Increased Medicare Margins Are Catching Congress's Eye

BY JANE HIEBERT-WHITE

As Congress and the Clinton administration move into a new round of balanced-budget wrangling, Medicare and hospital costs will figure prominently in it. To be sure, the number targets for total Medicare savings are lower this year than they were in 1995, but they would hit hospitals particularly hard.

Although many analysts predict another stalemate—or at least no agreement until after the November elections—the new Republican proposal does show where many lawmakers believe they can find the savings necessary for a balanced budget. And Congress's focus on hospitals as a source of Medicare savings may be sharpened by recent evidence that hospitals are enjoying higher profit margins.

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MEDICARE CUTS: THE NEXT ROUND

The Republican balanced-budget and tax plan, approved May 16 by the House of Representatives, would cut the growth of Medicare spending by $168 billion over six years. The Senate approved its own budget resolution May 21. Although the House figure is much less than the $270 billion targeted in the GOP's 1995 plan, which would have stretched the cuts over seven years, it is more than the $124 billion proposed by the Clinton administration and has a time frame that is shorter by a year. Both House and Senate plans would cut Medicaid by $72 billion.

The new Medicare budget plan is similar to one Republicans proposed in January 1996, but it would increase cuts to hospitals by approximately $25 billion. A coalition of healthcare providers—including the Catholic Health Association (CHA), the American Hospital Association, and the Federation of American Health Systems—responded May 10 with a joint letter to key House committee chairpersons. "We are gravely concerned about the level of reductions," said the coalition. "[The] now larger Medicare Part A reductions mean that hospitals are likely to experience actual reductions in payment rates under the committees' proposal."

In a May 16 letter to members of the Senate, the coalition said: "Not only are these unprecedented reductions, but they would have a disproportionate adverse impact on hospitals. To achieve reductions of this magnitude, Congress may need to adopt policies that would freeze or actually reduce payments per beneficiary."

At press time, House leaders had not said how these targets would be reached. However, remarked CHA lobbyist Jack Bresch, "the debate looks pretty much the same as last year. The numbers are lower, but the hospital community still thinks they are excessive, as far as balancing the budget is concerned."

Hospitals, said Bresch, "are willing to take our hit and make our contribution." However, he added, hospital groups believe that these cuts may jeopardize the nation's social "safety net," especially Medicaid. One key hospital concern, Bresch said, is that the savings would be used not just to balance the budget, but also to fund a tax cut. He added that budget cuts of the size envisioned by Republicans could have unfortunate "ramifications for communities, in that they could cost them hospital jobs," and could also reduce the quality of hospital care.

Bresch said CHA is in the process of reformulating its "responsible balanced budget proposal" of a year ago for 1996. CHA's proposal will outline a balanced budget that also protects programs for low-income families and individuals, Bresch said. It will not include a tax cut, he added.

New projections from Medicare's trustees, released June 5, are heightening the debate in Congress about cutting Medicare hospital spending. The trustee's 1996 report shows that the program's hospital trust fund will go broke in 2001, a year earlier than predicted in 1995. Even more ominous is the fact that, last year, the hospital trust fund paid out more than it received in payroll taxes. The bankruptcy timetable has fluctuated around a 5- to 10-year period since the 1970s. However, 1995 was the first year in which fund expenses exceeded revenue.

Gail Wilensky, a GOP adviser and former Medicare administrator, explained in an interview why Congress has targeted hospitals for Medicare savings. "First," she said, "it's where the largest single piece of money is. And, second, the Medicare margins indicate there are still some savings to be made."

Hospital Financial Trends

New data from the Prospective Payment Assessment Commission (ProPAC) indicate that, because hospitals were so successful at holding down costs in 1994-96, their Medicare profit margins went up substantially. From a low of -2.5 percent in 1991, the Medicare inpatient margin rose to 4.7 percent in 1994. ProPAC estimates that it will turn out to be 6.6 percent for 1995 and 8.8 percent for 1996.[1] This increase is seen as the result, primarily, of hospitals' efforts to constrain costs. Indeed, hospitals' costs per case for Medicare patients fell 1.3 percent in 1994.

ProPAC Deputy Director Stuart Guterman and two colleagues state in a forthcoming report that "in a rapidly changing environment, hospitals have maintained—and in some cases, even improved—their financial status . . . through reductions in cost growth that are unprecedented in their magnitude and duration."[2]

In an interview, Guterman agreed that these enlarged profit margins are attracting the attention of Congress as it looks for places to save. "Medicare as a purchaser has an obligation to control costs in light of a changing environment," he said. "On the other hand, there's the question of fair payment and maintaining the underlying principles for setting Medicare payment levels. . . . In fact, [recent Medicare hospital] payment updates have been as low as at any time in the history of PPS."

Guterman also pointed out that ProPAC, which advises Congress on the Medicare prospective payment system (PPS), expressed concern in its March 1996 report that hospitals might not be able to hold costs down over a long period—for example, the seven years stipulated in the 1995 Republican budget proposal. ProPAC did agree in its report, however, that hospitals could probably take lower Medicare payment updates for a year or two.[3]

Hospitals and National Health Spending

A glance at some numbers concerning national health spending shows why Medicare is so important to hospitals' bottom line—and also why Congress finds hospitals such a tempting target. In addition, these new data from the Health Care Financing Administration's (HCFA's) Office of National Health Statistics show that the increase in hospital costs has slowed dramatically.[4]

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In 1991 hospital care costs grew 10.1 percent over the previous year. But this growth rate then slowed to 8.1 percent in 1992, 6.2 percent in 1993, and 4.4 percent in 1994. Overall national healthcare spending has also slowed, to 6.4 percent in 1994, its lowest rate of growth in three decades. However, since 1992 total increases in hospital spending have outstripped increases in hospital costs.

HCFA researcher Katharine Levit and two colleagues prepared and analyzed the new data. They have reported in *Health Affairs* that, of 1994's 4.4 percent hospital cost increase, price inflation accounted for 3.6 percent and population increases for 1 percent. Thus, according to Levit and her colleagues, "removing price and population increases from hospital growth produced a decline in the use and intensity of hospital services per person in 1994 (−0.2 percent), the first time since the introduction of Medicare's prospective payment system in 1983 that such declines [have] occurred."

In 1994 hospital care accounted for the largest piece of the total healthcare spending pie: 35.7 percent, or $338.5 billion. Hospital care is overwhelmingly financed by third parties, the figures for 1994 being: private health insurance, 34.2 percent; Medicare, 30 percent; Medicaid, 14.6 percent; and other government and private sources, 18.3 percent. Individual consumers paid for only 2.9 percent of hospital care out of pocket.

Wilensky said the new HCFA figures showing slower growth for both hospitals and the overall healthcare system may, in fact, be the harbinger of a long-term trend. "There is every reason to believe we are at the beginning of the cycle [of a growth slowdown]," she said. One cause of such a slowdown, she said, is the continued presence of excess capacity in the healthcare system. "There are still gains to be made, though [making them will require] aggressive purchasers to persist, band together, and continue to hold down costs," Wilensky said.

Looking into the future, Wilensky sees a period of healthcare consolidation. However, she wonders what will happen after the nation gets through this period of "easy" cost cutting through consolidation and downsizing and reaches more of an

equilibrium in the healthcare system. "Will the growth rate be one we're satisfied with" at that point? she asks. Will we, if we are not satisfied, be "willing to take the heavy-handed steps necessary to lower costs?" Americans clearly said no to heavy-handed government reform in 1994. Will they allow the market to do the reforming?

HOSPITALS AND EXCESS CAPACITY

One key area market reformers are looking at is excess hospital capacity. Princeton economist Uwe Reinhardt reports that, "between 1980 and 1995 total inpatient admissions per thousand population and average length-of-stay declined by about 20 percent each; consequently inpatient days per thousand declined by about 40 percent."[5] These dramatic cuts have increased hospitals' excess capacity. Reinhardt questions whether the strategy to empty U.S. hospitals has really helped control national healthcare costs.

The economist says that, although hospitals are nowadays seen as expensive places to provide healthcare, this view is not accurate. "A more appropriate characterization of hospitals is that they are the setting for both very expensive activities and relatively inexpensive activities, all centered on patients." Indeed, Reinhardt observes, emptying hospitals has helped spawn new home health and postacute care industries, adding to the costliness of the U.S. healthcare system.

Reduced lengths of stay have also left hospitals with fewer days from which to recoup the costs of fixed overhead. Reinhardt argues that hospitals missed the boat by charging flat rates per diem to managed care plans. In doing this, hospitals were trying to cover the same amount of overhead from both the early days of a stay, when patients need a good deal of medical attention, and the later convalescent days, when such attention is minimal. Cost-sensitive HMO managers, looking for places to cut, zeroed in on the more discretionary, but still expensive, convalescent days. Convalescent care is thus now provided elsewhere—either via home health or in a postacute care facility—in a "cheaper" setting (or sometimes not at all). But, as Reinhardt points out, the hospital still exists, and it still has to cover its fixed overhead. Today's national healthcare costs include the overhead for both hospitals and the new postacute care facilities.

In a recent interview, Reinhardt added: "There's an old economist's principle: Do not try to recover overhead from items that are discretionary to the consumer or that the consumer is very price sensitive to." He has this advice for hospitals:

> The first one, two, or three days are nondiscretionary; that's what the overhead should be loaded onto. You shouldn't load a lot of overhead onto the latter days, which are convalescent. Hospitals need to figure out profiles of cost per day in an episode, and try somehow to have a daily charge that varies with the number of the day in the stay. For instance, a normal delivery might cost $2,000 for the first day, $400 for the second, and only hotel charges after that.

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This, Reinhardt said, would be a less expensive way for the nation to use its hospital capacity. If hospital beds were to fill up, the convalescent day charges could then be increased, he said. "We're drowning in beds—why not use them?" Reinhardt asked. He suggested that one reason the nation has not seen massive hospital closures, even in times of 50 percent occupancy rates, is because "the savings from shutting a hospital bed are very trivial. Once the bricks and mortar are there, and you can staff it flexibly, the bed is not expensive."

Reinhardt thus offers a new message to those healthcare leaders who think downsizing and consolidating are the only means to survival. He advises them to change their pricing policy on beds so they can compete with home health agencies and postacute care facilities. But, whether healthcare leaders choose to take this route or continue to consolidate, one thing is clear: Lawmakers in Washington, DC, will keep an eye on hospital profits as they search for ways to ensure Medicare's survival. □

NOTES

1. Stuart Guterman, Jack Ashby, and Timothy Greene, "Hospital Costs, Financial Condition, and the Role of Cost Shifting," *Health Affairs*, Fall 1996.
2. Guterman, Ashby, and Greene.
3. Prospective Payment Assessment Commission, *Report and Recommendations to the Congress*, ProPAC, Washington, DC, March 1, 1996.
4. Katharine R. Levit, Helen C. Lazenby, and Lekha Sivarajan, "Health Care Spending in 1994: Slowest in Decades," *Health Affairs*, Summer 1996, pp. 130-144.
5. Uwe E. Reinhardt, "Spending More through 'Cost Control': Our Obsessive Quest to Gut the Hospital," *Health Affairs*, Summer 1996, pp. 145-154.