]

Cost increases became more visible after 1966 because a larger share of hospital expenditures were financed out of government budgets. The Medicare and Medicaid programs are considered the major culprits for these accelerated government expenditure levels.[4] The experience following the introduction of Medicare is consistent with the view that hospital utilization responds to change in net price brought about by third-party coverage. At that time, insurance coverage for the elderly improved dramatically, while that of the rest of the population remained essentially unchanged. Survey data indicate that between 1965 and 1968, hospital admission rates decreased for every group except the elderly, for whom admission rates increased approximately 25 percent.[5]

The demand for hospital care can be divided into demand by the under 65 group and demand by the 65 and over group. The older group receives a substantial subsidy (Medicare), thereby shifting their demand curve to the right, while demand by the younger group remains unchanged. The total demand curve thus shifts upward. Hospitals respond to the increased demand by adjusting their costs upward with their prices, and changing the nature of the product they provide. This causes an increase of inputs which correspondingly causes increases in costs.[6]

Martin Feldstein attributes this typical hospital response to the dominant role of the nonprofit hospital in the health care industry. "These institutions have more than two-thirds of the short-term general beds, admit 58 percent of the patients, and employ more than 65 percent of all hospital employees."[7] Feldstein asserts, that hospital administrators pursue goals such as paying employees generously and equiping their hospitals with the most advanced scientific medicine in order to enhance prestige. Hospitals respond to increases in demand by doing things which will increase their costs up to the highest level consistent with maintaining a desired level of occupancy.[8] Feldstein further asserts, that this has an important policy implication because controls on particular components of

cost can have essentially no effect on total cost increases, since they are determined by changes in demand and the supply of beds.[9]

Economies of scale are often brought up in discussions of hospital costs. Theoretically, the relationship between hospital cost and size should be U-shaped. As the size of the facility increases, its average cost per unit should decrease, reach a minimum, and then increase.[10] However, because of the conceptual and data limitations in conducting hospital studies, it is difficult to estimate for the effects of economies of scale for hospital costs. Economists studying hospital costs disagree as to whether the various studies have been able to hold all the other factors affecting hospital costs constant.[11] An interesting finding of studies on economies of scale is that the mix of patients in the hospital is an important determinant of hospital costs and can, in some cases, explain up to 50 percent of the variation in average costs between hospitals.[12]

Questions concerning the issue of economies of scale need further investigation, but are beyond the scope of this paper. There are studies on both sides of the issue, and comments suggest that economies of scale should be present. Ernst and Ernst (1961) found economies of scale in certain departmental operations of the Charlotte Rehabilitation Hospital. It was suggested that economies of scale should exist in obstetrical facilities and maternity programs.[13] Another area where it should be present, is in the overhead component of hospital costs.[14]

From an economic point of view, measuring hospital output is very difficult and well recognized as a significant problem in data collection. In order to discuss cost trends, a focus on the cost of some unit is necessary. Present data sources most commonly used for cost comparisons are patient days and admissions. Neither one is in any sense a homogeneous unit because changes in the nature of the average patient day or admissions have important effects on cost.[15] However, these two data sources are useful because they are the only uniform measures of the quantity of outputs available.

If one is to test the hypothesis that TEFRA's impact will have limited consequences on overall hospital costs, a model has to be designed that takes into account the variables that will accurately measure the impact with reliability and validity. However, it is very possible that data would not exist for many of the variables in such a model. One reason for this might be that some of the variables are unobservable and thus unmeasurable. On the other hand, the

variable may be observable but perhaps data have never been collected for it.[16]

A literature search of hospital cost studies have generally dealt with models to compare costs among hospitals. Studies have not been able to analyze costs within hospitals, especially at the departmental level, because of lack of data.[17] However, one study by Ingbar and Taylor for hospitals in Massachusetts did just this. Information from their model is useful for my purpose in order to design data sources for measurement. They found that a hospital's costs are largely determined by expenses of its primary services. The primary service department expenses are quite highly correlated with the total hospital service expenses but there is sufficient independent variation to perform analysis at the departmental level. The five major service departments are, (1) laboratory, (2) radiology, (3) operating room, (4) nursing service, and (5) administration.[18]

An ideal model to measure hospital cost components depends upon how the cost information is to be used. In this case, the model needs accurate data to compare costs attributed to two separate patient populations in two different time periods. The first period, pre-legislation fiscal year 1982, is to be compared to a post-legislation period, fiscal year 1987, after the three year phase-in period is over. Since TEFRA's impact zeros in on the elderly population, the model, out of necessity, will be constructed to measure differences in this groups hospital usage compared to the hospital patient population under 65 years old. The model requires an accounting scheme to breakdown expenditures by the different hospital units. The purpose of this is to be able to pinpoint those units responsible for the cost incurred by the organization,[19] and therefore, relate them to the populations involved in the comparison. Budget practices, especially with the common use of computerized cost reports, can use accounting techniques to separate out service costs provided to the 65 and over population as well as data on those under 65 years old. Take for instance, the operating room service cost center. Ideally, data is needed to separate out costs of providing operating room services to both population groups, holding everything else constant. Since TEFRA places a limit on what they will reimburse a hospital for a specific surgical diagnosis, the revenue report generated for both populations for the same diagnosis will reveal what costs are charged to which group. This data can be compared to see if cost accounting procedures were shifted upward, stayed the same, or shifted downward for the two populations. If a reduction in reimbursement for the elderly population is anticipated, hospitals may shift more costs to the younger population group, thus defeating the TEFRA legislation's objective of lowering the rate of growth in

hospital service costs.

At this point it is necessary to digress from the model design and to discuss variables that can influence the data sources other than those parameters we want to measure. These variables are called exogenous factors, that if not controlled will distort the data collected. It is extremely important to maintain a pure data base in order to prevent contamination of the data collected. One factor to consider is collective bargaining contracts that could significantly alter costs from one period to the next. If a contract is negotiated after the first time period but will be in effect over the next period, an adjustment factor for changes in salaries and benefits must be accounted for. Another situation that can distort the data collection is changes in service levels contributed to outside influences other than TEFRA's impact. For example, the development of a new operative procedure for removal of cataracts which can be done on an outpatient basis will cause a decrease in the aged population admitted for this type of service, thus impacting on reimbursement. This would be especially significant in relation to operating room departmental costs, which is one of the primary service departments within the model. Similar advances can occur in operative procedures typically utilized by the under 65 population. For instance, arthroscopic knee surgery is far less costly than standard procedures to operate on a knee. It is routinely performed now on an outpatient basis. Either of these conditions can distort the service level data base for which we want to measure future trends. Other types of technological advances may have the opposite effect on costs from the comparison above. Highly sophisticated computerized X-ray equipment is extremely costly and requires skilled technicians to operate it. If the development of this equipment occurs after time period one but its impact is felt in time period two, distortion of cost data in period two will result.

Controlling for inflation is already taken into account in the legislation as will be seen later on in the hospital example section of this paper.

External environmental factors must be accounted for in the model. For example, the local economy and its high unemployment will alter utilization patterns. People lose hospital benefits or because of lost income, leave the area. This may change occupancy rates and impact on reimbursement levels for hospitals.

These and possibly other exogenous variables play a significant role in model design. The structure of the data base must take these influences into account; otherwise, the model may become contaminated.

Since data will not have been collected for the post-legislation period, the nature of the data will be conceptual, breaking down a single hospital cost structure, then, observing for changes in particular cost components for both time periods in relation to the five primary service departments. The specific services to investigate are compared to the utilization patterns of both the over 65 age group and the under 65 age group. Cost reports need to be programed to identify usage patterns in both age categories. Cost reports for the primary service departments will need to identify the two population groups according to the percentage of utilization. Analysis of the data will show if changes occurred over pre-and-post legislation periods. Revenue reports are another source of data because they are based on costs incurred to provide the services. For a hospital, especially in the long run, revenues from all sources must cover costs. Hence, charges will be largely determined by costs, and thus the same factors that influence costs will eventually affect charges.[20] Significant changes in sources of revenue, combined with analysis of cost reports will add to information concerning TEFRA's impact. Hypothetically, if the proper controls are in effect, data analysis will explain whether the legislation made a difference on total hospital costs. For example, revenue received from Medicare for a particular diagnosis in both time periods will need to be compared. If there is a reduction in revenue for the post-legislation period, examination of the total cost structure for the hospital will need to be done to determine if a shift occurred in costs to other insurers or if an actual total cost reduction resulted.

The conceptual model has attempted to describe a data base for measuring TEFRA's impact. Short run results will be available in the near future. However, what is more important is to observe the legislation's impact in the long run. This will enable us to see if what we expect to observe happens over time. In other words, will costs return to pre-legislation trends. Political pressure may cause the government to restore coverages and subsidies for the affected populations.

Once the data are analyzed and the hypothesis tested, many alternatives are possible. One is that the hypothesis is accurate and there is minimal or no impact felt by hospitals. Another possibility is that a significant curb in the growth rate of hospital costs did occur. Another possible result is that in the short run a reduction in the rate of growth is observed, but due to public pressure

this changes, and in the long run the rate of growth for hospital costs return to pre-legislation levels. An unlikely, but possible, alternative is that the legislation is successful from the government's point of view and other health care subsidizers (BC/BS, commercial insurance companies) adopt similar policies and procedures for their reimbursement plans. No matter what the outcome, the results raise important questions. These questions will now be explored.

Organizations are resistant to change and hospitals are no exception. Whether change is good or bad depends on ones' viewpoint. However, quite often there is strong forces holding it in check. This is the typical social climate of most organizations.[21] In fact, leaders of organizations, in this case hospital administrators, use these forces to their advantage and strive to sustain them.[22]

Change does occur in organizations despite barriers against it. Some is voluntary and some is involuntary. Once change occurs, forces develop within the organization to resist further change.[23] No one really believes that everything about a system can be changed; therefore, many established practices continue and change is focused only on selected areas which are considered especially important.[24] One thing that hospitals know is that bigness allows some flexibility to endure change and survive.

Hospitals today are developing elaborate ways to dampen the impact anticipated through TEFRA. With the lack of data to confirm whether the impact will be significant, hospitals are proceeding with the assumption that the legislation will cause substantial losses in revenue. There are numerous areas within the hospital where the administration can begin to deal with outside forces of change. Monitoring case mix volumes is extremely important to anticipate future changes in patient types. Expanding out-patient services which are not affected by TEFRA is a major current practice. In fact, anticipated lost inpatient revenues can be lessened by revenues from out-patient services. Hospital budget departments are monitoring staffing levels and comparing them to occupancy rates to determine the staffing requirements necessary to carry on operations. Since hospitals are labor intensive, much expense can be saved by carefully controlling departmental staffing levels. This raises the question of quality and quantity trade off in providing hospital medical services. One of the choices that any hospital must make in determining the use of its limited resources is the combination of quantity and quality of medical services it wishes to provide. A second set of choices that must be made is how best to

produce medical services. A third set of choices deals with the distribution of medical services.[25] People differ in their values as to how these choices should be made, however, it is necessary to establish criteria for what is considered good performance. Debate over appropriate public policy in hospital care is often confused because a clear distinction is not made between differences in values and differences in the best way to achieve a particular set of values. The question of quality-quantity trade off is a significant issue in and of itself. Except for the comments above, detailed discussion is beyond the scope of this paper.

The trend in our locality for hospitals is not to cut back in operations, but to seek other sources of revenue to compensate for TEFRAS's reimbursement reductions. Satellite X-ray clinics, rehabilitation units, and out-patient laboratories are being placed in parts of the community to reach new sources of patients. Small hospitals are merging with larger hospitals for financial support. Seminars on health education, community educational series, and special fitness clinics are being offered by area hospitals to entice citizens to come to their particular institutions when health needs are apparent.

Hospital administrators are particularly interested in micro-economic issues for their specific institutions. "If ways could be found to tie some expenses that are now set according to the number of patient days expected to the number of patient days actually treated - that is, if more of the fixed costs could be transformed into variable costs - total costs would probably decline, since the expected number of patient days must include a healthy margin of error, given peak loads, seasonal shifts, weekend troughs, and other peculiarities in the demand for hospital care."[26] Administrators are also looking at outside ways to reduce costs. Such practices as pooled facilities, and group purchasing may enable administrators to transform fixed costs for the hospital into ones that are at least variable at the micro level, thereby lowering the over-all magnitude of fixed costs. To participate effectively in such programs, hospitals may find it impossible to act alone.[27]

Hospitals are very powerful political units. With assistance from special interest groups, and creative manipulations to maintain revenue levels, hospitals may find that they can offset reductions in one source of reimbursement by developing alternative sources of income.

The government hopes that the new legislation will brake the increase in hospital costs, but by how much is anybody's guess. It is possible that although costs are shifted around within the hospital industry, overall health-price increases will not abate. New Jersey has had a fixed-payment system for years, without making any startling gains on hospital cost increases.[28]

Historical information is provided in the next section of this paper. The current crisis in health care expenditures can be contributed to many factors. One major contributor is the federal government and its role as a subsidizer of medical care. Another factor is the multiple actors participating in the health care system. A third factor is the poor design of the cost reimbursement formula.

Historical background information will set the stage for further development of this paper. It is important to view changing public policy directed at the problem of health care for the United States.

Prior to the 1930's payment for medical care was derived by direct payment by the patient receiving the service. Physicians and hospitals were very conscious of the financial impact of their service provided, because the patient paid for this care almost totally out-of-pocket. Total per capita health care expenditures were $29.16 in 1929, and nearly all of the 87 percent derived from private sources came directly out of the pockets of patients.[29]

The development of Blue Cross and Blue Shield programs in the 1930's led the way for growth of private, third-party payment programs. The original Blue Cross/Blue Shield programs were sponsored and controlled by participating hospitals. However, today, these plans are no longer hospital controlled. The Blue Cross plans covered hospital care costs and Blue Shield covered physician services and payment was based on a fee schedule which over time gave way to a "prevailing fee or usual, customary and reasonable" charge system.

From a financial standpoint, Blue Cross and Blue Shield payment programs had significant impact. This occured in two ways. First, it divorced the payment for health care services from the actual recipient of those services for those covered by the plans. Price began to lose its significance as a rationing device both in regards to supply and demand. Second, to the extent that these plans negotiated reimbursement arrangements that differed from existing pricing structures, dual prices resulted.[30]

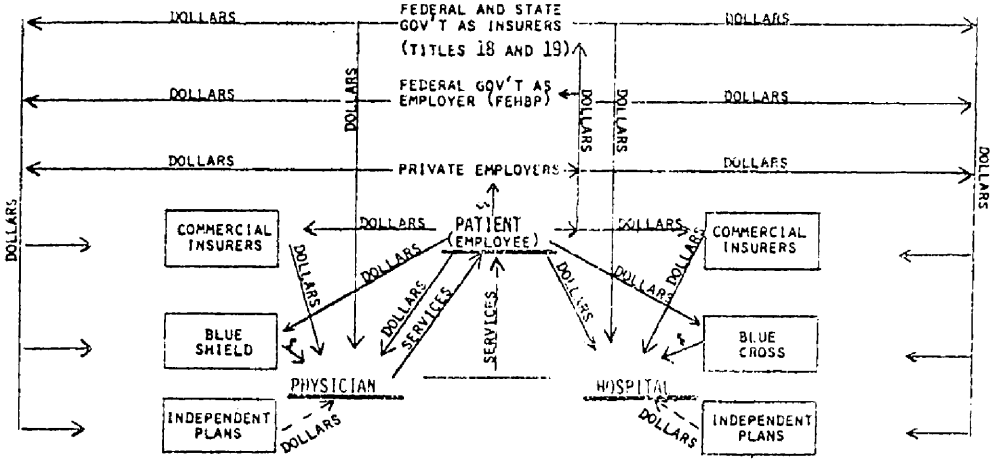
From the mid-1940's to the early 1960's, development of private third-party payment programs began to be seen as employee fringe benefits. Commercial health insurance companies began to compete against the Blues. Hospitals now had to contend with a multitude of reimbursement arrangements. Thus, hospitals and physicians began to receive less and less direct out-of-pocket payments from patients.

The 1960's saw the federal government enter the health care system, first as an employer providing a fringe benefit to its employees (Federal Employees Health Benefit Program), and then as a subsidizer of health care for the elderly and the needy (Medicare and Medicaid respectively).

Figure 1 demonstrates the complex payment systems presently in operation nationally. Recognition and understanding of this structure helps to reveal the difficulty of developing a national policy that is able to control the rising health care costs.

FIGURE 1

PAYMENT FOR HEALTH CARE SERVICES (MID-1960'S TO PRESENT)



Source: U.S. Dept. of HEW, Social Security Bulletin, July 1978, p.5

The growth of private and public health insurance plans has significantly changed the health care portion of the economy. The impact on society has been both beneficial and in some ways harmful. Without the widespread existence of these programs, many portions of the population would be without health care. The difficulty lies in separating the different components that have caused the rise in health care cost through these programs. Many other changes also occurred during the same time third-party plans were developing. Improved technology, better medical education, and growing consumer expectations played a role in expanding the health care system.[31] In addition, some argue that these components cause a viscious cycle. Does better and more expensive technology give rise to more insurance or does the existence of insurance coverage encourage the development and use of specialized technology? And, if there is too much first dollar coverage in the plans, is it the fault of the programs or the tax laws which provide significant incentives to give such fringe benefits?[32]

The impact on health care cost by multiple insurance programs will only get worse even if a cap is placed on benefits and services. The reason for this is the change in utilization by the public sector. An introduction to the health care cost problems would be incomplete without a discussion of the current trends in health care utilization.

It is not suprising that the elderly and poor are heavy utilizers of health care services. It is a fact that the incidence of illness is greater in these populations. A 1977 national survey showed that 70 percent of those age 65 and over had visited a physician within the last six months, almost 13 percent more than all other people.[33] The elderly also have a greater chance of being hospitalized and of being in the hospital longer for a particular illness than others. Eighteen percent of people 65 and over had at least one hospital episode in 1977 compared to only 9.5 percent for other age groups.[34] More significantly, is that the average length of stay for a hospital visit was 11.1 days for people 65 and older, 4 days longer than those under 65 years old.[35] As of 1977 those 65 and over constituted about 10.5 percent of the population, however, they accounted for about 29 percent of all personnel health care expenditures. Hospital services for this group accounted for the largest single share of the total health expenditures for 1977. From the standpoint of impact of insurance programs, table 1 demonstrates the trend in the relative share of expenditures for various services. For example, in 1977 twice as much was paid to hospitals as to physicians even though physicians received a larger share of the total pie until 1940.[36]

Table I

PERCENTAGE DISTRIBUTION OF NATIONAL HEALTH EXPENDITURES FOR SELECTED YEARS

Type of expenditure	Years ending June—							Year ending September 1977[1]
	1929	1940	1950	1960	1965	1970	1975[1]	
	Percentage distribution							
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Health services and supplies	94.2	96.0	93.0	93.4	91.7	92.6	93.9	94.6
Personal health care expense	88.2	87.9	86.5	87.9	86.1	86.9	86.8	87.7
Hospital care	18.1	25.0	30.7	32.9	33.8	37.4	39.1	40.4
Physicians' services	27.7	24.4	22.4	21.6	21.6	19.4	19.3	19.8
Dentists' services	13.3	10.4	7.8	7.5	7.0	6.5	6.4	6.2
Other professional services	6.9	4.5	3.2	3.3	2.5	2.0	1.9	2.0
Drugs and drug sundries	16.7	16.0	13.7	13.9	11.9	10.3	8.4	7.7
Eyeglasses and appliances	3.7	4.6	3.9	2.9	3.0	2.6	1.4	1.3
Nursing-home care	..	.7	1.5	1.9	3.3	5.5	7.6	7.8
Other health services	1.8	2.4	3.3	4.0	3.0	3.2	2.8	2.7
Expense for prepayment and administration	3.6	4.1	3.6	3.9	3.8	3.6	4.7	4.7
Government public health activities	2.5	4.0	2.9	1.6	1.7	2.1	2.4	2.3
Research and medical-facilities construction	5.8	3.5	7.0	6.6	8.3	7.4	6.1	5.4
Research	..	.1	.9	2.3	3.6	2.7	2.4	2.3
Construction	5.8	3.4	6.1	4.3	4.7	4.8	3.7	3.1

[1] Revised estimates.
[2] Preliminary estimates.
SOURCE: U.S. Dept. of HEW, *Social Security Bulletin*, July 1978, p. 15.

In the end, the entire population pays the total health care bill in the form of out-of-pocket payments, higher taxes, and higher prices for goods and services. However, a staggering 70 percent of all personal health care expenditures came from third-party payment programs. The 70 percent is made up of 40 percent from public third-party plans and 30 percent from private insurance plans, with only a small portion from philanthropy and industrial medicine. (see table 2). Note that third parties paid 94 percent of the dollars paid to hospitals.[37]

Table II

PERCENTAGE DISTRIBUTION OF PERSONAL HEALTH CARE EXPENDITURES BY TYPE OF EXPENDITURE AND SOURCE OF PAYMENT—FISCAL 1977

Source of payment	Total	Hospital care	Physicians' services	Dentists' services	Other professional services	Drugs and drug sundries	Eyeglasses and appliances	Nursing-home care	Other health services
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Direct payments	30.3	5.9	38.8	79.5	43.5	83.1	91.9	41.4	....
Third-party payments	69.7	94.1	61.2	20.5	56.5	16.9	8.1	58.6	100.0
Private health insurance	27.6	36.6	36.7	15.5	24.2	7.8	1.9	.9	.....
Philanthropy and industrial implant	2.0	2.3	.1	.....	3.5	.....	.....	.7	25.6
Government	40.1	55.2	24.3	5.0	28.8	9.1	6.2	56.9	74.4
Federal	27.9	39.2	18.0	3.1	21.3	4.9	3.2	33.3	56.1
Medicare	14.6	23.6	13.8	.....	14.2	.....	.....	2.9	.....
Medicaid	6.4	5.1	3.2	2.2	5.7	4.6	.....	28.6	4.5
Other	6.9	10.4	1.1	.8	1.3	.3	3.2	1.9	51.6
State and local	12.1	16.0	6.3	1.9	7.5	4.2	3.1	23.6	18.3
Medicaid	5.0	4.0	2.5	1.7	4.4	3.5	.....	22.0	3.5
Other	7.2	12.0	3.8	.2	3.1	.7	3.1	1.6	14.9

SOURCE: U.S. Dept. of HEW, *Social Security Bulletin*, July 1978, p. 7.

More recent data from the 1980 Census of Population Reports show a steady growth in the group 65 years and over. Between 1980 and 1981 the United States experienced a 3 percent increase in the number of residents 65 years and older.[38]

Future changes in health care policy must deal with the impact of the elderly population. Short term plans for changes in reimbursement structure or procedures dealing with reduction in covered services may be more costly in the long run due to the growth in the aged population.

The next section of this paper deals with the legislative history of both Medicare and Medicaid. These two programs have played a tremendous role in the expansion of national health care expenditures. More significantly, these programs appear to have shaped the country's national policy with regard to health. In today's national climate of reduced federal government involvement, the original goals and objectives appear to be shifting.

LEGISLATIVE HISTORY

The last four years of the Johnson Administration were encompassed with major changes in the field of welfare legislation. The most significant among these was the passage of Medicare - a program of hospital insurance for the aged, financed through the Social Security System.

Congress in 1965 passed the Medicare bill which was generally considered the most important welfare measure since passage of the original Social Security Act in 1935. The success of the enactment was contributed to the increase in liberal democrats throughout the post-war period, especially as a result of the 1964 Presidential election.

The Medicare proposal had been one of the most intensely lobbied issues to come before Congress. One of the major actors within the political arena, and Medicare's chief opponent was the American Medical Association. These lobbyists argued that the program would lead to socialized medicine and would greatly increase the cost of medical services. History reveals that they were wrong on the first issue, but correct on the second.

The other significant change in the original Social Security Act throughout the period from 1965 to 1968 was the establishment of a new program of aid to the poor for medical services. This seemed to be the trend in Congress for many programs developed by the easing of eligibility requirements under Social Security. This new program, called Medicaid, contributed even more to the cost of medical care. It was clear within a year after the inception of these two programs, that they were contributing to a major increase in medical costs throughout the nation. During hearings on the omnibus 1967 Social Security bill, many witnesses told Congress that hospital costs were increasing dramatically and they would continue to go up as much as 15 percent a year in each of the next few years.[39] However, this did not dampen the victory felt by the democratic administration.

The actual signing of the law took place on July 30, 1965. President Johnson proclaimed that with HR 6675, PL 89-97, that "No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years. No longer will young families

see their own incomes, and their hopes, eaten away simply because they are carrying out their deep moral obligations to their parents, and to their uncles, and to their aunts."[40] President Johnson went on to say that the law had a few defects such as the payment of certain specialists, but that he was confident they would be quickly remedied.[41]

As with much of the other liberal legislation passed by the 89th Congress, the ease with which Medicare and Medicaid were enacted was the result of the big Democratic victory in the November 1964 elections. Although the Senate gained only two more Democrats in the 1964 elections, the margin in favor of the Medicare vote was wider than in previous votes. The new margin of support was believed to be a recognition that the 1964 elections had shown the popular appeal of Medicare.[42]

An interesting side note to the 1965 era of liberalized national health care policy was the control and influence of Wilbur D. Mills (D-Arkansas), within the Ways and Means Committee of the House of Representatives. Because the Medicare proposal amended the Social Security Act, it was classified as revenue-raising legislation. The Constitution provides that these types of legislation must originate in the House but cannot be offered on the House floor. In other words, the Medicare measure had to be reported from committee. Thus, the approval of the House committee with jurisdiction over Medicare - the Ways and Means Committee - was all important.

Wilbur D. Mills was among the opponents to the previous years Medicare bill and was influencial in tabling those years bill. However, when the pro-Kennedy Administration took office in 1961, it placed key supporters on the Committee. By 1963 opposition had shrunk to one vote. At the beginning of the 1965 session, the Ways and Means Committee ratios were revised from D15 - R10 to D17 - R8, reflecting the new Democratic ratio in the House.

In 1964 Wilbur Mills issued a statement expressing some sympathy with prepaid health insurance for the elderly, but said he would not support it because such a program would overtax the Social Security System. Many observers believed, when Mills finally switched to support Medicare in 1965, that it was not due to modifications for expenditures in behalf of Medicare, but that the major reason for Mills' about face was the unwillingness to be on the losing end of the issue.[43]

The following section discusses the provisions of HR 6675, especially relating to Medicare and Medicaid. It is important to analyze the components of each program because it gives insight as to the wide range of causes for increased health care costs. It also demonstrates the poor policy planning mechanism designed by the originators of the bill. The specifics of each program will give background as to why the current changes in national policy concerning the federal involvement of health care has chosen reimbursement as the mechanism for change.

MEDICARE

The overall purpose of H.R. 6675 is as follows:[44]

To provide a coordinated approach for health insurance and medical care for the aged under the Social Security Act by establishing three new health care programs: (1) a compulsory hospital-based program for the aged; (2) a voluntary supplementary plan to provide physicians' and other supplementary health services for the aged; and (3) an expanded medical assistance program for the needy and medically needy aged, blind, disabled, and families with dependent children.

A. HEALTH INSURANCE AND MEDICAL CARE FOR THE AGED

The committee's bill would add a new title XVIII to the Social Security Act providing two related health insurance programs for persons 65 or over:

(1) A basic plan in part A providing protection against the costs of hospital and related care; and

(2) A voluntary supplementary plan in part B providing protection against the costs of physicians' services and other medical and health services to cover cetain areas not covered by the basic plan.

The basic plan would be financed through a separate payroll tax and separate trust fund. The plan would be actuarially sound under conservative cost assumptions. Benefits for persons currently over 65 who are not insured under the social security and railroad retirement systems would be financed out of Federal general revenues.

Enrollment in the supplementary plan would be voluntary and would be financed by a small monthly premium ($3 per month initially) paid by enrollees and an equal amount supplied by the Federal Government out of general revenues. The premiums for social security, railroad retirement and civil service retirement beneficiaries who voluntarily enroll would be deducted from their monthly insurance benefits. Uninsured persons desiring the supplemental plan would make the periodic premium payments to the Government.

The Secretary of Health, Education, and Welfare would be required, to the extent possible, to contract with carriers to carry out the major administrative functions relating to the medical aspects of the voluntary supplementary plan such as determining rates of payment under the program, holding and disbursing funds for benefit payments, and determining compliance and assisting in utilization review. No contract is to be entered into by the Secretary unless he finds that the carrier will perform its obligations under the

contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as he finds pertinent. The contract must provide that the carrier take necessary action to see that where payments are on a cost basis (to institutional providers of service), the cost is reasonable cost. Correspondingly, where payments are on a charge basis (to physicians or others furnishing noninstitutional services), the carrier must see that such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the other policyholders and subscribers of the carrier. Payment by the carrier for physicians' services will be made on the basis of a receipted bill, or on the basis of an assignment under the terms of which the reasonable charge will be the full charge for the service. In determining reasonable charges, the carriers would consider the customary charges for similar services generally made by the physician or other person or organization furnishing the covered services, and also the prevailing charges in the locality for similar services.

The bill provides that the payment to hospitals and other providers of services shall be equal to the reasonable cost of the services and that the methods to be used and the items to be included in determining the cost shall be developed in regulations of the Secretary in accordance with the provisions of the bill. The regulations may provide for payment of the costs of services on a per diem, per unit, per capita, or other basis, may provide for the use of estimates in different circumstances, may provide for the use of estimates of cost of particular items or services and may provide for the use of charges or a percentage of charges where this method reasonably reflects the cost.

The appropriate basis of payment for hospital services when payment is made by public or private agencies has been the subject of extended and painstaking consideration for more than a decade. Governing principles have been developed which have attained a large measure of agreement. It is the intent of the bill that in framing regulations full advantage should be taken of the experience of private agencies in order that rates of payment to hospitals may be fair both to the institutions, to the contributors to the hospital insurance trust fund, and to other patients. In framing the regulations the Secretary and his staff will consult with the organizations that have developed these principles as well as with leading associations of providers of services.

Similar principles can without undue difficulty be developed to establish fair basis of payment to extended care facilities and home health services agencies.

The cost of hospital services varies widely from one hospital to another and the variations generally reflect differences in quality and intensity of care. The same thing is true with respect to the cost of the services of other providers. The provision in the bill for payment of the reasonable cost of services is intended to meet the actual costs, however widely they may vary from one institution to another, except where a particular institution's costs are found to be substantially out of line with those of institutions similar in size, scope of services, utilization, and other relevant factors.

Although payment may be made on various bases the objective, whatever method of computation is used, will be to approximate as closely as practicable the actual cost (both direct and indirect) of services rendered to the beneficiaries of the program so that under any method of determining costs, the costs of services of individuals covered by the program will not be borne by individuals not covered, and the costs of services of individuals not covered will not be borne by the program. The basis for the computation of the cost of beneficiaries may vary by institution. The most usual hospital cost reimbursement procedures now in use by plans that pay for inpatient services are based on the average, per diem cost of the patients in the institution to which payment is made, adjusted to reflect the provisions of the plan. Some institutions, however, base their charges to the public on careful cost ascertainment or accounting and change their charges only when there is a change in the cost of the service involved. In these and other appropriate cases reimbursement would be permitted on the basis of the ratio of cost to charges for the services actually received.

In other institutions some of the charges are set according to prevailing rates in the area, or are based on other considerations and not solely on the actual costs of the particular items and services rendered. Except where a close correlation of cost and charges would be shown, other methods would have to be applied to achieve equitable reimbursement.

The concept of reasonable cost and the principles and methods for translating this concept into practice in individual circumstances are of concern to consumers, providers of service, insuring organizations, and State and Federal governmental programs.

In the determination of reasonable costs of services consideration should be given to all necessary and proper expenses incurred in rendering the services, including normal standby costs. Reasonable costs should include appropriate treatment of depreciation of buildings and equipment (taking into account such factors as the effect of Hill-Burton construction grants and practices with respect to funding of depreciation) as well as necessary and proper interest on capital indebtedness.

Many hospitals engage in substantial educational activities, including the training of medical students, internship and residency programs, the training of nurses, and the training of various paramedical personnel. Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program.

Identifiable expenses for medical research, on the other hand, over and above the costs closely related to normal patient care, would not be met from the trust fund. Available research funds are generally ample to support important basic medical research.

In some cases, the charges hospital patients pay include a share of the cost of rendering services to free and part-pay patients as well as a share of uncollectible bills. The committee has given careful consideration to the question of the effect that the proposed program would have on charges to other paying patients. The insurance system will reduce the losses of hospital income from bad debts or for care of free or part-pay aged patients which might otherwise be included in charges to other paying patients by paying the full cost, except for the deductible and coinsurance, for substantially all patients over 65.

The hospital insurance program would be financed through a separate payroll tax that would be paid by employees, employers, and the self-employed, except as to railroad retirement eligibles whose benefit financing is discussed elsewhere. The proceeds of this tax would be earmarked to a newly established hospital insurance trust fund, which means that these funds will be kept completely separate from the taxes which support the present social security program. The earnings base of the new tax would be the same base as that for the social security tax so that the recordkeeping tasks of employers and the Government would be left largely unaffected by the establishment of a separate contribution for hospital insurance.

MEDICAID

Health Insurance and Medical Care For The Needy[45]

Medicaid, a new Title XIX to the Social Security Act was designed to substitute a single system of medical assistance for the many fragmented services administered through welfare programs.

"Medical Assistance" is defined under the bill to mean payment of all or part of the cost of care and services for individuals who would meet the eligibility requirements under State guidelines but must at least cover the following required services:

Inpatient hospital services
Outpatient hospital services
Other laboratory and X-ray services
Skilled nursing home services
Physician services

Under the bill, States may include other services or medical care recognized under State law. For example, a State may include services by chiropractors and podiatrists.

Standard Provisions:

-that a plan shall be in effect in all political subdivisions of the State.
-that there shall be provided an opportunity for a fair hearing for any individual whose claim for assistance is denied or not acted upon with reasonable promptness.
-that there shall be safeguards against disclosure of information concerning applicants.
-that all individuals wishing to make application for assistance shall have the opportunity to do so.
-that the State plan include a discription of the standard, methods, and administrative arrangements which affect quality of medical care that a State will use in administering medical assistance.
-that the State agency will make such reports as the Secretary may from time to time require.
-that medical assistance must be made available to persons receiving assistance under other current State plans and must not be less in amount, duration, or scope under the new plan.
-that States must develop reasonable standards consistant with the objective of the Titles, although States may set limitations on income and resources which an individual may hold.

> The financing of the Medicaid program is a shared State-Federal plan. The Federal medical assistance percentage is determined in accordance with a formula described in the bill. It provides that a State whose per capita income is equal to the national average per capita income shall receive 55 percent Federal matching States whose per capita income is below the national average shall receive correspondingly higher proportions of Federal funds up to a maximum of 83 percent. States whose per capita income is above national average shall receive correspondingly lower percentage but not less than 50 percent. In addition, the States are to receive one half of all other expenditures found by the Secretary to be necessary for the proper and efficient administration of the State plan.

Medicare and Medicaid both created by the Social Security Amendments of 1965 have similar objectives. The administration of these programs is somewhat different as well as eligibility requirements. Medicare generally reflects the program assumption that the services provided are a right earned by making Social Security contributions throughout one's working life. Almost all persons automatically qualify for the program at age 65, regardless of financial status. In other words, benefits are based on a universal age criterion.[46]

In contrast, Medicaid eligibility is based on public welfare principles. The program fixes income, resources, and family composition criteria to determine access to medical assistance. This program's eligibility criteria thus becomes highly complex and variable in every situation.[47]

The next section of this paper will analyze the components responsible for the tremendous increases in health care costs, specifically related to the program design for Medicare and Medicaid. The cost reimbursement plan adopted by the originators of these programs were not far sighted enough to see the problems of inefficiency and waste. It will be demonstrated that it is almost impossible to restrain health care expenditures under a cost payment plan as originally designed.

There is little doubt that our nation whose health care delivery system is substantially private, but whose health care financing system is mostly public, will continue to be so in the future. It is absolutely necessary to understand the relationship of public financing and private delivery because this is the basis for the current cost problems.

The decision to proceed with federal financing for the aged and poor originally contained several important assumptions:[48]

- -Medically necessary benefits under the program would be physician-ordered services that relieved discomfort and improved personal health status.
- -Public programs would be administered by private insurers in a manner that mirrored their private business. Hospitals would be paid reasonable costs, the common Blue Cross method, and physicians would be paid the lower of their usual, customary and prevailing charges to all of the patients.
- -Provider participation and beneficiary understanding would take priority over cost.

These assumptions were widely believed and supported even though little deliberate or thorough examination was done at the onset. Victor Fuchs, one health economist who is skeptical toward the value of the medical care system stated clearly his conclusions on governmental interventions:

> "In my view, National Health Insurance and other governmental interventions in health are best viewed as political acts undertaken for political and social objects relatively unrelated to the health of the population. This seems to be an inescapable conclusion from the evidence now available."[49]

Despite a few outspoken critics such as Fuchs, the deep historic national commitment to health has not substantially changed. This is easily seen in the institutional arrangements that encourage their continued growth and development, including personal income tax deductions for medical expenses, provisions of health insurance as an employment benefit, subsidies for health manpower training and research, as well as government financing of Medicare and Medicaid.[50]

A major problem in the rising cost issue deals with the question of efficiency. Hospitals are traditionally reimbursed for whatever costs are incurred rather than on the basis of a standard rate. Such a system neither rewards efficiency nor does it penalize waste. For example, hospitals which are reimbursed for all allowable expenses incurred during the previous year, are almost assured that new equipment and expanded facilities will be covered no matter how excessive their costs. Another example is physician reimbursement which is based on "customary, prevailing, and reasonable" charges. It does not pay for a physician to charge any less than others in the area and in fact is raised as other physicians raise theirs in the community.

Another significant factor pertaining to the cost issue deals with the recent technological advances in medicine. This has led to increased resource intensity on any given day at a hospital. The problem is that these technological innovations raise the cost substantially, without a measureable result. For instance, the notable increase in the cost of treating heart attacks has largely been a result of the use of intensive care units. Yet some studies of the effectiveness of early home care versus extended hospital stays for heart attack victims suggests that there is no difference in outcomes for low-risk patients who are discharged early and spared the economic expense of hospital care.[51] This issue of cost versus technological advances is not clear. Some people measure the costliness and technical sophistication of services as a mark of quality,especially in regards to hospital services. Patients depend on physicians to assist them in their utilization decisions and physicians are not likely to economize on services that offer even the slightest chance of benefit, particularly since they bear none of the cost themselves.

The last statement probably is even more significant as a cause for rising health care costs than technological advances. When there is a separation of payment responsibility from the decisions to seek care, no one even takes cost into account. Although costs are paid by individuals and their employers as insurance premiums, they do not affect the demand for services at the time of purchase. Patients who have paid for their insurance are often quoted as saying that they are going to get their money's worth.

In general, hospitals have performed inadequately. The reasons for this poor performance have been mentioned above. To summarize, a service benefit health insurance policy that both removes any incentive for patients to reduce their hospitalization costs and reimburses the hospital on the basis of its costs will continue to inflate health costs above other economic measures. Also, the physician's freedom from fiscal responsibility for the method of patient treatment selected will feed the increasing cost problem.

With this current situation out of control, the federal government has now taken a new stand on the public policy issue of health care. The Reagan Administration has taken charge through new legislation, specifically designed to change the reimbursement structure of the Medicare and Medicaid programs. The Tax Equity and Fiscal Responsibility Act of 1982 contains several provisions that will significantly affect reimbursement from these two federal programs. The following material outlines in detail the specifics of the Act and its implications when compared to the original cost reimbursement structure.

THE TAX EQUITY AND FISCAL RESPONSIBILITY ACT

The Tax Equity and Fiscal Responsibility Act of 1982, signed into law by President Reagan, contains several provisions which will significantly affect hospital reimbursement from the Medicare and Medicaid programs. The Health Care Financing Administration (HCFA) published in the Federal Register a schedule of limits on hospital inpatient operating costs that may be reimbursed under Medicare for cost reporting periods beginning on or after October 1, 1982 (FR 43296). These limits were developed in accordance with Public Law 97-248 (Tax Equity and Fiscal Responsibility Act or TEFRA). The interim final rule implements Section 101 which directs the Secretary to control the rate of growth in hospital costs per discharge from one cost reporting period to the next.

Although the Act contains several sections, such as elimination of the nursing salary differential, Hill-Burton free care limits, HMO provisions, and reimbursement for hospice care, this paper will deal specifically with Section 101. This section is summarized below:[52]

> Sec. 101 (a) (1) Title XVIII of the Social Security Act is amended by adding at the end thereof the following new section:
>
> "Payment to Hospitals For Inpatient Hospital Services"
>
> The Secretary, in determining the amount of the payment that may be made under this title with respect to operating costs of inpatient hospital services shall not recognize as reasonable costs for the provision of such services by a hospital for a cost reporting period to the extent such costs exceed the applicable percentage of the average of such costs for all hospitals in the same grouping for comparable time periods.
>
> The Secretary shall establish case indexes for all short-term hospitals and limits for each hospital based on general mix of medical cases.
>
> The Secretary shall provide for such exemptions from, and exceptions and adjustments to, the limitation established as he deems appropriate.

Section 101 of TEFRA is extremely complex and covers many different areas. It is necessary at this time to discuss the implications of the provisions in the Act. First, routine cost limits will be extended to total inpatient operating costs, such as routine care, ancillary services and special care units. The limit

is set at 120 percent of the mean cost per discharge for each HCFA determined hospital peer group. The limit decreases to 115 percent in fiscal year 1984 and 110 percent 1985. However, in no instance can the limit be less than the hospitals' allowable cost-per-case for the cost reporting period to establishment of the new limits. Adjustments to these limits include sole community hospitals, and hospitals which serve a large proportion of low-income or Medicare patients. Second, the HCFA will compute an average Medicare cost per discharge for each group based on 1981 cost reports, and roll them forward for estimated inflation to 1983. This average will be multiplied by 120 percent to get a base limit. That limit can be adjusted for differences in area wages and individual hospital case mixes.

The case mix adjustment has unique bearing on the calculations. What has happened is that the HCFA has accumulated case mix data for all hospitals for several years now. It has done this by taking 20 percent of all Medicare claims, recording the discharge diagnosis and grouping them by diagnosis using the Diagnostic Related Group (DRG) grouping system. From this data the HCFA will construct an index for each hospital that reflects its unique case mix. Then, the average cost per discharge for a hospitals' group will be multiplied by each hospital's case mix adjustment to determine that hospitals' own limit. For example, a hospital with a case mix that shows a 10 percent intense level could have the limit set at 110 percent of the group limit. Conversely, a hospital whose case mix is 10 percent less intense could have its limit set at 90 percent.

Per case reimbursement target is the third special provision under the Act. This implies that a hospital's operating costs are evaluated in comparison to a target amount per discharge. This target is established for each hospital based on its previous year's allowable operating costs per discharge. In the first year the target rate will equal the prior year's cost increased by the forecasted percentage increase in the hospital wage and price index plus one percentage point. For the next two years, the increase will be increased by the forcasted market basket plus one percentage point. A hospital with operating costs below the target rate will be paid its costs plus the lesser of (1) 50 percent of the difference between operating costs and the target amount, or (2) 5 percent of the target amount.

With passage of the new reimbursement limits and the target rate, hospitals will have to operate within two separate limits at the same time.

SUBTITLE B - MEDICAID

Title XIX of the Social Security Act is amended by adding at the end thereof the following new section:

"Use of Enrollment Fees, Premiums, Deductions, Cost Sharing, and Similar Charges".

This amendment can be summarized by stating that states are allowed to require nominal copayments from their medically and categorically needy beneficiaries except under the following conditions:

(1) Under 18 years of age
(2) Pregnancy related services
(3) Receiving emergency services (as defined by the Secretary)

The copayment must be nominal in amount (to be defined by the Secretary). A state may impose twice the nominal amount for outpatient services received at a hospital emergency room if the services are not emergency and if beneficiaries actually had available to them alternative sources of non-emergency services.

State plans must require that no participating provider can deny services to a beneficiary unable to pay the copayment amount. And if beneficiaries are unable to share in the cost of their care, a provider must absorb the debt. This means that providers will experience reduced payment due to Medicaid bad debts because the legislation states that the government is not responsible nor will they reimburse providers for bad debts.

Implications of TEFRA pertaining to Medicare and Medicaid are far reaching in nature especially in the future reimbursement mechanism. The first three years will be an adjustment period. The following section will discuss ways hospitals will have to prepare for the change in reimbursement structure. But first, an understanding of the previous cost reimbursement structure is necessary for comparison sake.

The Social Security Administration, through the Department of Health and Human Services, (formerly HEW when cost reimbursement was inaugurated), list thirteen specific and four general principles of reimbursement under the Medicare program.

The specific principles cover:

Depreciation
Interest expense
Bad debts, charity and courtesy allowances
Cost of educational activities
Research costs
Gifts, grants and income from endowments
Value of services of non-paid workers
Purchase discounts and allowances, and refunds of expenses
Compensation of owners
Cost to related organizations
Allowance in lieu of specific recognition of other costs
Return on equity capital of proprietary provider
Inpatient routine nursing salary cost differential

The general principles of reimbursement cover:

Costs related to patient care
Determination of cost of services to beneficiaries
Adequate cost data and cost finding
Payments to providers[53]

These principles regulate what are "allowable" costs for Medicare reimbursement. Because hospitals in general are not able to identify specific costs with specific services rendered and, in particular, with specific beneficiaries of such services, the Medicare Program devised its RCCAC principle. This principle, the Ratio of Charges to Charges Applied to Costs, presupposes that costs follow charges in relatively the same proportions. For example, if 15% of the charges for operating services were made to one class of patient, then 15% of the costs of this service are chargeable to that class of patients.[54]

When the RCCAC principle is applied to determine the ultimate reimbursement costs, all costs must, of necessity, be related to revenues. Under this method, general service and overhead expenses such as laundry, housekeeping, medical records, school of nursing, etc. could not be put into the calculation of reimbursable costs unless these expenses were distributed to income-producing centers. Therefore, Medicare provides for what is called single "stepdown" cost apportionment. This type of cost apportionment allocates the costs of nonrevenue-producing service departments to all other depts.,the costs of which have not been previously allocated, eventually "stepping-down" all costs to revenue-producing departments, both ancillary and routine costs.[55] Final settlement of inpatient costs are calculated by applying one over-all RCCAC percentage to the total and adding the result to a per patient day cost for routine care.

Earlier discussion of the cost reimbursement problem consisting of waste, inefficiency, and lack of incentives for cost containment are specifically dealt with by changes implemented in TEFRA. It is obvious that the Medicare cost reimbursement structure of past years did not curtail rising cost to any significant degree. What hospitals face now is another story.

To begin with, routine cost limits have been tightened to the point that many hospitals are at or over the limit established for their peer groups. Even hospitals that have been able to stay under the limit by identifying costs more properly allocated to ancillary services will find that the extension of the provision now includes all inpatient services, thus reducing the ability to cover costs within these other areas. In addition to the extended limits, hospitals are faced with limits set on a per discharge basis instead of on a per diem basis. It is implied by the Senate Finance Committee Report that the "committee anticipates that the Secretary would continue to apply any other exemptions, exceptions, and adjustments now allowed under the routine operating cost limits that he deems appropriate for the new overall limits on operating costs."[56]

It is recommended that hospitals begin to prepare for these changes in reimbursement limits by analyzing their case mix and developing procedures for monitoring changes caused by the limits. It is further suggested that hospitals should (1) audit their medical records function to insure complete and accurate diagnosis data are being recorded; (2) analyze physician utilization patterns, particularly of ancillary services; and (3) intensify productivity monitoring and cost containment efforts throughout the hospital.[57]

Exceptions or adjustments are provided for when there are changes in case mix and other situations that are beyond a hospital's control which can greatly inflate operating costs. Monitoring of hospital plans to reduce services normally provided just to reduce its costs, allow the Secretary to adjust the method for determining payment to that hospital. For example, a recent trend in hospitals is to withdraw from Social Security (FICA) program. However, the Secretary is now able to reduce a hospitals' payment by the amount of FICA taxes that would have been paid.

Analysts of the TEFRA regulations believe that the target rate provisions of the Act will have a far more effect on many hospitals than the operating cost limits. The target amount is established for each hospital based on its previous year's allowable operating costs per discharge. This amounts to a "cap" on a hospitals cost per discharge, thus creating an incentive for efficient hospitals. A hospital whose actual costs are less than its target rate will be reimbursed its acutal cost, plus 50 percent of the amount by which its costs are below the target. Hospitals above their target will be penalized by not receiving reimbursement of their costs above the target.

The Michigan Hospital Association (MHA) and the Michigan Health Care Financial Management Association havedeveloped responses to the TEFRA provisions. Although biased because of their affiliation with Michigan hospitals, their comments warrant discussion.

According to MHA, the cost limits set up by the HCFA are understated because they do not reflect cost increases which have occurred for reasons other than inflation. The new limits are calculated in cost reports available in April of 1981 which represent hospital reports for fiscal years ending during calendar year 1980. MHA contends that the limits were not appropriately updated to reflect non-inflationary increases in actual operating costs that occurred since the cost reporting period from which the data was collected. Costs resulting from changes in type, quality, and quantity of services as well as increases in the intensity of services should be recognized by the HCFA.

The MHA also contends that the case mix categories penalize hospitals with a unique service mix because they only reflect differences in primary diagnoses. They fail to recognize other dimensions of case mix that influence costs, such as severity of illness, and patient characteristics.[58] For instance, the 356 case mix categories designed by the HCFA do not account for secondary diagnoses, the use or non use of surgery and patients' age. Each of these variables influence the utilization of hospital services by the particular mix of patients. By using only the primary diagnosis to classify patients, the HCFA does not take into account the severity of the patient condition, and therefore, understates the case mix adjustment for hospitals with larger percentages of the more severely ill patients.

The MHA recommends two further adjustments that they feel are necessary to make a more equitable case mix methodology. They are: (1) identify specific conditions under which hospitals with unique service mix may obtain exceptions from the limits, or (2) adopt a case mix methodology that adequately addresses secondary diagnoses, the presence or absence of surgery, primary and secondary surgical procedures, the patient's age, and the patient's referral status.[59]

MHA is very concerned with the way the HCFA has developed its plan to curb growth in inpatient hospital costs. The section that deals with this is under Section 101 and is labeled target rate of increase provision. MHA contends that this does not adequately meet legitimate hospital costs and the appeal process is much too cumbersome for a hospital to seek relief when they need it. MHA recommends the following items which should be considered along with the original guidelines.[60]

1. Input prices which deviate substantially from expected behavior and are beyond the control of the hospital;
2. Net costs attributable to volume and case mix which might not have otherwise been recognized;
3. Net cost of new services which might not otherwise have been considered;
4. Determination or other requirements imposed by or through the program;
5. Government legislation and regulation, licensure and accreditation, and court rulings;
6. Substantial errors in assembling, presenting, and interpreting facts and duties;
7. Medical technology and increased intensity that resulted from the services which have certificate of need approval or have been determined not to need certificate of need approval that might not otherwise have been considered.

The appeal process for the target rate of cost increase is another area where MHA feels that there is an unjust burden placed on hospitals. In most cases, Medicare appeal decisions are not rendered for at least 18 months following the close of the fiscal year in question. This amount of time is much too long for hospitals to operate without adequate reimbursement. MHA recommends the use of a prospective reimbursement plan such as used by Blue Cross and Blue Shield. This will enable hospitals to have a constant flow

of working capital on a timely basis even if they are in an appeal process.

To better understand the impact on hospitals, an example of an acute care hospital will be given. Following the example, strategies will be discussed on how hospitals will proceed with lowered reimbursement from Medicare and Medicaid.

HOSPITAL EXAMPLE [61]

The TEFRA regulations are causing hospitals to evaluate their financial reimbursement levels from Medicare and Medicaid much more closely. The financial impact of the extended limits and the target rate incentive system basically involve three variables, (1) a cost limit based on the mean cost per case for a HCFA determined group of hospitals, (2) a target rate based on each hospital's previous year's allowable costs, and (3) the actual cost per case for the first cost reporting period subject to the new limits. In the example below, values for the 1981 group mean cost per discharge are used along with the case mix adjustment factor, the 1982 cost per discharge of the hospital, and the 1983 actual cost per discharge of the hospital. From this, the hospital is able to calculate the cost limit, the target rate and the incentive payment.

Provider Name: Anonymous

Location: Flint

Number of Beds. 399

Cost Period: 10-1-82 to 9-30-83

Bed Size (Table I Federal Register, Vol. 47, No. 180, 9-30-82)
100 to 404

Labor Related Component:	2776.13 (Federal Register)
Non Labor Component:	731.05 (Federal Register)
Total:	3507.18

Wage Index:	1.1849 (Federal Register)
Case Mix:	1.0523 (Federal Register)
No. of Interns/Residents:	63
Education Factor:	.0606
Fye Adjustment Factor:	1.0000

Computation of Cost Limit

A. Labor Related Component	2776.13
B. Wage Index	1.1849
C. Adjusted Labor Related Component (AXB)	3289.44
D. Non-Labor Component	731.05
E. Adjusted Limit (C+D)	4020.49
F. Case Mix	1.0523
G. Adjusted Limit (EXF)	4230.76

EDUCATION ADJUSTMENT FACTOR

a. No. of Interns/Residents	63
b. No. of Beds	399
c. Intern/Resident Ratio (a÷b)	.1603
d. Divide by (factor given)	.1
e. Adjusted Ratio (c÷ d)	1.603
f. Education Factor	.0606
g. Adjusted Education Factor (eXf)	.09714
h. Add (factor given)	1.0
i. Adjusted Education Adjustment Factor (g+h)	1.09714

1. Adjusted Limit (gXi)	4230.76
2. FYE Adjustment Factor	1.0
3. Revised Cost Limit (1X2)	4641.76

Calculation of the 1983 Target Ratio

1982 Inpatient Ancillary Cost (hospital cost report)	$5,959,370
Inpatient Routine Cost	7,830,840
<less> Depreciation, routine service and cost of medical education program	< 2,346,442 >
Total Cost Subject to Target Rate	$11,443,768

1982 Total Medicare Discharges			3,470
1982 Cost per Discharge	$\frac{11,443,768}{3,470}$	=	$3,297.92

1982 Cost per Discharge	3,297.92
1983 Market Inflation (HCFA)	8.40%
Adjustment Factor (HCFA)	1.00%
1983 Target Ratio	3607.92

HOSPITAL EXAMPLE SUMMARY

The hospital in question has an inpatient discharge cost limit of 4641.76 and a calculated target rate of 3607.92. Therefore, the hospital is below the limit for peer group hospitals (urban hospitals with 100 to 404 beds). Since the hospital is grouped by using a median for all hospitals, 50 percent of the hospitals in the group will be below the limit and 50 percent above the limit. The way the regulations are written, it catches hospitals on both accounts. Hospitals above the limit will lose 75 percent of the costs above the limit the first year and 100 percent by the third year. Hospitals below the cost limit are then subject to their target rate limit in preceeding years plus a forecasted market inflation rate plus one percent. This example demonstrates that the new TEFRA regulations are designed to curb hospital spending. Whether it controls the rising health care costs for the nation is still to be answered.

The new Act unquestionably will reduce reimbursement to hospitals. Hospitals are reacting by analyzing their entire personnel operation. Some are placing a moritorium on hiring, reducing temporary and casual employees, and cutting part-time hours to a minimum. Hospitals are also expanding the financial department's role in the operation of the hospital. Identifying cost finding areas in detail are now priorities. Budgets are much more closely monitored and overruns are dealt with quickly. Long range planning, a relatively new speciality in health care institutions, has become a significant administrative department. The most significant strategy local Flint hospitals have developed recently is the legal creation of a holding company which acts as a parent corporation running the non-profit hospital. The holding company can develop private profit-making operations to feed money into the parent corporation and thus have money available to the non-profit hospital for continued operation, thus reducing the impact of lost reimbursement from Medicare and Medicaid. This particular subject is very interesting but beyond the scope of this paper. The Federal involvement through reimbursement program reductions appears to have done what it was designed to accomplish from a public policy concept. Time will tell whether a curb on rising health care cost can be achieved, the fact remains that Medicare and Medicaid cost share will be reduced.

CONCLUSION

Although the underlying goal is to reduce the trend of rising health care costs, it may be the Reagan Administration's objective at this time to reduce the federal government's share of the cost by developing legislation such as TEFRA. Knowing that the elderly population will continue to increase, knowing that this population requires more and more health care, it is realistic to assume that the cost will also continue to rise at a substantial rate. A question not asked let alone not answered, is who will pay for Medicare and Medicaid's portion of the health care bill? It is obvious that the federal government does not plan to continue paying for it. It will be very interesting to see what happens in the next decade on both sides of the issue. Whether legislation such as TEFRA continues to expand, whether hospitals find new and creative financing arrangements, remains to be seen.

I believe that the hypothesis stated at the onset of this paper is a central issue concerning not only the hospital component of the health care system, but encompasses the entire spectrum of policy action dealing with health care issues. Attacking the cost problem ignores other important aspects of health care. Issues such as availability, quality, utilization, and moral obligation questions are not addressed by the recent legislation. History in public policy analysis has repeatedly demonstrated that unless all aspects of the issue are incorporated into the policy plan, it is doomed to failure.

FOOTNOTES

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3. Ibid., p. 199
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5. Ibid., p. 210
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7. Ibid., p. 174
8. Ibid., p. 212
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11. Feldstein, op. cit., p. 185
12. Ibid., p. 185
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14. Ibid., p. 113
15. Feldstein, op. cit., p. 198
16. Robert S. Pindyck, Econometric Models and Economic Forecasts, p. 379
17. Mary Ingbar, Lester Taylor, op. cit., p. 41
18. Ibid., p. 44
19. Howard P. Tuckman and Teufik R. Nas, Accion Cultural Popular (Colombia): Alternative methods for determining project costs, p. 148
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21. Herbert Kaufman, The Limits of Organizational Change, p.10
22. Ibid., p. 35
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26. Mary Ingbar, Lester Taylor, op. cit., p. 117
27. Ibid., p. 117
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31. Ibid., p. 31
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FOOTNOTES - continued

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48. Robert A. Derzon, "Containing Health Care Costs", The Western Journal of Medicine, p. 425
49. Ibid., p. 426
50. Ira E. Raskin, "Controlling Health Care Costs: An Evaluation of Strategies", Evaluation and Program Planning, p.2
51. Ibid., p.3
52. Ernst and Whinney, "The Tax Equity and Fiscal Responsibility Act of 1981", p.1
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60. Ibid., p. 10
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