

Medicare Reforms Cut Hospital Payments, Add PSO Option

BY JANE HIEBERT-WHITE

The Balanced Budget Act (BBA) of 1997 gave hospitals some good news and some bad news on the Medicare front. On the upside, the BBA, which was signed into law August 5, 1997, gives hospitals and other providers a chance to serve Medicare beneficiaries through provider-sponsored organizations (PSOs). On the downside, cuts to hospital Medicare margins will be substantial, including a freeze in the update factor for fiscal year 1998—the first in the history of Medicare's prospective payment system (PPS). This column examines some of the implications of the Medicare cuts and new PSO options for hospitals.

MEDICARE SAVINGS AND HOSPITAL MARGINS

The goal of the BBA cuts is to get the average increase in net Medicare spending down to about 5.5 percent per year by FY 2002, versus the FY 1997 increase of 8.84 percent. This will keep the Medicare Hospital Insurance Trust Fund solvent a bit longer—through 2006.

The legislation's reforms do not begin to address the problem of covering the Medicare bills of the massive baby boomer generation, once it starts retiring. The act did set up a commission to look into longer term reforms, however. The commission's report is due in December 1998.

About 44 percent of savings to Medicare, and almost 30 percent of total savings in the BBA come from hospital payments—and half of those are from cuts to the hospital Medicare payment update factor. The Congressional Budget Office (CBO) estimated that under the BBA, savings from inpatient hospital payments will total \$32.9 billion between FY 1998 and FY 2002 and \$82.8 billion between FY 1998 to FY 2007.¹ Savings from cuts in the update factor are estimated at \$17.1 billion for FY 1998-FY 2002 and \$46.3 billion for FY 1998-FY 2007.

The BBA set the Medicare PPS update factor for hospital inpatient care at 0 percent for FY 1998, market basket index (MBI) minus 1.98 percent for FY 1999, MBI minus 1.8 percent for FY



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2000, MBI minus 1.1 percent for FY 2001 and FY 2002, and at the MBI for FY 2003 and beyond. Analysts predict, however, that future legislation will likely cut the FY 2003-and-beyond figure below the MBI as well, resulting in even greater Medicare savings from hospitals. The MBI is currently running about 2.8 percent.

NEW PROPAC ESTIMATES

The Prospective Payment Assessment Commission (ProPAC), at its September 23 meeting, released controversial new estimates of how hospitals' Medicare margins would fare under the new BBA. For example, hospitals' Medicare margins are estimated to average *higher* in FY 2002 (15.3 percent) after all the cuts, than they will in FY 1997 (14.2 percent). In FY 1995, Medicare margins averaged 10 percent. Without BBA, however, ProPAC analysts pegged the FY 2002 Medicare margin average at 24.2 percent.

Hospital groups argue that focusing solely on the Medicare margin distorts the true picture of how hospitals are faring in the marketplace. Medicare inpatient revenue is about 28 percent of hospitals' business. However, ProPAC estimates total hospital margins at 6.2 percent for FY 2002—"about what it is now," said ProPAC deputy director Stuart Guterman. Without cuts from the BBA, total hospital margins would have reached 9 percent in FY 2002.

In a September 23 letter to ProPAC chairman Joseph Newhouse, American Hospital Association (AHA) President Dick Davidson called the commission's report "reckless. . . . It will again be misconstrued by many as a picture of the financial health of hospitals and health systems. It is nothing of the kind. It is inaccurate and misleading."

Davidson added, "The reality is that payments rarely cover the cost of all patient care. . . . What's needed is a broader more complete look by the government at hospitals' fiscal soundness—a comprehensive set of relevant indicators beyond margins. Health care policy must not be made with fragments of information. We owe the American

people a complete picture. Only then can the tough decisions on the future of Medicare be made with confidence.”

In reply, Newhouse, who now serves as vice chairperson of the new Medicare Payment Advisory Commission (MedPAC), which merges ProPAC and the Physician Payment Review Commission as part of the BBA, wrote October 6: “I agree with you that a single indicator cannot adequately describe the financial status of the hospital industry. . . . [However], as has been the case since the beginning of the Medicare prospective payment system (PPS), the indicator of most interest was the PPS margin. This is commonly viewed as the single best indicator of the adequacy of payments under PPS, because it provides a direct comparison of those payments and the costs to which they correspond.”

Newhouse, an economist at Harvard University, added: “I must point out—as was emphasized in the staff presentation—that this result is heavily dependent upon assumptions about hospital cost increases over the period from 1995 . . . through 2002. However, even if hospital inpatient costs per discharge grow at a rate equal to the PPS hospital market basket index . . . it is clear that PPS payments would well exceed costs for the vast majority of hospitals.” Regarding total hospital margins, Newhouse commented: “Although slightly more than 20 percent of all hospitals had negative total margins in 1995, this figure was lower than in any year since PPS began in 1984. And, although other changes may exert increasing pressure on hospitals’ continued viability, ProPAC’s analysis shows that the PPS provisions in the BBA do not inappropriately reduce Medicare payments for inpatient hospital services.”

Gail Wilensky, who chairs MedPAC, said in an interview that “MedPAC will continue to talk about both total hospital margins and Medicare margins, but total margins are more relevant,” because they show how hospitals are doing in the marketplace. She added, however, that “one could argue that consolidation [of hospitals] is not necessarily bad for the country—depending where it occurs and what happens to vulnerable populations.” She noted that “this next period is not going to be an easy time for providers with excess capacity amid aggressive purchasing and the pressure to hold on to market share.” However, with hospital margins at “all-time highs,” Wilensky remarked, “obviously hospitals are doing a lot of the right stuff [in their] in-house versus outsourcing policies, mix of personnel, emphasis on customer service, and efficiencies in the form of fruitful partnerships. However, the frenzy of activity to

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Hospital groups claim that the freeze in the update factor for FY 1998 punishes hospitals for being efficient in the newly competitive healthcare market. The ProPAC estimates show that hospitals have managed to hold down their costs, with overall expenses increasing by only 0.3 percent during the first five months of 1997. Hospital revenue declined 0.1 percent during the same period compared with the first five months of 1996, however. Indeed, since 1994 hospitals have managed to hold costs to an annual rate of increase hovering around 2 percent. This is a stark change from the late 1980s and early 1990s, when hospital expenses per adjusted admission were increasing at annual rates ranging from 8.1 percent to 9.5 percent, according to ProPAC analysis of AHA data.

In an interview, Princeton economist Uwe Reinhardt said that part of the reason why Congress adopted a zero price increase for hospitals “is because hospitals are only 60 percent full. Medicare is saying, We are not willing to pay for excess capacity. It is fair to say that, if we look at employment statistics of hospitals, they did not lay off people in the 1980s and early 1990s. Hospitals never actually became as efficient as they should have been. One way to force [efficiency] is to give them zero” in the update factor.

“I’m not sure you can call that totally ‘reckless,’” Reinhardt continued. “The difference between Democrats and Republicans is that Democrats are generally very kind to providers. Republicans are saying, We don’t quite trust you. We don’t know when you’re faking it and crying wolf and when it’s real. Let’s see what happens when we freeze [payments to hospitals]. For all we know, nothing will happen.”

Reinhardt advised providers to “take that zero update and try to see if you can, with merging and affiliations on a voluntary basis, squeeze out enough of the excess capacity to live within that update amount. That’s the moral challenge. A balanced budget paradigm changes the morality of public lobbying. Every time you get more, someone else gets less.”

Former CBO Director Robert Reischauer also suggested that the Medicare cuts to hospitals were justified. “Over time Medicare has gone from being a meager payer to an adequate payer to—in some parts of the country, for some services—a generous payer. There’s no sense in having the government pay more than necessary.”

Reischauer, now a senior fellow at the Brookings Institution, said in an interview that “we remain a nation with tremendous hospital overcapacity. Consolidation and shrinkage are

going to be required over the next decade. The notion that you can fight this is like trying to rein in the tide."

Wilensky, an economist and senior fellow at Project HOPE, noted, however, that the pressure to keep hospital costs down in the face of the new Medicare cuts "puts tension on providers worried about their mission" of serving the substantial number of uninsured people. Hospitals most committed to this mission "may be the most vulnerable," she said.

NEW MEDPAC GOALS

The newly combined Medicare commission formed by the BBA is "consistent with what we're seeing in health care," said Wilensky. Having separate Medicare commissions for hospital payments and physician payments was a "historical accident," she said. Now there is a need to "look at Medicare reform as a whole . . . and the commissions were tripping on each other," she noted. However, Wilensky was quick to add that the government should not yet abandon the financial constraint of the Medicare Part A Hospital Insurance Trust Fund. So while the blending of Medicare commissions has been achieved, it is not yet time to blend the financial payment structures of Medicare Part A (hospitals) and Part B (physicians).

Wilensky said her goals for the new commission will be driven in large part by MedPAC's legislative mandate to recommend payment updates and look at issues of access, liability, and the effect of Medicare on the rest of the system. She said she would also examine ways to improve measuring risk selection. "We will have our hands very full," she said. Wilensky added that 15 is "a tight number" of commissioners to serve on MedPAC; "a couple more might have been useful." What is more, the legislation limits the commissioner selection to but seven providers—a minority position. Some hospital observers have questioned whether rural hospitals, for instance, will be adequately represented on the new commission.

NEW MEDICARE CHOICE: PSOs

Along with cutting Medicare spending and consolidating the government's Medicare commissions, the BBA also offers a host of new choices for coverage to the elderly and disabled beneficiaries. The hope is that new managed care options will further help control rising Medicare costs, though a number of analysts, such as economist Marilyn Moon of the Urban Institute, estimate that some of the options will initially add to Medicare's costs and will require careful monitoring.

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One new option for Medicare beneficiaries is the provider-sponsored organization (PSO), in which hospitals or physicians directly take on the capitated financial risk typically borne by an insurer. Said Wilensky, "PSOs provide a politically important safety valve to allow physicians and hospitals to join forces and compete head-on with insurance-based HMOs. . . . It gives them a chance to put their money where their mouth is."

Hospital groups, including the Catholic Health Association (CHA), lobbied vigorously for the inclusion of PSOs in the Medicare reforms of the BBA and also for federal preemption of PSOs from state insurance laws related to financial solvency and capital adequacy. The BBA allows potential PSOs to seek a waiver of state law by filing an application with the Secretary of Health and Human Services (HHS) no later than November 1, 2002. The waiver would be effective for three years and nonrenewable. The HHS secretary has set a target date of April 1, 1998 for the presentation of federal solvency standards for PSOs and a deadline of July 1, 1999 for the completion of all PSO rules.

Providers' Concerns Provider groups have raised concerns about state regulation and financial standard setting for PSOs. Josephine Musser, Wisconsin's health insurance commissioner and president of the National Association of Insurance Commissioners (NAIC), outlined some of the concerns raised by providers. "The complaints early on from physicians were that the states were too slow to license provider-sponsored plans. However, we found only one instance of a state that took more than ninety days to license such a plan."² She added that "another argument made by providers was that the financial requirements for launching a plan were too high. Wisconsin requires \$1.2 million. I think, in this day and age, if you don't have \$1.2 million in assets, you should probably not be in the health insurance business."

Musser noted that the NAIC has worked to develop a risk-based capital model that "gives credit for the ownership of the delivery system, perhaps the hospital or medical clinic itself, and the technology within such facilities." Thus, she argues, "PSOs don't need to be codified in federal statute. There's nothing sufficiently different about them that they should be exempted from state regulation.

"Another piece about PSOs that bothers us a great deal," continued Musser, "is the lack of consumer safeguards and protections. We fear . . . that the enforcement mechanism won't be there. . . . Any start-up business is at high risk the first two or three years. Who is going to deal with the continu-

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CHAUSA

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mission, ethics, leadership development, and spiritual care. "We want to share members' wisdom and best practices so that they don't have to spend their time inventing the same wheel," she said.

Among the planned offerings are chat rooms on specific ethical topics, resources for prayer and ritual, links to Church documents, and news bites related to the subject areas.

In December CHA will introduce a new website resource, *Organizational Integrity in Catholic Healthcare Ministry: The Role of the Leader*. Using hyperlink technology to deliver Scripture, poetry, Church documents, glossary definitions, and more, this tool explores the nature of leadership and decision making in healthcare as a ministry. (Next month's issue of *Health Progress* will examine this resource in more detail.)

OTHER FEATURES

In addition to updated content, CHAUSA also has a new structure that makes it easier to access the members-only information, without having to click through a lot of pages. Other features include:

- Directory of Catholic healthcare in the United States and Canada
- Back issues of *Catholic Health World*, *Health Progress*, *Washington Update*, and *Health Policy Issue Brief*
- Resources and information on sponsorship, continuum of care, and *New Covenant*
- Calendar, listing meetings held by CHA (with links to brochures) and other organizations
- Employment opportunities in the Catholic healthcare ministry
- Information on the 83rd Catholic Health Assembly, including complete program information (when available), online registration, and guides to New Orleans —Susan K. Hume



CHA's website can be reached at www.chausa.org. For more information, contact Dan Jones at 314-253-3457 or, by e-mail, djones@chausa.org.

MEDICARE REFORMS

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ation of coverage for the individuals? Under state law, we can take over companies having insolvency problems and provide for continuity of coverage. The federal government has no ability or authority in any of the proposals to do that."

Rule-Making Committee In the meantime, the federal Negotiated Rule-Making Committee was set to hold its first meeting October 21, 1997, with meetings planned for November, December, January, and February, before it reports to the HHS Secretary on March 1, 1998. Groups on the committee include CHA; Premier, Inc.; AHA; American Medical Association; American Association of Health Plans; American Association of Retired Persons; American Medical Group Association; Blue Cross/Blue Shield; and NAIC, to name a few. Committee conveners Judy Ballard and Celia Ford, of the HHA Departmental Appeals Board, wrote September 8 to the Health Care Financing Administration (HCFA) that reaching consensus on the financial standards would be "challenging" since it could affect competition in the healthcare market and will be technically complex. Some questions to be addressed are:

- Should solvency standards for PSOs be equivalent to other risk-bearing organizations?
- How should delivery system assets be taken into account?
- How should Medicare protect enrollees from being liable if a PSO becomes insolvent?

Bill Cox, executive vice president of CHA, wrote in an October 20 letter to HCFA: "We believe that PSOs can provide another avenue for Catholic healthcare to continue its mission in a way that promotes more coordinated preventive, acute, and postacute care. . . . CHA is particularly interested in making sure that Medicare beneficiaries continue to be allowed to rely on not-for-profit providers who historically have responded well to the healthcare needs of the community."

Other questions about PSOs raised by some policy observers involve the possi-

bility of adverse risk selection. Will doctors, who are in a position to know the health risk of patients, funnel the healthiest people to their PSOs? Reischauer, however, views the access problems as coming "less from PSOs and more from the private fee-for-service option" in the new Medicare+Choice plan. Reischauer said that his "concerns with PSOs have more to do with their financial stability." Wilensky noted that PSOs may allow risk-based capitation in rural areas, where it might not otherwise be available. She did agree that "we're going to have to respond to risk selection. It's time to start doing something" about it.

REFORMS ARE SUBSTANTIAL

While the new Medicare reforms in the Balanced Budget Amendment did not go as far as some policy analysts hoped they would—means testing and raising age eligibility got cut out in the conference committee, for example—the reforms do represent substantial change for Medicare beneficiaries and for providers. For hospitals, it means a decrease of 10.6 percent on PPS payments and a decrease of 3 percent total hospital revenues in 2002, according to ProPAC estimates. But it also means a chance to form provider-sponsored organizations to serve Medicare beneficiaries.

Before Congress moves ahead to address further Medicare reforms—especially the more drastic changes that may be necessary to preserve the insurance program of the baby boomers—many members want to "take time to step back and see the effects of the changes they've instituted," said Wilensky. "Not an unreasonable position," she concluded. □

NOTES

1. Congressional Research Service, "Medicare Provisions in the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33)" Washington, DC, August 18, 1997.
2. John K. Iglehart, "Interview: State Regulation of Managed Care: NAIC President Josephine Musser," *Health Affairs*, November-December 1997, pp. 36-43.