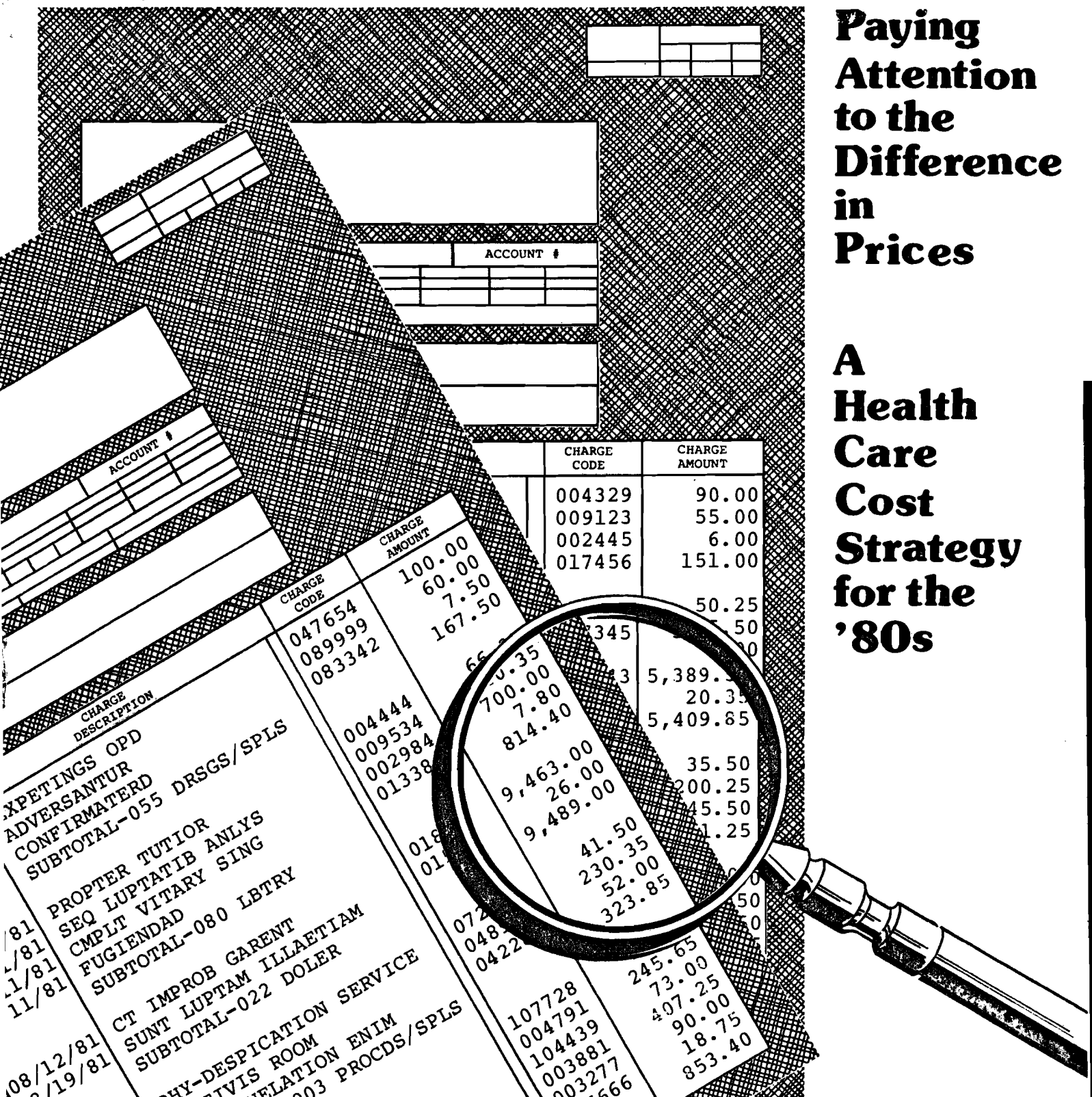
CITIZENS LEAGUE REPORT



Paying Attention to the Difference in Prices

A Health Care Cost Strategy for the '80s

CITIZENS LEAGUE REPORT

PAYING ATTENTION TO THE DIFFERENCE IN PRICES

A Health Care Cost Strategy for the 1980s

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September 29, 1981

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TABLE OF CONTENTS

COVER DESIGN BY RITA GRABOWSKI

INTRODUCTION

The research program of the Citizens League, for more than a decade now, reflects a continuing interest in strategies to restrain health care costs, to achieve efficiencies that make the system affordable. Back in 1970, the League recommended a demonstration in facilities sharing between a private and public hospital, as an alternative to higher capital costs of complete independence.

In 1977, the League issued a report which recommended that costs could be brought under control by eliminating the excess capacity in the system, that is, cutting back on the number of beds in hospitals, and the number of hospitals. The report supported the regulatory strategy of certificate of need review, as administered by the Metropolitan Health Board, and strongly urged a greater voluntary effort by the health care providers themselves, particularly the hospital trustees.

While some progress has been made in recent years with the capacity problem, health care costs continue to spiral well beyond the rate of inflation for the rest of the economy. The League's present study, authorized in mid-1980 and completed in the fall of 1981, springs from the hypothesis that the basic problem confronting attempts to control health care costs is one of an dysfunctional market. In an industry dominated by the third-party payment system and devoid of meaningful competition based on price or quality, no one has any incentive to restrain spending.

The report which follows represents a significant, new direction in the League's policy approach: we are suggesting that the way to hold down costs and uphold quality in the health care system lies in creating a realistic market characterized by competition among providers and incentives for participants to make cost conscious decisions. Suggesting the virtual opposite of the present condition, the report concentrates on individual responsibility, on making people responsible to make sensible decisions based on information provided.

The report, on the other hand, does not purport to be the definitive statement on restructuring the entire system. Concentrating somewhat narrowly on the "efficiency" of the system, it leaves unanswered legitimate questions of "equity." Determining how persons of severely limited means would have access to any altered system is a policy question of immense importance. And while achieving greater efficiency in the system has something to do with facilitating equitable access, the challenge remains to redesign the means by which the poor are provided with care.

The report is also limited in other ways. For example, it contends that to have true competition, one must get information into the hands of the public that makes comparisons on price and quality possible. While price comparisons appear relatively manageable, many insist that finding measures of quality will prove an intractable problem. Indeed, it is a difficult matter, and measures currently available are somewhat primitive. But we must start somewhere. Other industries, similarly complex, operate in a real market, in which competition takes place on price and quality.

Other questions not addressed include the rising importance of programs directed at wellness and incentives for health promotion; specific patterns of physician decisions about treatment; implications for medical malpractice cases; the future of public teaching hospitals; and the long-term financing questions for medical research. It is an unending agenda. Making the system respond to realistic market forces is a good next step.

FINDINGS

Our metropolitan area is at a crossroads in its policy debate over how to control rising health care costs.

The Twin Cities metropolitan area has a history of activism in fighting rapid health care cost increases; however, these efforts have rapidly intensified in the last five years.

In 1977, the Citizens League issued a report entitled "More Care About the Costs in Hospitals." That report concluded, after comparing the Twin Cities to the Seattle/Tacoma area (a region demographically comparable to our own), that our community had between 1,500-3,500 excess hospital beds. That conclusion was also based on the twin facts that Twin Cities hospital utilization was declining significantly (thereby causing more beds to be empty) and that the region made more use of its inpatient capacity than most other areas of the country. (In other areas of the nation there was greater utilization of outpatient facilities than was the case here.) Since increasing pressures were developing to decrease use of existing hospital capacity, the League study noted that excess capacity would become even more of a problem in the future.

The League report argued that the reduction of beds should be carried out voluntarily, by the hospitals themselves. As the report stated:

"This reduction should be carried out by the hospital community itself. The public sector must set some overall policy direction–about the size, shape and structure of the hospital system. But (unless the private sector fails to act) the government should not move to close beds or hospitals by public authority."

The report then urged the trustees of the local hospitals to form Trustee Councils to study the problem and make recommendations on strategies to remove excess capacity.

At just about this time, the Metropolitan Health Board formed the Viable Hospital Task Force "to develop a systems model for viable hospitals and hospital organizations appropriate for the seven-county metropolitan area." This group produced two important recommendations: first, the region should reduce 2,000 licensed acute hospital beds, primarily by closing whole hospitals, and secondly, that local hospital trustees should, themselves, develop a plan to reduce the excess capacity.

In an unprecendented step nationally, two Twin Cities Hospitals Trustee Councils were formed. The West Metropolitan Hospital Trustees Council represented 12 hospitals in Hennepin County. The East Metropolitan Hospital Trustees Council represented 15 hospitals in the counties of Dakota, Ramsey and Washington. Both groups produced thoughtful reports. However, the Metropolitan Health Health Board substantially adopted the strategy proposed by the West Metropolitan Hospital Trustees. That strategy called for a voluntary phased process which would, over a threeyear period (1979-1981), be expected to reduce 1,042 hospital beds in Hennepin County, if ongoing evaluation continued to indicate that that was necessary. The report proposed several means of effecting that reduction including reduction of licensed and operating beds, consolidation of specialized services not meeting Health Board guidelines (e.g., open heart surgery, obstetrics, pediatrics) and merger or closure of hospitals if indicated.

From this report, the Health Board, a year later, produced its own strategy for reducing beds and consolidating specialized services. A summary of the Board's four-phase plan appears below.

Phased Implementation Plan

Phase I: All hospitals develop and submit long-range plans to the Health Board. The Health Board develops procedures and criteria for phased reduction of excess inpatient acute care capacity and consolidation of specialized care services (completed March 31, 1979).

Phase II: Hospitals complete bed reductions based on Phase II formula (by December 31, 1979).

Phase III: Hospitals complete consolidation of specialized services (by December 31, 1980).

Phase IV: Hospitals complete bed reduction, including the merging, consolidating or phasing out of entire insti-

tutions (by December 31, 1983).

The Metropolitan Health Board has recently released its Phase IV report offering nine alternative computer models for "merging, consolidating or phasing out entire acute inpatient hospital facilities by 1983." Since its publication the Phase IV report has occasioned a great deal of controversy in the region. Several hospitals have filed legal suits in anger over what they perceive as a report which inflicts irreparable harm to their inpatient acute business. Numerous newspaper and television stories have chronicled the aroused sentiments of various community groups and elected officials. Representative Bill Frenzel sent an irate letter to Metropolitan Council Chairman Charles Weaver. Both Governor Quie and U.S. Senator Rudy Boschwitz paid visits to Mount Sinai Hospital in Minneapolis in order to assure their support for the hospital's continued existence. (One of the nine models in the report calls for Mount Sinai, Lutheran Deaconess and Samaritan Hospitals to "consider consolidating, merging, or phasing out their total inpatient acute care services.")

As the Health Board notes in the executive summary of its report, "at this time, the report contains no specific recommendations as to the preferred method of reducing excess hospital bed capacity from the system." The report will be given two evenings of public testimony and comment in early November. Following those hearings, the Health Board will decide how it will proceed, with the result to be forwarded on to the Metropolitan Council for final action.

All of this places the metropolitan region at a major crossroads in its policy debate over the appropriate means of controlling health care costs. The Metropolitan Health Board has no actual power to mandate the closing of whole hospitals. However, the Board could use its certificate of need power to deny capital projects to those providers which, in its estimation, should consider merger or outright closure.

Another possibility would be to rely on the affected hospitals themselves to reduce specialty services, merge or close voluntarily.

A third option would be to acknowledge that the health care system, as a market system, has not worked effectively, and to try to reconstruct a functioning market. The Health Board's Phase IV report currently contains no scenario that would eliminate excess hospital bed capacity and unnecessary investment in the health care system through competitive means.

Ultimately, the decision about how best to proceed in this complicated arena will belong to the Metropolitan Council, which created the Health Board and which has to date basically concurred with its implementation strategies.

In making its decision, the Metropolitan Council will likely ask itself the following questions:

- How effective has certificate of need been as a mechanism for stopping excess investment in the health care system? What kind of an impact has it had on hospital costs? Has certificate of need had some additional, unintended negative impacts on the health care system?

- How effective has the voluntary effort been in controlling costs and reducing excess capacity? Could it be relied on to solve the problem?

- Is the "problem" excess capacity or market failure?

In succeeding sections evidence will be presented on the effectiveness of the regulatory effort and the voluntary effort.

The record of regulatory efforts reveals only limited success.

Certificate of Need

The most prominent part of the existing regulatory system is the state's certificate of need law. Adopted in 1971, this law requires all health care facilities (i.e., hospitals, nursing homes, extended care facilities) to obtain a certificate of need before making any expenditures for construction or equipment, if:

- The cost is greater than $100,000 and if the project would have some effect on the hospital's diagnostic or therapeutic facilities.

- Construction results in a change in the facility's type or scope of services and if the cost is greater than $50,000.

- The project will increase the institution's bed complement.

Certificate of need reviews are conducted by the Metropolitan Health Board and other regional Health Systems Agencies (HSAs) around the state. After the Health Board decides on a project, it is considered by the Metropolitan Council and later by the Commissioner of Health.

In the eight years of the certificate of need law's existence, the Metropolitan Health Board has reviewed 424 certificates and approved 399 of them for a percentage rate of

TABLE I

CAPITAL EXPENDITURE REVIEW
METROPOLITAN HEALTH BOARD RECORD
(1972 – 1980)

FISCAL YEAR	APPROVED	DENIED/WITHDRAWN	TOTAL
1972-1973	$ 30,951,812	$ 00	$ 30,951,812
1973-1974	8,035,587	15,780,509	23,816,096
		15,596,870 D*	
		184,000 D*	
1974-1975	21,827,869	1,075,825	22,903,694
		600,000 DW	
		464,825 D	
1975-1976	93,836,305	3,355,000	97,191,305
		705,000 DW	
		2,650,000 DW	
1976-1977	79,162,056	28,567,889	107,729,945
		314,000 W	
		690,000 D*	
		1,600,000 D	
		1,860,000 D	
		2,427,000 D	
		340,000 W	
		1,117,000 D*	
		970,500 D*	
		19,250,000 D*	
		(16,000,000)	
1977-1978	17,311,865	5,443,187	22,755,052
		607,000 D	
		1,922,413 D	
		1,161,000 D	
		390,000 W	
		977,000 W*	
		385,690 D*	
1978-1979	22,897,044	2,041,535	24,938,579
		2,041,535 D*	
1979-1980	31,223,266	56,070,500	87,223,266
		70,500 D	
		56,000,000 D	
TOTAL	**$305,245,804**	**$112,263,945**	**$417,509,749**

* Indicates that the project was subsequently approved or modified. When all of the subsequent approvals are subtracted from the total Denied/Withdrawn column that figures becomes $74,301,350 rather than $112,263,945.

NOTE: These reviews include both acute care and long term care projects.

SOURCE: Metropolitan Health Board, 1980.

94%. (Of the 399 approved, 28 were approved with modifications usually resulting in less expensive total project costs). In dollar terms it has approved $305.2 million worth of new capital investments and denied $74 million. (See Table I.)

In the ten years that it has been conducting certificate of need reviews, the Minnesota Department of Health has reviewed a total of 555 certificates and approved 519 of them (94%). In dollar terms this translates to a total figure of $1.328 billion reviewed; $1.234 billion approved, and $94 million denied. (See Table II.)

Each set of figures includes the controversial 1979 decision affecting Fairview Community Hospitals' $28 million proposal for a new hospital in Burnsville. (The Fairview proposal was resubmitted in 1981, was approved by the Health Board and the Metropolitan Council and was awaiting approval by the Department of Health when this report was written.) Both sets of figures exclude two extremely expensive approvals granted within the last year—the new Veterans Hospital proposal ($240 million) and the University of Minnesota Hospitals' reconstruction project ($250 million).

In addition to the extremely low rate of denial, the impact of the certificate of need law in controlling hospital expenditures has been limited because:

- The certificate of need law does not necessarily result in reduced utilization of health services. While it may limit expansion of the system, it does not limit the extent to which existing capacity can be used.

- The doctor has been exempted from the requirement of obtaining a certificate with two exceptions: (1) if an ambulatory surgical center is proposed and (2) if the equipment in the doctor's office is to be used by in-hospital patients. While in-hospital utilization may be limited by controlling the amount of available facilities, total utilization has not decreased because services are available in the physician's office.

- The Health Board can only react to proposals by hospitals and cannot initiate action to reshape or reduce the size of the hospital system. The Health Board has begun attaching conditions to its recommendations, but the legality of this action has not been tested.

- Requests for certificates of need are reviewed one by one throughout the year. The Health Board has not set any goals (or ceilings) for total capital spending per year. As a result, if any hospital can prove need, or if the Health Board cannot prove there is no need, then there is little alternative but to make a positive recommendation.

The certificate of need process has, to a certain extent, been effective in reducing hospital expenditures and had some positive effect on the hospital system. For example:

- The process itself has probably been a deterrent to some kinds of construction. That is, knowing they would have to go through the review process and fearing rejection has probably discouraged some hospitals from considering certain kinds of projects–for example, bed expansion.

- Hospital trustees and administrators can use the review process and their concern about rejection as a means of resisting pressure from doctors and others to expand facilities.

TABLE II

MINNESOTA DEPARTMENT OF HEALTH
STATISTICS REGARDING CERTIFICATE OF NEED

TIME PERIOD	PROJECTS APPROVED	($ IN MILLIONS)	PROJECTS DENIED	($ IN MILLIONS)
July 80-April 81	78	$ 445.5	6	$ 6.1
July 79-June 80	69	95.8	2	57.7
July 78-June 79	32	69.4	1	4.0
July 77-June 78	46	71.0	2	3.1
July 76-June 77	63	155.4	4	5.2
July 75-June 76	55	151.5	1	.8
July 74-June 75	55	56.7	5	3.6
Nov. 71-June 74	121	188.5	15	13.7
TOTAL Nov. 71-April 81	**519 (93.5%)**	**$1,233.8**	**36**	**$94.2**

NOTE: These reviews include both acute care and long term care projects.
SOURCE: Minnesota Department of Health.

- Hospitals have been forced to plan their capital programs with a greater amount of care. While it has been mostly private, many probably initiated their own internal long-range planning programs.

- Hospitals have felt more pressure to begin sharing programs and services with other hospitals.

Perhaps the most cogent comment on the effectiveness of the certificate of need process was rendered by the noted health care economist Anne Somers, who stated:

"The certificate of need programs are inherently at odds with the present reimbursement system. As long as the institutions can demonstrate that they are able to pay for the proposed new facility or equipment because of assured third party reimbursement, it is extremely difficult, politically, to prohibit construction or purchase. Conversely, unless unnecessary and expensive additions are prevented in advance, it is almost impossible to deny reimbursement."

Rate Review

In addition to the certificate of need, the state's mandatory Rate Review Program is the second major component of the regulatory strategy which is already in place. The mandatory Rate Review Program was enacted during the 1975 legislative session. The law requires that every hospital in the state have its rates reviewed on an annual basis. This review can be done either by the Minnesota Department of Health or by an outside agency authorized by the Health Department. The Minnesota Hospital Association, an organization of hospitals, has set up a Rate Review Program and has been authorized by the state to do reviews. With the exception of a couple of outstate hospitals, all hospitals are now being reviewed by the Minnesota Hospital Association program.

The program has been given authority to *review rates* and not to *set rates*. Hospitals are not bound by the findings of the rate review process. That is, they may fix their rates at higher levels than those recommended through the annual review. However, it is widely held that hospitals will not ignore the comments they receive through the rate review process. If they do, they fear that the Legislature could easily change the law to allow rate setting rather than rate review. The machinery set up to do reviews could be easily adapted to a rate setting program.

As it is currently functioning, the Rate Review Program is aimed at insuring that hospitals are competently managed. Based primarily on the hospital's size, occupancy and case mix, assumptions are made about its rate structure.

These assumptions are based on a community standard formulated from the rates of other hospitals in the community having similar case mixes and being similar in size and occupancy. Hospitals with rates higher than what had been assumed are given the closest review.

In the review process, hospitals are not currently penalized (i.e., given negative comments) for low occupancy. As such, they are permitted to raise their charges to whatever level is necessary in order to cover their costs. The Rate Review Program will watch carefully to make sure the administrator has done as much as possible to cut his variable costs, for example, to have cut staff, closed off a wing, or taken other steps consistent with low occupancy. But, at this time, it is not suggesting that the hospitals with low occupancy also cut their fixed costs, that is, permanently close or sell a portion of their facilities.

Until the Rate Review Program begins to watch fixed costs as closely as it appears to be reviewing variable costs, there is likely to be controversy over whether any significant control over expenditures is being accomplished. At present, hospitals seem to be under little pressure to take steps to lower their fixed costs. Rather, they are permitted to increase charges for those services which are fully used in order to cover their expenses for maintaining unused or under-utilized facilities.

Professional Standards Review Organization

The third major piece of regulatory machinery is the Professional Standards Review Organization (PSRO). Under this federal program, physicians review care provided to Medicare and Medicaid patients to ensure that services are medically necessary and appropriate, cost efficient and meet professional standards of care. A PSRO is responsible for quality, necessity and appropriateness of care as well as cost. The federally designated local authority for the Twin Cities region is the Foundation for Health Care Evaluation.

Unlike the other two regulatory programs discussed, PSRO is the only regulatory tool which operates to impact the demand side of the cost containment problem. Both of the others are strictly limited to the supply side.

Growing Uncertainty Over the Future of Regulation

President Reagan, in his budget proposal, has suggested that all federal funds for the Health Systems Agencies (HSAs) and Professional Standards Review Organizations be eliminated by 1983. (Congress has yet to act on the proposal.)

Since all the HSAs in our state are funded entirely from federal sources, this will mean that they will either have to secure funding elsewhere or close down. The Metropolitan Health Board, as this region's HSA, faces similar prospects.

The Reagan Administration has announced its intent to rely much more heavily on competition as a means of health care cost control than regulation, although it has not as yet offered a competitive strategy to bring that about. This trend towards competition and away from regulation can be seen in other areas as well. The airline industry, for example, has been deregulated. So have the trucking and communication industries, though in varying ways. Natural gas will be deregulated by 1985.

Whether as a result of a desire to adapt to changing times and circumstances, or out of a true philosophical turnaround, regulators themselves are beginning to voice second thoughts about the ultimate effectiveness of regulatory methods in attaining health care cost containment. For example, Barbara O'Grady, the chairperson of the Metropolitan Health Board, told a Citizens League breakfast audience last spring that, eventually, certificate of need could be phased out if appropriate market controls were in place. In the Health Board's Long-Range Hospital Plan for the Twin Cities area (September, 1981) can be found this important passage:

"Recent laws and regulations ... have attempted to simulate rather than stimulate competition. Regulation will be necessary until true market forces are at work in the system. ...It has become evident that regulation tends to treat the symptoms rather than the problem. That is not to say that regulation is not needed, but it should work to solve the problem as well as treat the symptoms."

The report then goes on to enunciate principles "to assist movement from a regulated to a competitive health care environment." Among the principles cited is the following statement:
"A certain amount of regulation will always be necessary, but regulation by itself will probably fail."

The voluntary effort has produced notable change

Metropolitan area hospital trustees have taken a far more active leadership role in cost containment measures than is the case nationally. Hospital trustees have reviewed the problem of excess capacity, recognized its existence and offered strategies to eliminate it. Beyond that, at least 1,224 hospital beds have been taken out of service, according to Metropolitan Health Board statistics. Some hospitals have reduced more beds than their Health Board determined reduction goal. Others have reduced far fewer than the goal figure set for them. (See Table III.)

It should be noted, however, that the majority of beds reduced were "paper beds"–beds which institutions were licensed to operate but which, in fact are not being operated (staffed). Nor are the beds out of the system, since the hospitals are still licensed to operate them at their discretion.

Although cost containment efforts have enjoyed only limited success, the commitment in this community remains to deal effectively with this problem. It is a problem that is growing more difficult each year.

The Twin Cities metropolitan area is fortunate to enjoy the ongoing committment of many key sectors in dealing with this problem. The Metropolitan Health Board has played a key role in educating the public about the problem. An activist press has continued to devote a great deal of time and space to the health care cost dilemma. Many actors in the provider community have begun to address this problem in a constructive fashion. Both labor and business are concerned and becoming increasingly active. The Minnesota Coalition on Health Care Cost and InterStudy are major community resources in this area.

The Twin Cities area, like the rest of the country, continues to experience a major problem with rising costs for health care.

National Trends

A recent Metropolitan Health Board publication noted that:

"Nationally, health expenditures have nearly tripled in nine years. In 1979, the nation paid about $212 billion for health care, or 9 percent of the gross national product (GNP). In 1970, the nation's health tab was approximately $75 billion, 7.6 percent of the GNP. Expenditures for health care soared from $359 to $943 per capita during the same period. By 1985, total health care expenditures in the nation are expected to reach 10.5 percent of the GNP; by 1990, the forecast is 11.3%.

In the future health care costs are projected to continue to increase at an even greater rate. A recent article in *Business Week* stated:

"The rise in health care costs over the next two decades will make the increase of the last 20 years seem minuscule in comparison. By the year 1990, Americans will spend more

TABLE III

METROPOLITAN HOSPITALS COMPLIANCE WITH METROPOLITAN HEALTH BOARD SUGGESTED REDUCTION GOALS

HOSPITAL	PHASE II BED REDUCTION GOAL	BEDS TAKEN OUT OF SERVICE	ATTAINED + BELOW GOAL -
WEST METRO			
Abbott-Northwestern	77	97	+
Children's	20	20	+
Eitel	28	9	-
Fairview	45	55	+
Fairview-Southdale	16	1	-
Golden Valley	59	34	-
HCMC	55	54	-
Lutheran Deaconess	47	47	+
Mercy	11	11	+
Methodist	36	36	+
MMC	111	76	-
Mt. Sinai	17	17	+
North Memorial	55	0	-
St. Mary's	18	18	+
Unity	18	16	-
University of Minnesota	126	146	+
West Metro Total	**739**	**637**	**9+ 7-**
EAST METRO			
Bethesda	34	28	-
Children's	7	9	+
Divine Redeemer	21	17	-
Gillette	18	0	-
Midway	34	52	+
Mounds Park	24	18	-
St. John's	26	26	+
St. Joseph's	106	106	+
St. Paul-Ramsey	81	119	+
Samaritan	61	0	-
United	141	212	+
East Metro Total	**553**	**587**	**6+ 5-**
METRO TOTAL	**1,292**	**1,224**	**15+ 12-**

SOURCE: Metropolitan Health Board Phase IV report on General Acute Inpatient and Specialty Services, p. 32, July 1, 1981.

money on health care than on the entire 1980 federal budget. According to the Health Care Financing Administration, at the present rate of increase, national medical costs will almost double every five years, a rate that would put our medical care spending at $2.3 trillion by the Year 2,000 and at $4.1 trillion by 2005." (BW, Feb. 23, 1981)

Local Trends

Hospital operating expenditures in the metropolitan area, including those of the Veterans Administration, totaled about $808 million dollars in 1979. To strike a comparison, the total net taxes payable from the property tax in this

area for 1979 was $779 million. The occupancy rate at hospitals has averaged about 75 percent. On the average, one of every four beds is empty.

According to Minnesota Blue Cross/Blue Shield, the average charge to Twin Cities area hospital patients was $295 a day in 1980, up 17.7% from 1979. That increase exceeded both the consumer price index (which rose 12.4% last year) and the CPI's hospital charges component (which rose 14.5% last year).

Factors Encouraging These Trends

Medical Technology. Example: End-stage-renal disease is the only catastrophic disease that is fully covered by public funds. In 1972 Medicare coverage was extended to all individuals with this disorder regardless of financial need. Two years later, 8,848 patients were treated at a cost of $286 million. By 1984, the projected expenditures will be $3 billion for an estimated 60,570 patients. Each year, more technology is available, expanding the treatment potential. As costs rise with this potential, the question about some upper limit draws closer.

A Growing Surplus of Physicians. The final report of the Graduate Medical Education National Advisory Committee to the Secretary of Health and Human Services (1980) stated that by 1990, this nation will have a surplus of 70,000 physicians. In Minnesota in 1977 we already had a surplus ratio of primary care physicians to population as defined by the federal Health and Human Services Department. In 1977, Minnesota had 85.6 such doctors per 100,000 people. The federal agency said a surplus is 50 or more per 100,000.

Inflation. An average hospital bill in 1958 cost $340. In 1978 it was $1,430, an increase of $1,090, 58% was due to inflation.

Excess Number of Hospital Beds. In 1977, the Citizens League argued on the basis of a comparison of the Twin Cities to Seattle/Tacoma that the metro area had a surplus of 1,500-3,500 excess beds. According to the Metropolitan Health Board, the number arrived at through community consensus is around 2,000 beds. While there is disagreement as to how much of a factor excess capacity is in health care cost escalation, there is agreement that excess capacity adds to consumer costs and creates incentives for providers to manufacture demand.

Relatively Higher Utilization of Health Care System. The Twin Cities makes more use of its hospital beds than do other communities. This may in part be due to the local style of medical practice, and also may have something to do with Roemer's Law suggesting that "empty beds beget patients." (See Table IV.)

Extent of Insurance Coverage. Group insurers in every state are required to provide certain health insurance benefits. Comparing these benefits, state by state reveals that Minnesota has more mandated benefits than any other state. Minnesota's Catastrophic Health Law requires that certain levels of benefits be provided to employees. The law con-

TABLE IV

HOSPITAL UTILIZATION AND EXPENDITURES BY REGIONAL AND NATIONAL LEVELS

	MINNEAPOLIS/ SAINT PAUL	UNITED STATES TOTALS	INTERSTUDY ADEQUACY LEVELS
Number of hospitals	39		
Number of beds	11,117		
Beds/1,000 population	5.5	4.6	3.0 maximum
Hospital employees/1,000 population	15.1	12.5	9 maximum
Admissions/1,000 population	174	162	130 maximum
Inpatient days/1,000 population	1,433	1,230	800 maximum
Occupancy rate	71.0%	73.6%	85% minimum
Length of stay	8.3	7.6	
Surgeries/1,000 population	89.5	80.5	
Expenses/inpatient day	$239.62	$222.00	
Expenses/capita	$343.39	$237.10	
Average annual % change of expenditure per capita	12.5%	13.7%	

SOURCE: InterStudy, 1980 and Hospital Statistics, 1979 Edition, American Hospital Association. Some figures are derived.

tains an enforcement provision which states that failing to comply could mean the elimination of an employers tax deduction for health care premiums. The greater the number of mandated benefits, the higher the cost of group insurance. (See Table V.)

Relation of Reimbursement to Revenue. The incentive to providers is to provide more care in order to secure more revenue via reimbursement. Thus providers are hurt if they try to do "less."

Labor-Intensive Nature of the Health Care Industry.

Some observers contend that personnel costs are the most rapidly rising cost center in most industries in recent years. Certainly, a system lacking the usual market restraints on revenue potential would face even more pressure for higher wages and salaries.

There seems to be a greater sense of urgency now to "do something" about the rise in health care expenditures.

Health care is continuing to consume more and more of the nation's GNP, causing invisible trade-offs to be made between the health care system and other systems, such as transportation and education. State and local officials are more concerned because the cost burden of existing programs is shifting from the federal to the state level and from the state to the local level.

Recent reductions in state funding would leave it up to the counties as to whether to pay for the health care of the working poor. If all reductions proposed are implemented and the county decides to continue supplying health care

TABLE V

A COMPARISON OF SELECTED MANDATED BENEFIT COVERAGE IN MINNESOTA AND OTHER STATES (1981)

Mandated Benefits for Group Coverage*	Benefit Mandated in Minnesota*	Total Number of States Mandating This benefit (including Minnesota)
Alcoholism	Yes	31
Mental illness	Yes	24
Well-child care	No	3
Reconstructive surgery	Yes	2
Abortion	No	1
Kidney dialysis	No	1
Complication of pregnancy or pregnancy as any other disease	Yes	24
Ambulatory surgical centers	Yes	8
Home health care	No	10
Social workers	No	2
Unmarried females	Yes	12
Rehabilitation/Occupational therapist	No	2
Convalescent nursing home	No	1
Oral contraceptives	No	1
No reduction for Medicaid	Yes	11
Incapacitated dependents	Yes	34
Spouse conversion	Yes	13
Continuation of coverage after employment	Yes	15
Continuation of coverage during a strike	No	5
Mandatory conversion	Yes	21
No termination while disabled	Yes	3
Filing required prior to coordination of benefit with no-fault insurance	Yes	4
State Health Care Plan	Yes	2

*Not Exhaustive.

SOURCE: Marlene Grant, Attorney, Prudential Insurance Company.

for the indigent, taxpayers in Hennepin County, for example, would wind up paying an additional $40 million in property taxes by 1983. (A 24% increase.) Robert Taylor, former Associate County Administrator and Director of Hospital and Health Services for Hennepin County, said he fears the main effect of these changes would be to shift costs to the county–$12 million in the last half of this year and $28 million in 1982.

Business is becoming more concerned. Nationally, businesses were projected to have spent $63 billion on health care premiums in 1980, an increase of $20 billion compared with 1978. Health insurance premiums increased by 14 to 20% for most businesses.

Illnesses and accidents and their ensuring claim costs have made these impacts on employers:

- Workers Compensation premiums increased by 269% from 1967-1977.
- Corporate health care costs increased from an average of $1,000 to $2,500 per employee during the same decade.
- Employer health care costs have risen at twice the rate of salaries.

Local business firms are also becoming more concerned about escalating health care costs and are taking some initial steps to minimize their impact.

Lewis Cope of the *Minneapolis Tribune* reported in July 1981, that fourteen area business firms, have contracted with the Foundation for Health Care Evaluation to review hospitalization of their employees covered by conventional (non-HMO) health insurance. The firms want to use cost efficient outpatient care, rather than hospitalization, when it can do the job. This can help control the cost that both the firms and their employees pay for health insurance. If it works it could mean more empty hospital beds.

Minnesota Blue Cross/Blue Shield has started a program designed to reduce, by about 10%, their subscribers' hospitalization for psychiatric and alcoholism treatment. Again, the idea is to substitute outpatient care when it will work. Again, it could mean more empty beds.

While definitions of competition differ, there are elements which appear to characterize most competitive systems.

There is a fair amount of controversy surrounding the term "competition." Discussion of this term tends to be clouded by value judgments over what the impacts of a competitive system have been or could be. Nonetheless, most theorists acknowledge a basic set of elements which constitute a classical economic model of competition. (They differ frequently over the role of government in a market system, including whether government should have any role.)

Several resource sessions with local economists helped this task force to produce the following list of principles of a competitive system:

- Competition is an exchange system based on a pricing mechanism.
- Price acts as a rationing mechanism in encouraging the efficient coordination, allocation and distribution of goods.
- "Needs" are determined through economic choices.
- Economic choices are made on a price-conscious basis.
- Buyers and sellers of service are price-conscious.
- There is a wide range of product choices and options.
- There are many sellers, none of whom dominate the market.
- There is ease of market entry and exit.
- Both buyers and sellers must face the economic consequences of their actions. Buyers stand to gain or lose based on their market decisions. Sellers are "at risk" of going out of business.
- Information on price and product is readily available.
- Buyers understand the products they are considering purchasing.
- Buyers can freely choose to buy or not to buy the product.
- Buyers have a reasonable period of time to consider purchase of the product.

The Twin Cities area health care system contains some elements of competition, but functions largely as a non-competitive system.

Presently, there are many forms of competition operating in the Twin Cities health care system.

There is growing competition between physicians and hospitals. As employers and insurers become increasingly concerned about rising health care outlays, more incentives are being instituted to treat ailments outside the hospital wherever possible. In turn this tends to heighten competition between doctors seeking to treat patients in their offices and hospitals seeking to treat them in their institutions. Since physicians are largely exempt from the state's certificate of need law, many have acquired the same kinds of expensive new technological equipment for which hospitals must demonstrate "need." These clinics then compete with hospitals for those diagnostic and treatment services.

Competition among hospitals can be expected to intensify in the future since there are growing numbers of physicians and declining numbers of hospital inpatient days. There is competition among hospitals for preferred physicians. Traditionally, hospitals have competed for specialist physicians who hospitalize in order to attract, through them, more patients. In order to be attractive to physicians, hospitals have invested heavily in extremely sophisticated, expensive forms of new technology. Such expenditures have led some to call this type of competition "a medical arms race."

There is competition among insurance carriers between conventional insurers and prepaid forms of insurance. Conventional insurers compete on administrative costs, claim service, financing, and sometimes premiums. Additionally, since more large employers are beginning to self-insure, competition between this approach and conventional insurance is emerging.

Finally, there is growing competition between fee-for-service systems, typically insured programs, and prepaid systems, such as Health Maintenance Organizations (HMOs).

It is the absence of price competition that separates the current system from genuinely competitive practices.

Despite the many forms of competition noted above, there cannot be true competition apart from price competition. Without price competition, the other variants, in the words of Walter McClure, a health cost consultant, are "cost generating, not cost saving."

In April 1980, a Minnesota Department of Health study (average charge data for nine selected diagnosis for 21 Twin Cities hospitals, Fiscal Year 1978-1979) provided evidence that true price competition does not exist in the Twin Cities hospital system. The study concluded that hospitals providing comparable patient care show widely-differing prices for substantially the same procedures.

The purpose of the study was to present average Medicare length of stay and charge data for a set of nine common diagnoses for 21 hospitals located in and around the Twin Cities area. These diagnoses were selected by physicians because their treatment patterns were well defined. Data were gathered from the Medicare Fiscal Intermediary, Blue Cross/Blue Shield of Minnesota. The data set was comprised of Medicare claims (approximately 180,000) submitted by hospitals for the period July 1978 through June 1979. Each of the diagnoses in the data base was ranked according to a statewide frequency of occurrence. It was found that 33 primary diagnoses account for 50% (approximately 90,000 claims) of all Medicare admissions in Minnesota. For each of the 33 diagnoses, hospital-specific data were prepared by Blue Cross/Blue Shield. For those diagnoses requiring surgical treatment, these hospital-specific data included the charges at the highest and lowest cost hospital providing treatment as well as an average or mean charge. The data base also included the longest length of stay and the shortest length of stay at hospitals providing the treatment as well as an average or mean. Finally, the number of occurrences for each type of medical treatment was noted.

Following are some selected results of the study: Surgically treated malignant neoplasms of large intestines cost $6,569 at the highest cost hospital and $3,046 at the lowest cost hospital. The average cost for the procedure was $4,598. Surgically treated malignant neoplasms of the bladder cost $4,587 at the highest cost hospital and $1,107 at the lowest cost hospital a ratio of 4.14 to one. The average cost was $2,003. Surgically treated senile cataracts cost $1,655 at the highest cost hospital and $886 at the lowest cost hospital. The average cost was $1,274. Surgical treatment of an inguinal hernia cost $3,936 at the highest cost hospital and $1,723 at the lowest cost hospital. Surgical treatment of hyperplasia of the prostate cost $3,936 at the highest cost hospital and $1,723 at the lowest cost hospital. The average cost was $2,449.

A new set of statistical data released in September 1981 by the State Health Planning and Development Agency corroborates the existence of unexplained cost differences between hospitals for treatment of diagnoses. Fred Sattler, currently with the Northwestern National Life Insurance Company and formerly with the state Department of Health, said in his presentation of the data that one diagnosis, senile contaract, surgically treated, represented about as clear a comparison as any type of diagnosis. Table VI shows data for metropolitan area hospitals, with the number of cases observed included in parentheses. The new data represent an important new set

of information for several reasons. First of all, it is a complete set; it shows *all* cases that were treated by the hospital for the sample population. Secondly, the population group, Medicare patients, represents a basically homogeneous age group, that is, those over 65. Most other statistics on hospital charges usually are developed from a fraction or sample of a given population. Also, typically, the sample group would include several age groups, with age being a potentially important factor in the type, and therefore, the cost, of care. (While the study included such semi-rural facilities at Stillwater, New Prague, and Sanford Memorial, a careful observer might not want to lump them with major metropolitan facilities which treat many more patients and might be expected to attract a different patient population. Also data from Hennepin County Medical Center should not be used for comparison since they include some physician charges in the bill. The charges referred to here do not include physicians' charge.)

The amount of a hospital bill isdetermined by (a) the type and number of services/procedures prescribed by doctors and (b) the unit prices for each service/procedure as

TABLE VI

AVERAGE CHARGE BILLED FOR SELECTED DIAGNOSES

	Malignant Cancer of the large intestine, surgically treated	Malignant cancer of the breast, surgically treated	Malignant cancer of the bladder, surgically treated	Senile cataract, surgically treated	Essential benign hypertension, medically treated	Inguinal hernia, medically treated	Diverticula of colon, medically treated	Urinary tract infection, medically treated	Hyperplasia of prostate, surgically treated
Abbott-NW	$ 4,880 (47)	$2,714 (64)	$1,518 (78)	$1,163 (743)	$1,530 (74)	$1,781 (77)	$1,319 (75)	$2,027 (45)	$2,783 (134)
Bethesda	4,079 (29)	2,465 (8)	1,920 (27)	1,476 (56)	1,487 (41)	1,435 (27)	1,407 (22)	1,704 (24)	2,281 (53)
Divine Redeemer	4,740 (2)	2,449 (5)	2,475 (10)	1,795 (7)	1,824 (6)	1,766 (14)	1,219 (4)	1,325 (3)	2,449 (28)
Eitel	6,076 (10)	3,290 (11)	1,744 (22)	1,168 (142)	1,043 (9)	1,462 (17)	1,270 (13)	1,305 (5)	2,319 (41)
Fairview-Mpls.	6,350 (6)	2,121 (8)	1,939 (39)	1,205 (13)	1,624 (5)	1,203 (29)	942 (16)	1,725 (5)	2,311 (48)
Fairview-South	3,015 (6)	1,930 (27)	1,589 (48)	1,050 (348)	1,262 (12)	1,110 (44)	1,237 (51)	1,509 (9)	2,161 (88)
Forest Lake	2,613 (4)	1,832 (1)	1,658 (1)	—— (——)	716 (7)	2,019 (5)	1,184 (7)	597 (3)	1,975 (2)
Golden Valley	—— (---)	—— (---)	—— (—)	—— (——)	1,642 (3)	1,462 (3)	—— (—)	1,568 (6)	3,195 (2)
Hastings	3,446 (3)	2,016 (1)	967 (2)	1,238 (33)	735 (3)	1,210 (6)	3,697 (1)	1,217 (1)	1,554 (8)
Henn. Cty. Med. Ctr.	11,082 (6)	5,173 (11)	3,579 (15)	3,360 (53)	2,236 (19)	2,805 (19)	2,106 (3)	2,683 (28)	4,128 (36)
Luth. Deaconess	9,022 (1)	2,623 (5)	1,433 (19)	1,819 (24)	2,166 (9)	1,641 (20)	2,091 (13)	2,425 (8)	3,270 (28)
Mercy Medical Ctr.	5,705 (12)	1,931 (5)	4,311 (9)	1,575 (43)	1,174 (9)	1,387 (15)	1,130 (13)	1,248 (16)	2,692 (39)
Methodist	4,195 (27)	2,450 (27)	1,398 (27)	952 (69)	1,218 (30)	1,259 (45)	1,255 (26)	1,437 (31)	1,859 (87)
Metro. Med. Ctr.	6,206 (27)	3,399 (36)	3,109 (38)	1,268 (248)	1,469 (37)	1,918 (52)	1,142 (77)	2,187 (20)	2,501 (90)
Midway	5,105 (19)	2,565 (25)	3,041 (28)	1,358 (84)	1,305 (48)	1,273 (43)	1,152 (42)	1,332 (21)	2,039 (67)
Mounds Park	3,642 (6)	2,242 (9)	2,457 (5)	1,283 (141)	1,598 (7)	1,649 (16)	1,543 (17)	1,535 (14)	2,421 (11)
Mount Sinai	7,023 (6)	3,145 (25)	1,584 (50)	1,502 (195)	1,522 (14)	2,320 (29)	2,415 (11)	2,185 (18)	2,533 (72)
New Prague	872 (3)	1,631 (3)	652 (7)	—— (——)	1,408 (7)	1,143 (18)	1,327 (8)	1,071 (3)	1,029 (3)
North Memorial	3,790 (25)	1,805 (15)	1,262 (53)	861 (153)	1,306 (39)	1,273 (71)	1,204 (33)	2,607 (22)	1,843 (80)
Ramsey	5,435 (8)	3,181 (7)	4,998 (9)	1,671 (38)	1,055 (4)	1,846 (11)	1,093 (2)	2,086 (16)	4,441 (26)
Riverdale Memorial *	5,396 (1)	1,846 (1)	—— (—)	—— (——)	729 (3)	1,625 (3)	1,573 (2)	1,849 (3)	3,312 (7)
Saint Francis	4,955 (3)	1,904 (9)	940 (8)	1,149 (52)	1,076 (8)	1,771 (14)	1,020 (6)	1,842 (6)	1,962 (25)
Saint John's	5,071 (19)	2,642 (22)	2,934 (23)	1,319 (37)	1,311 (27)	1,619 (28)	998 (22)	2,163 (12)	2,475 (54)
Saint Joseph's	7,724 (15)	2,935 (18)	2,501 (17)	1,277 (185)	1,445 (20)	1,459 (21)	1,014 (19)	2,153 (19)	2,468 (56)
Saint Mary's	5,424 (14)	2,142 (25)	1,308 (39)	1,266 (50)	1,674 (16)	1,564 (22)	2,529 (6)	2,136 (9)	2,115 (39)
Sanford Memorial	4,592 (1)	1,740 (2)	—— (—)	—— (——)	1,392 (2)	1,066 (5)	590 (4)	—— (—)	1,567 (8)
Stillwater	3,201 (9)	1,653 (8)	782 (3)	822 (97)	797 (4)	1,397 (13)	544 (4)	1,189 (9)	1,454 (11)
United	8,469 (33)	3,485 (31)	1,882 (34)	1,300 (239)	1,302 (54)	1,826 (48)	1,483 (84)	1,840 (37)	3,401 (125)
Unity	5,947 (7)	1,699 (6)	4,626 (10)	1,462 (164)	1,201 (11)	1,862 (22)	1,304 (8)	1,459 (7)	2,379 (52)
U of M	5,773 (31)	4,304 (34)	6,707 (36)	1,623 (45)	1,782 (11)	2,623 (15)	1,016 (3)	2,891 (3)	4,510 (64)
Waconia	6,913 (4)	1,924 (7)	981 (27)	1,215 (21)	1,078 (8)	1,102 (23)	1,303 (9)	1,710 (7)	1,960 (39)

* Now closed.

SOURCE: State Planning Agency, September 9,1981.

charged by a hospital. Based on information now available to us, it is not possible to know what accounts for differences in total charges from hospital to hospital. It may be differences in unit prices, it may be differences in the number of services/procedures prescribed, or it may be some combination thereof.

Beyond the absence of true price competition, the Twin Cities area health care system lacks other important elements of classical economic competition.

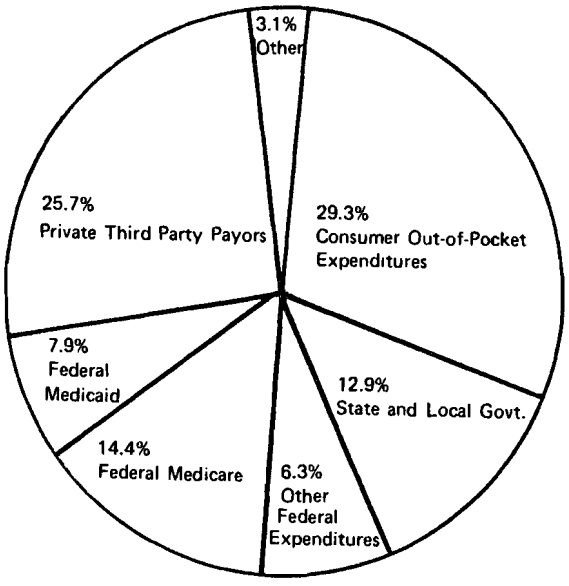
Price and quality information about the various forms of health care services are not readily available to consumers. Although price information can be obtained, it has not been compiled in any kind of form that would facilitate easy reference or comparisons among providers' charges. The lack of such information makes it difficult for employers and insurers to know what the "norm" for a given medical procedure or treatment is. Additionally, the lack of such information could serve as a deterrent to utilization decisions between systems (i.e., whether to seek outpatient treatment or inpatient care).

Consumers are not price-sensitive, being largely insulated from the consequences of their decisions because of the extensiveness of health insurance coverage. When the major portion of medical costs are borne by a third party, demand for care is practically infinite. Today, over 70% of all Minnesota health care expenditures are paid for by a third party. (See Table VII.)

More than 90% of all hospital expenditures are paid for by a third party. (See Table VIII.)

TABLE VII

PERCENT DISTRIBUTION OF MINNESOTA HEALTH CARE EXPENDITURES BY SOURCE OF PAYMENT ($3,608,707,000) Minnesota: 1979

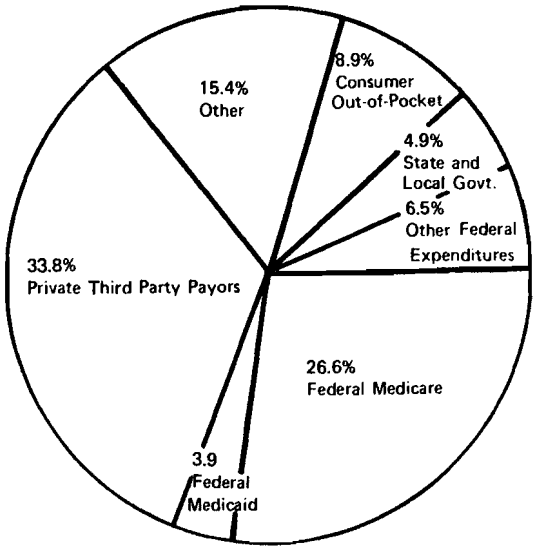


NOTE: Philanthropy was less than .1% for 1979 and therefore is not shown.

SOURCE: Minnesota Coalition on Health Care Costs.

TABLE VIII

SOURCE OF FUNDS FOR HOSPITAL SERVICES ($1,393,538,000) Minnesota: 1979



SOURCE: Minnesota Coalition on Health Care Costs.

Because insurance, whether provided by the government or private carriers, lowers the real price to the consumer at the time care is sought, it encourages increased utilization. Because health insurance is a tax-free benefit, employees are encouraged to seek more of it. In that sense a true choice between additional income and additional health insurance does not exist. This leads then to over consumption of insurance coverage. Individuals have little incentive to seek less costly health plans.

The extensiveness of most health insurance plans substantially reduces incentives for health care providers to operate in a cost effective manner.

Over consumption of insurance inevitably leads to excess production. Physicians are encouraged to provide more tests, and more services, in more expensive settings (hospitals), realizing that their "usual and customary charges" will be reimbursed. Insurers raise their premiums in response. The insurance authorities (including the state insurance commissioner) have been willing to continue approving such increases. Employers complete the cycle by enduring premium increases and passing them on in the form of increased product prices thereby triggering even greater inflationary pressures in the economy.

Another indication of the absence of a genuinely competitive market is the way that the certificate of need process acts as a major barrier to market entry.

In order to open a new health care facility a provider must first be granted a certificate of need and a license by the Minnesota Department of Health. Although certificate of need was intended to eliminate excess hospital capacity, some critics, such as Dr. Richard Frey, chairman of the Minnesota Coalition on Health Care Costs, contend that it has had exactly the opposite effect. In other words, it has functioned to lock existing excess capacity in place. Other critics contend that the certificate of need process, by opposing "duplication" of health care services, actually works to protect existing providers from the threat of new forms of competition. This issue surfaced, for example, in the early 1970s when Fairview Community Hospitals, Inc. successfully opposed a for-profit hospital in the Bloomington area. It surfaced again in 1979, ironically, when Fairview sought to build its Burnsville hospital. At that time, the Burnsville proposal faced active opposition from six area hospitals: Metropolitan Medical Center, Methodist Hospital, United Hospitals, Eitel Hospital, St. Francis Hospital and Sanford Memorial Hospital. During that certificate of need process, proposal advocates suggested that denial of the certificate would amount to protecting those inner-city hospitals in which the majority of identified excess capacity existed. (After an initial denial Fairview's proposal for a Burnsville hospital was approved by the Metropolitan Health Board on September 9, 1981.)

The most recent example of this sort of dispute came in the August 1981 Metropolitan Health Board certificate of need hearing concerning an independent surgi-center in the Golden Valley area. Five hospitals, all located in the immediate service area, opposed that project which was denied by the Health Board in the fall of 1981. (The issue still was pending when this report was written because the Metropolitan Council had asked the Health Board to reconsider its decision.)

Finally, over time a great deal of the risk through the capital acquisition process has been eliminated.

This has had the effect of virtually guaranteeing new hospital capital projects from the very outset. Listed below are a few of the trends which have made that outcome possible:

Borrowing. There is a long-established practice of borrowing (issuing bonds) for hospital expansion. But after the 1960s, a significant proportion of the cost of most hospitals was paid by community fund drives, or by other kinds of gifts and grants (including those from taxpayers: Hennepin County General Hospital is financed by payments from the taxpayers over 20 years; the federal Hill-Burton program represents another source of tax financing). In this system there was, one way or another, a decision required by someone other than hospital officials as to whether or not to finance construction. More recently, however, hospitals have been moving fully toward debt financing. Drives for donations for hospital capital are a rarity today. So are appeals for tax support, and the use of federal Hill-Burton monies is declining. In part, this is a result of reimbursement practices and public subsidies.

Reimbursement. Some years ago insurers, private and public, agreed to permit hospitals to include, as a part of their daily charge, an item for capital: that is, depreciation and for the reimbursement for any interest on their debt. This had the effect of guaranteeing, almost without limit, that whatever facilities and equipment were built and installed, the hospitals could be reimbursed for them. This greatly reduced the risk of investment in hospital capital, and virtually eliminated the need for hospitals to ask for dollars from other parties in advance of the approval and construction of their project. Rather, it fostered the trend toward use of the bond market.

Subsidy. Rapidly through the 1970s a further trend has seen hospitals making use of public credit, through tax-exempt revenue bonds. Under existing law, the interest income to investors on bonds issued by governmental subdivisions is exempt from federal and state income taxes. Creditors therefore accept a lower rate on the bonds. This reduces the cost of money to hospitals, which in turn permits lower daily rates. The practice is attractive also to local public authorities, who can get hospitals built with no tax revenue involved, and with no charge against their net debt. The impact is on the federal and state governments, whose income tax collections are reduced by the tax exemption.

This has made obsolete the kind of financing done for Hennepin County in 1969 (a referendum for $25 million, repaid by property taxes). A study by Booz, Allen & Hamilton in late 1978 estimated that debt financing by that time represented about 78% of hospital capital; and that this would rise to 100% by 1983, with tax-exempt issues accounting for 80% of the total. Philanthropy, grants and internal operations, the study projected, will disappear by 1985 as a source of revenue for this purpose.

This approach has been used by hospitals in Minnesota. Prior to 1978 the authority to do so was derived from the general statutes providing for tax-exempt revenue bonds in the state. In that year, Chapter 609 specifically authorized their use for hospitals and health care facilities. What is reported to have been the largest bond issue for hospital capital in the United States at that time took place in the Twin Cities area, in Saint Paul, for United Hospitals.

The decision as to whether to use tax-exempt revenue bonds currently is made by the city council of the municipality in which the development is to take place.

The idea behind tax-exempt bonding is to enable municipalities to stimulate development to locate in their communities which might not otherwise occur.

Municipalities may grant such bonding for a variety of types of development, including commercial, industrial, residential, and, among other types, hospitals. Early in 1980, as a part of a follow-up to its 1977 report on restraining growth in hospital beds in the metropolitan area, the Citizens League recommended that tax exempt revenue bonds for hospitals be approved within the Twin Cities area, not only by the municipality but by the Metropolitan Council, on recommendation of the Metropolitan Health Board.

The granting of the tax-exemption for hospital bonds, the League felt, should be based on areawide considerations, not just the interests of a local municipality for development.

Some important preconditions for real competition are now in place in the Twin Cities area market.

- Excess capacity.

- A growing excess supply of physicians (could result in pressure for increased utilization or could provide more opportunities for making physicians cost sensitive).

- Growing competition between the fee-for-service and the prepaid sector.

  HMOs are paid a flat monthly fee to provide virtually all medical services a family may need. Whether a patient is hospitalized or is treated on a less expensive basis, the subscriber pays the same amount. For that reason, it is in the economic interest of the HMO and its doctors to control costs. Members must get their medical care through the HMO to be covered; so its doctors are in direct control of health care costs.

  About 420,000 Twin Cities area residents–one out of every five–are now HMO members. That total is up 70% from two years ago.

  A study by the Minnesota Department of Health predicts that Twin Cities HMO membership will reach 777,900 by 1985. That would be one out of every three residents.

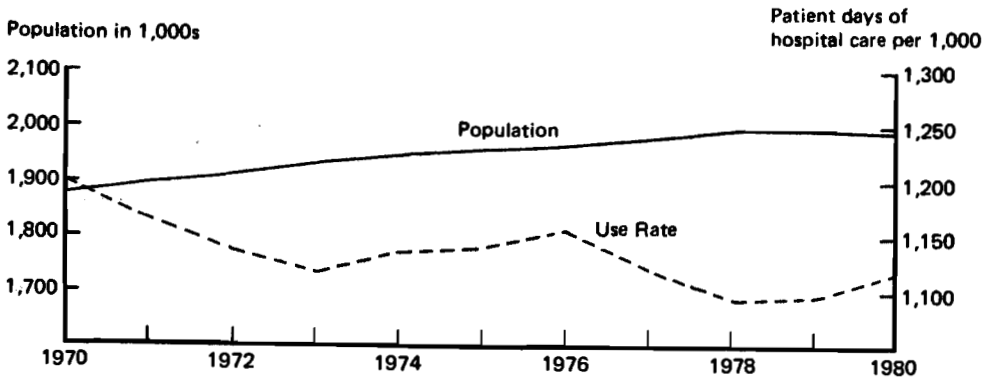
  According to Paul Ellwood of InterStudy, about 80% of all Twin Cities area doctors now participate in one HMO or another.

- Private utilization review and increasing pressure for lower utilization.

- Declining rate of utilization. According to statistics provided by the Council of Community Hospitals, "patient days" (excluding chemical dependency and psychiatric care) dropped almong 9.0% of 175,000 days between 1976 and 1978 alone, while patient days per 1,000 population dropped by 231 days or 17.8% over the years between 1970 and 1978. (See Table IX on Trends In Population And Use Rates.)

TABLE IX

TRENDS IN POPULATION AND USE RATES*
1970 through 1980



*Current data shows a sharp decline in use rate during the first quarter of 1981.

SOURCE: Metropolitan Health Board.

CONCLUSIONS AND RECOMMENDATIONS

The "problem" in health care costs today is market failure.

The problem is not excess beds (capacity) nor excess utilization (demand). These are only symptoms of a much larger problem–a system that can not gain control of its use of resources.

The health care system lacks the elements of a well functioning competitive system in the classic economic sense. There is no price competition. Price and quality information are not readily accessible to consumers even after they purchase services. Neither consumers nor providers are cost-sensitive, since they are insulated from the consequences of their decisions by their ability to pass costs along. Providers virtually incur no risk of going out of business and have inadvertently been protected from new forms of competition. There are major barriers to market entry.

The health care system has many forms of competition, but because there is no price competition, the competition which does occur is cost-generating, not cost-saving. Some have termed it "a medical arms race."

Regulatory policy has not been effective in controlling health care costs. What is needed is a fundamentally different combination of competition and regulation.

Regulatory policy has typically tried to control health care providers' behavior directly rather than strengthening the weakened market forces to which providers respond. Moreover, regulatory policy has dealt almost solely with the supply side of the cost containment problem. It asks this question: "How many hospitals, beds and services do we need?" An important question, but asking it has tended to focus the cost containment debate on facilities rather than the malfunctioning of a market that generates unnecessary beds and costs. What is needed is attention to the market structures which make the system work the way it does.

Because the health care market is not structured in such a way as to produce true economic competition, merely ending governmental regulatory policies will not serve to improve the functioning of the market. Moreover, as this country saw at the beginning of the 20th century, unrestricted competition may lead to monopolies or oligopolies, the very antithesis of competition. In the hospital sector today, we may be seeing in the growth of multi-hospital systems the rise of tomorrow's national health care firms. Multi-hospital systems have increased their share of the beds in the United States from 2% in 1965 to 32% in 1979.

Finally, few would suggest, in the absence of an effective income maintenance strategy, that government stop subsidizing the purchase of medical care for the poor or elderly as a purely *laissez-faire* strategy would demand. Fewer still would advocate the abolition of licensure laws, life and safety codes or other such quality assurance mechanisms.

What is needed then is neither pure competition nor pure regulation, but rather a hybrid of them both, working together in fundamentally different ways.

The time has come to adopt competitive means to achieve regulatory ends.

During the last few decades, the classic response to "market failure" has been government regulation. In the health care sector it has become clear that such regulation has only aggravated the problems of a dysfunctional market. In that sense, the current situation represents both market failure *and* regulatory failure. The appropriate policy response to this dual situation, then, should be market reconstruction.

If a competitive marketplace is to be built, the role of government must change. In the past, government has either left the market alone (*laissez-faire*) or it has tried to supplant it (regulation). What government has rarely done is to provide incentives to the market to make it work, and exercise continuing oversight to assure that the ensuing competition is fair and sustained over time. That is precisely what it must now do.

The role of government should be to decide on policy or strategy. But it need not implement that policy itself. Particularly in the health care sector public policy should

decide what should be done and try to structure the appropriate market incentives to bring that about. How radically different this idea is (of a hybrid of competition and regulation) from what has occurred in the past can be seen in the following diagram:

A HISTORY OF HEALTH CARE POLICY

	Pre-1940	1940-79	1980-
Who decides	o	x	x
Who implements	o	x	x/o
Who evaluates	o	x	x/o

KEY: o - Private; x - Public or Government.

Prior to the 1940s, most decisions were made on a "private" basis. If there was enough demand for a hospital, as expressed in a critical volume of people or private capital support, it was built. If there was not, it wasn't. This proved to be a problem in that it created pockets of the country which were medically underserved. It was also a problem for those without the resources to purchase care.

In order to address those problems, government abandoned its longstanding *laissez-faire* policy and intervened in the market directly. As it did so, society gradually came to accept the notion that government has a legitimate role to play in the market and the idea of the "pure" market economy was rejected.

During the next phase (1940-1970) government played an increasingly significant role in the health care marketplace. Where there were shortages of hospitals and physicians, government helped provide them. The elderly and the poor were enabled to purchase care through Medicare and medical assistance programs. As the impact of health care cost inflation on the rest of the economy began to be understood, government sought to control that directly through regulation. Toward the end of the 1970s regulatory controls grew in scope and power.

Today, many people, including some regulators, are beginning to reject the regulatory model. Experience has shown that it has increased providers' costs (which are ultimately passed on to the consumer), shielded providers from new forms of competition and, therefore, helped to sustain inefficient institutions in the market.

Having rejected both a purely *laissez-faire* model and a purely regulatory one, what next? It is natural for there to be some confusion and apprehension about this. Since people relate best to what they have already experienced, the current debate over health policy tends to be framed in terms of *laissez-faire* competition *versus* market regulation. This is a misunderstanding in that it limits policy alternatives to an either/or decision. There is a third alternative: market reconstruction.

It is this third option that is needed now. For it to work, policymakers should decide on the appropriate policy but let the implementation of that policy occur in the market through the vehicle of peoples' choices.

The key to cost containment in the future then will lie less in affecting hospitals, and other providers' behavior than it will in affecting the environment in which their behavior is determined. The Twin Cities community should now move aggressively to structure competitive incentives into the health care system as a means of controlling health care costs.

Inefficient hospitals should be forced to close as a result of consumers' choices rather than through regulatory decisions.

The dispute between the Metropolitan Health Board and local hospital providers has now reached crisis proportions. While both sides are acting from the best of intentions, it is clear that the present state of affairs is becoming excessively divisive and should not be allowed to continue.

The Metropolitan Health Board has recently released a report suggesting various means to remove excess hospital capacity. Its recommendations are institution-specific. Some of its recommendations ask certain providers to consider "consolidating, merging, or phasing out their total inpatient acute care services." They also lay out some other alternatives. But, as could be expected, most of the community's attention has focused on the suggestion that designated hospitals consider closing.

The policy issue here is not excess capacity but rather the absence of a viable health care marketplace. Health Board members and trustees of the hospitals freely admit that there is a great deal of excess capacity and that it should be eliminated. The important question is how the local marketplace generated so much excess capacity and how that can be prevented in the future. When excess capacity is viewed as the problem, the issue is who decides which institutions should close. When market failure is viewed as the problem the issue becomes how the market can be made to work.

The community should now shift its focus to this larger issue: making the market work. The Health Board should be spared the necessity of making decisions about which institutions should close. In a larger sense, it is questionable whether private institutions should be designated for

closure by a public agency. Were a true economic market functioning, such decisions would never have become "public" in the first place. These decisions should be made in the marketplace by informed consumers, the sum of whose purchasing decisions will constitute "implementation."

Should the region then give up the goal of eliminating excess capacity? No. A health care marketplace, if structured correctly, can be made to eliminate the present excess capacity. The challenge is to restructure the health care market in such a way as to *assure* that excess capacity *will* be eliminated through the medium of consumers' choices.

What follows is a strategy to achieve that end. In structuring a competitive marketplace in the Twin Cities, priority attention should be given to the demand side. Our strategy offers five demand side recommendations. At the same time however, the supply side should not be neglected. Our strategy offers two supply side recommendations.

1. In order to enhance consumer cost consciousness and introduce true price competition, all health providers should release price and quality information.

2. Consumers should be given a real choice between additional income and additional health insurance.

3. Employers should offer employees a choice among several health insurance plans with varying levels of coverage, to encourage consumers to buy only the insurance they need.

4. Consumers should be informed, in advance, of how much employers and insurers will pay for a given medical condition. In order to contain costs and encourage competition, employers and insurers should set limits on reimbursement and offer incentives to use low-cost providers.

5. Both public and private employers should adhere to a "choices" strategy. But it is particularly important that the public sector do so now, to set an example and contain costs.

6. To provide for ease of market entry, certificate of need for hospitals should be eliminated.

7. Some public body with an interest in regional health care cost containment ought to determine when and under what circumstances tax-exempt financing for new construction should be granted.

In the following pages we discuss each point in greater detail and offer specific recommendations for implementation.

1. In order to enhance consumer cost consciousness and introduce true price competition, all health care providers should release price and quality information.

Although price data are available today, they are not easily accessible in forms which would allow for comparisons of one hospital's prices with another's or a physician's fee for a service provided in his office with the fee for the same service provided in a hospital. Such data as are available are not widely published nor is there much interpretive comment which could help consumers understand such data were they to become more widely available. The lack of such data and interpretive commentary does a disservice to all consumers of health care. It allows providers to operate in an environment in which little scrutiny is applied to pricing policies. (This situation is further aggravated because insurance companies are prevented, under existing anti-trust laws, from jointly negotiating prices.)

This situation can no longer be tolerated. If pricing information were to become more available, hospital prices in the metropolitan area would not continue to reflect as wide a range as studies show they now do. Immediate release of such information then is of the utmost importance. (The late Senator Nicholas Coleman introduced legislation to this effect in 1979.)

It is to the hospital industry's credit that it is beginning to respond to requests for price and quality data. The West Metropolitan Hospitals Trustee Council, in a statement released June 18, 1981, called for the release of price and quality data. An agreement has recently been signed between the Minnesota Hospital Association and the Minnesota Department of Health regarding the release of pricing information. Finally, the Council of Community Hospitals has agreed to begin the process of collecting charge data for the top 25 diagnoses with publication of hospital specific average charges by diagnosis in April 1983. "Full implementation of the Johns Hopkins (Caseplex) level of severity scale" would occur by January 1984.

We view these developments as significant. However we believe that public disclosure of hospital-specific charge data should go forward even as the Caseplex system is perfected. This could prove a relatively simple matter if area hospitals would authorize Blue Cross/Blue Shield to begin immediately to aggregate and release charge data.

Finally, the various county medical societies should initiate discussions at once which would lead to the imminent dis-

closure of price data.

a. All health care providers–including hospitals, nursing homes, HMOs and physicians–should voluntarily release price and quality data.

Only if all of these groups release such information can cost-effective decisions be made among systems (i.e., the acute care system versus the long term care system versus the community health care system.)

One of the most important and potentially beneficial impacts of the release of price and quality information is that employers and insurers will be able to associate providers with their price schedules. There will be providers who, in comparison to other providers offering the same service, can provide it at lower cost and relatively higher quality. Theoretically, once the more efficient providers can be identified, consumer utilization should shift to give them a competitive advantage in the marketplace.

It would be best if action on this important matter can be achieved voluntarily. If that proves to be impossible then the following legislative actions should be taken:

b. If price information disclosure practices are not voluntarily implemented by January 1982, the Minnesota State Legislature should pass legislation before the end of the 1982 session requiring that such information be released and widely disseminated in order to encourage price competition throughout the health care system.

At a minimum, the following price information should be published. A determination should be made of representative diagnoses, procedures, illnesses, injuries and medical conditions afflicting citizens of Minnesota. Hospitals and other providers offering treatment modalities for the same should be required to disclose institution-specific numbers of patients discharged; minimum, median and maximum length of stay; lowest, median and highest price for a service; and separation of the median price into various component prices for room and board and major ancillary services.

c. Health care providers should begin immediately to post prices for the most commonly delivered medical services.

Both the West and East Metropolitan Hospital Trustees should begin immediately to encourage their respective hospital institutions to release price information and post prices for common medical procedures.

The Minnesota Medical Association, the Physicians Metro Health Task Force and the various county medical associations should encourage member physicians to begin immediately to post the prices of common medical services in their offices.

d. In addition to price information, metropolitan hospitals should also release the following quality measures: age and diagnostic-specific adjusted mortality rates, incidence of iatrogenic conditions (conditions caused inadvertently or erroneously by physicians), and infection rates.

Why, in addition to recommending the release of price information should such quality measures as currently exist be released? The answer is that consumers should know, in advance, the risks confronting them as they enter a given hospital. For example, a significant new study by Dr. Harold Luft of the University of California indicates that there is a clear relation between volume of specialty service procedures performed and an institution's mortality rate for that procedure.

The higher the number of procedures, the lower the mortality rate. After studying the surgical results on over eight hundred thousand patients at nearly fifteen hundred American hospitals, Luft concluded that a patient's chances of dying are as much as 41% greater in a hospital performing fewer than 200 open heart surgeries per year than if he were operated on in another hospital performing more than that number.

Of the 12 Twin Cities area hospitals performing open heart surgery, only four hospitals did 200 or more such procedures in 1980. Of the remaining providers performing this service, according to the Metropolitan Health Board, three perform between 100 and 200 per year and four perform fewer than 100 per year. A program aired in June 1980 by KTCA–TV, *What Price Miracles?* concluded that, "recent mortality rates for the Twin Cities suggest that we should be concerned." KTCA's rough analysis indicated that "in the first six months of 1980, there were as many as seven of what Lufts study would call 'excess deaths' due to open heart surgery in low-volume hospitals."

These data should not be misconstrued. The Twin Cities health care system has a well deserved reputation for quality medicine. Volume alone in such procedures does not determine outcomes. But at the same time such data should not be ignored and should not be "hushed up." The public should have access to such information. It is in everyone's best interest–including providers' interests–that this information be shared. For example, one Minneapolis area hospital performs far fewer open heart procedures than the guideline figure of 200, but statistics show that its mortality rates are far lower than the national average. Should that institution be forced to stop providing that procedure? Perhaps the market should determine that answer.

We recognize that existing data on quality is very limited and that much work needs to be done to provide better data. But the absence of an abundance of good data today is not a reason to keep confidential whatever data now are available.

e. The Metropolitan Health Board and the Council of Community Hospitals should jointly provide the public with interpretive commentary on price and quality information.

It seems natural that, at times, the public sector will evaluate such data in one way and providers (physicians, HMOs, hospitals, nursing homes) in another. Both views are valuable and important for the public to understand. Only in that way can responsible utilization decisions be made by consumers.

The Metropolitan Health Board should, with the assistance of the Council of Community Hospitals, the Physicians Metro Health Task Force, and the Foundation for Health Care Evaluation, put together something resembling a "Consumer's Guide" to hospital care in the metropolitan area. That document should contain a profile of each hospital's charges. (A profile consists of all services that the provider performs and the amount the provider charges for each service.) From such a profile it could be seen whether a particular provider's charges are above or below the community norm. Both the Health Board and the provider or provider's representative should then help the public to understand or interpret those data. Over time, the Consumers Guide should be expanded to other providers including physicians, long term care providers, HMOs and others.

This action is necessary to enable consumers of health care to 1) compare a provider's charges to a community norm, and, 2) discriminate among providers whose charges for a service seem excessive.

f. HMOs and other group health providers with sufficiently large memberships should begin now to accumulate data on the health experience of their members.

These data, like other quality and cost measures, should be made available to the public, with appropriate interpretive comment, to permit informed comparisons. Comparisons that focus on the health patterns of representative populations, rather than solely on the cost-effectiveness of discrete services, will permit consumers to evaluate the overall effectiveness of various providers and will provide incentives to those providers to encourage healthy life styles among their "patients".

2. Consumers should be given a real choice between additional income and additional health insurance.

This choice cannot be said to exist in any meaningful way today because employer contributions to employees' health benefits are excluded from taxable employee income. (Section 106 of the Internal Revenue Code.) As a result of the exclusion, a tax shelter is created for workers who receive part of their compensation in the form of health benefits rather than as wages that would be subject to personal income tax. To the extent that this tax feature lowers the net cost of the non-taxable fringe benefits and thereby creates more of a demand for the benefit than might otherwise exist in the absence of such an incentive, it is fair to say that a true choice between additional income and additional health insurance benefits does not currently exist.

The exclusion of employer health contributions from employees' taxable income provides a considerable incentive for employees to bargain for and employers to offer more health benefits coverage. Martin Feldstein, the noted economist, has commented that the production of high cost care is, in fact, a self-reinforcing process. The risk of expensive care stimulates a demand for more comprehensive coverage while the growth of such insurance makes care even more expensive.

The exclusion may encourage employees to purchase more insurance than is necessary, leading to inefficiency and excessive cost in the use of health services. The end result then is a system of perverse financial incentives which leads to more expensive modes of treatment and even lower levels of consumer cost consciousness.

a. The United States Congress should cap the tax exclusion for employee health benefits. The tax cap should vary according to geographic area and age, so as not to allow groups to reap windfall gains because benefits differ by economic region and health status. Finally, the tax cap should be at or below prevailing geographic area insurance premium rates to allow the greatest possible employee choice.

In order to have the greatest impact on the employee, the tax cap must be set at or below prevailing premium rates in the geographic area in which he lives. This is so for two reasons. First, if the cap is set at a higher than normal premium rate it will become a "target" of sorts, encouraging unions to bargain up to that prevailing level. Second, and more importantly, keeping the cap at or below prevailing geographic area premium rates will pass on the

maximum amount of income to the employee from which he will have to make economic choices about the appropriate level of insurance coverage. Setting the cap low will also force the greatest numbers of employees to make such economic decisions.

b. Consideration should be given to converting the tax exclusion for employee health benefits into a capped tax credit.

This action is needed for two reasons. First, making the tax exclusion into a tax credit would have the effect of making consumer recipients more aware (via the refund) of how much they are spending on health insurance and increase incentives to examine whether comparable benefits could be obtained at lower cost. Second, such a recommendation seems to be more equitable.

3. Employers should offer employees a choice among several health insurance plans with varying levels of coverage, to encourage consumers to buy only the insurance they need.

a. All employers should make a fixed dollar contribution towards a health plan of an employee's choosing.

The employer contribution to employee health care plans generally should be independent of the cost of the plans themselves. Doing that would have the effect of requiring employees to pay extra, out-of-pocket, for each additional increment of coverage. An additional effect of this option would be to shift part of the costs to those employees with the greatest benefit costs. If an employer does decide to tie his contribution to a particular plan however, what must be avoided is tying that contribution to the highest cost plan available.

b. Large employers should offer their employees a limited choice of benefit plans with varying levels of coverage.

Whatever alternative plans the employer offered would then compete on the basis of premium rates. Generally, the greater the coverage, the higher the premium. Employers should consider offering HMO plans and benefit plans with some employee cost sharing involved.

c. Smaller employers should encourage competition between carriers to provide a standard plan to their employees.

By encouraging such competition to occur, small employers, can force carriers (HMOs, Blue Cross/Blue Shield, or insurance companies) to compete to provide the greatest number of benefits for the lowest premium cost. In order to promote true competition in this manner, however, between HMO s and conventional carriers, the Minnesota State Legislature should consider removing all benefit restrictions from the state's HMO statute. This would be a necessary step in order to allow HMOs to vary their benefit options to compete with conventional carriers. (HMOs are currently prohibited from offering low benefit options.)

d. The Minnesota Legislature should eliminate the legal barriers which prevent small employers from joining together for the sole purpose of purchasing group health insurance.

Because of administrative costs, small employers might not be financially able to offer their employees a number of different types of health insurance plans with varying levels of benefits. To encourage cost conscious use of the medical system by employees then, small employers might require a greater degree of co-insurance.

e. Employers should provide such financial counseling as seems necessary to facilitate employee health insurance decisions.

f. Business groups such as the Minnesota Coalition on Health Care Costs, the Minnesota Business Partnership, Chamber of Commerce, and the Minnesota Association of Commerce and Industry should take the lead in urging employers to offer a number of plans.

4. Consumers should be informed, in advance, of how much employers and insurers will pay for a given medical condition. In order to contain costs and encourage competition, employers and insurers should set limits on reimbursement and offer incentives to use low-cost providers.

It could be observed that all of the recommendations to this point (with the exception of the preceding comment on the necessity of releasing price and quality information) make only an indirect impact on providers. True enough. A major criticism of most of the competition proposals advanced by other parties has been that while they may encourage competition among insurance carriers and plans, they do virtually nothing to stimulate competition among medical providers. "Too often," as Walter J. McNerney, the national president of Blue Cross/Blue Shield, has written, "competitive pressure is diverted before it reaches the provider." Having argued for the release of price and quality data, the stage is now set to go further. For it is clear that to achieve any meaningful degree of competition and cost containment, competitive pressures must be brought to bear upon medical providers directly.

The major difficulty in bringing market pressures to bear on medical providers is the present insurance system.

Interestingly this is not so much a problem for prepaid insurance plans (HMOs) because the HMO is both the buyer and the supplier of care. Since consumers purchase coverage from an HMO on a capped basis, the HMO has an incentive to make cost conscious decisions. The really difficult problem is when hospital care is purchased through conventional insurance arrangements.

Since 75% of the Twin Cities population receive health insurance coverage through a non-prepaid insurer, the challenge to cost containment advocates is to design a vehicle to insure that consumers with conventional insurance coverage buy medical care in a cost conscious manner.

Once price information is released, this becomes an easier task. Under our recommendations, providers' prices for various medical services would be compiled into a "Consumers Guide" which would indicate what the community norm for a service is and how various providers' prices compare to that norm. Equipped with such knowledge, employers would contract with insurers to set limits on provider reimbursement that reflect prevailing community price norms.

Employers should then set reimbursement caps for various medical services and communicate this information to employees in the form of a reimbursement schedule. That reimbursement schedule would remain the same under any of the health insurance plans offered by the employer. Provided with this reimbursement schedule and information as to how local providers' charges compare with it, employees can be expected to "shop" for non-emergency care.

In order for employees' decisions in the market to make a direct impact on health care providers, that is, on physicians, HMOs, hospitals and nursing homes, financial incentives should be structured into each insurance plan to encourage employees to utilize those providers with prices at or below prevailing community norms. This could easily be done by insuring that each health plan offered contain provisions stipulating that the extent of co-insurance should vary depending upon cost-effective employee health care choices. For example, if an employee elects to use a provider with charges higher than the employer's capped rate then he would face a higher rate of co-insurance. Additionally, the employer or insurer might require that the employee pay some or even the entire difference between the capped rate and the provider's charge himself, out-of-pocket. If the employee selects a lower cost provider than the employer's capped rate, then he would receive a lower rate of co-insurance or possibly even first-dollar coverage. Employers should consider sharing some of the resulting cost savings with those employees who helped accumulate them.

Under this scheme then, whether an employee enjoys a given benefit would never be subject to change. What would be subject to change, however, would be the extent of the co-insurance that would depend upon an employee's cost-effective choice of provider. Every insurance plan offered should contain such co-insurance provisions allowing the employee to "earn" a greater benefit or lower out-of-pocket costs depending upon his utilization of lower cost providers.

a. As part of their contractual arrangements with health insurance carriers, employers should insist that insurers maintain or develop a system of reimbursement controls.

b. Employers and insurers should set limits on what they will pay for a given medical condition. The resulting price and benefit schedule should contain some relation to a community-based median price for a given medical service.

Conceivably, setting limits on reimbursement will have two immediate impacts on providers. First, it will allow the system to keep pace with the majority of physicians' charges, while placing some cost containment restraints on the upper levels of charges (i.e., those most likely to be "out of line"). Second, it will encourage true price competition by forcing providers to compete at the level of the community norm.

The reimbursement schedule would be flexible enough to take into account complications which might develop in an otherwise routine treatment procedure.

c. Employees should be informed, in advance, of the amount that is the spending limit for a given medical condition. Supplied with this information and a listing of local providers' prices for that procedure, employees should then be expected to "shop" for care in the medical marketplace.

It should be the insurance carriers' responsibility to provide persons covered in their plans with information regarding the reimbursement schedule and those providers in the community who may be utilized at full reimbursement. When listing physicians, insurers should also include information detailing the hospitals at which physicians enjoy privileges. Employers should also insist that insurers provide pamphlets and personnel to conduct seminars for employees so that they are clear about the level of personal financial responsibility they will incur under different choices. Finally, insurers should provide ongoing explanations to

covered employees about how they can benefit financially under this system.

In the short term, as more and more information about hospital prices becomes available, consumers will have the incentive to inquire about the cost of the hospitals at which their physicians enjoy privileges. As most physicians enjoy privileges at more than one hospital, consumers could begin to insist that they be hospitalized at the lowest cost hospital at which privileges are held. If all the hospitals are high cost, the consumer may decide to change physicians.

Over time as they are eventually equipped with more and more information, we would expect that consumers would want to examine first the relative cost of their present physician, comparing not only prices but the cost of the hospitals at which that physician maintains privileges.

The point is that a great deal of such "shopping" could occur prior to the point at which actual hospital care is needed. In a field that is generally as risk averse as health, consumers would have the incentive to select providers (physicians and hospitals) early. But even if that decision were prolonged, the opportunity to choose would, in most cases, still remain. This is so for the reason that in most instances of hospitalization, there is usually a time interval between the point at which the physician makes the decision to hospitalize and the event itself. This is even true for the use of metropolitan area hospitals emergency rooms where, according to Metropolitan Health Board statistics, approximately 85% of emergency room visits fall into the "not serious category, while less than 2% and 12% fall into the critical and urgent--not serious categories respectively."

(Again, the system of incentives and disincentives which we are recommending would not apply in emergency situations in which consumers were unable to exercise a true economic choice.)

d. Consumers should be given incentives to use lower cost providers.

Because individual consumers are not cost sensitive today, most health care theoreticians, acting in the name of cost containment, propose to penalize the individual by forcing him to pay more out-of-pocket as a means of insuring greater cost sensitivity. Often, they also urge an end to first-dollar coverage as well. But such strategies unfairly penalize consumers for their ignorance, when, in effect, there is no way consumers could know, now, the costs and benefits of using one provider versus another.

That situation changes, however, in a system in which price information is known and consumers are expected to take more responsibility for their own health. In that kind of system it could be expected that employers would find it in their interest to inform employees about which providers offer lower prices and offer financial incentives to induce them to use these lower cost providers. Consumers should be willing to participate in health plans which contain cost sharing provisions. *If consumers are willing to utilize providers whose charges are at or below what the employer is willing to pay, then the employee should be allowed to receive a greater benefit, receive a lower rate of co-insurance or garner some other type of net gain.* In some cases, employers might even be willing to allow first-dollar coverage for cost effective choices.

Simply put, employees should be allowed to "earn" lower out-of-pocket expenses or even first-dollar coverage by utilizing lower cost providers, since doing so can help to conserve the scarce resources of their employers.

The choice, as to whether to use the more cost effective providers (once identified), should not be forced upon the employee by third party payers or employers. That choice should remain squarely in the hands of the individual. But such choices should have consequences. *Employees choosing to utilize providers whose charges are higher than the employer's predetermined rate should be required to pay all or part of the difference in cost, receive a lesser benefit, or experience a higher rate of co-insurance.*

e. The extent of incentives/disincentives should be a topic for negotiation between employers and employees.

We believe that there is substantial room here for negotiation between unions and employers. A recent conversation with a "risk manager" for a national firm in Chicago indicated that it is in management's best interest to institute penalties for non-cost-effective behavior. For example, if an employer sought to increase the number of second surgical opinions obtained prior to employee surgery, he might offer insurance coverage which requires that employee undergo the additional examinations or else submit to a higher rate of co-insurance as penalty. Likewise, it would be in labor's best interest to bargain for a financial incentive such as a lower rate of co-insurance as a reward for cost-effective behavior (i.e., obtaining a second surgical opinion prior to surgery).

Quite logically, such financial incentives or disincentives could be negotiated through collective bargaining procedures and then be written into the health insurance agreement. In such negotiations, both labor and management should abide by the principle that the extent of employee benefits and out-of-pocket expenses should vary depending upon whether an employee is willing to engage in various cost effective behaviors. Under that principle, the potential to obtain a reward or incur a financial penalty ultimately remains in the hand of the individual consumer. *A few*

examples of desirable consumer behavior which might be encouraged by some type of incentive could include the following: incentives to utilize low-cost providers or pharmacies; incentives to undergo pre-admission screening or second surgical opinions; incentives to substitute generically equivalent drugs for name brand drugs; incentives to utilize out-patient facilities for mental illness and chemical dependency (when approved by the attending physician) and increased use of ambulatory surgery facilities for elective surgery or birthing wherever feasible.

f. As an added incentive, employers should consider sharing some of the cost savings achieved with those employees who helped attain it.

If such policy suggestions are followed, employers could well save considerable sums of money. Employers should consider sharing some of the cost savings achieved with those employees who helped to attain it.

There appear to be several ways to redistribute such cost savings:

Cash Rebates – Employers and insurers could agree to give cash rebates to those employees who helped achieve the most cost savings. This could be done on a sliding scale based on the number and amount of claims incurred by each individual. Fewer claims and lower costs than a certain threshold level could then become grounds for a rebate. A special rebate might be given for no claims or costs incurred although this would probably have to be age-adjusted. This option is immediately open to all employers who are self-insured. For those employers purchasing group policies through carriers, a question remains as to whether such a policy is prohibited under current Minnesota statutes which require that all parties covered under a group contract be given the same level of benefits. Would such a rebate clause unfairly discriminate among persons of the same class? We would contend that it does not since every person in the insured group would have an equal opportunity to garner increased benefits and lower out-of-pocket payments. However, since the rebate suggested above is not expressly sanctioned (or prohibited) under the law, *Minnesota Statutes 72A.07, subdivisions 8, 9 and 15 should be amended explicitly to sanction the practices advocated above.*

Employers should guard against redistributing more in aggregate rebates than is actually saved, and the amount of any rebate to an individual employee should vary according to such factors as age, sex, family size, maternity, health status, and whether a person has multiple coverage. There would seem to be four ways to prevent excessive rebates:

The employer could pay a fixed dollar amount toward an employee health plan. This amount should be less than or equal to the cost of the lowest cost plan option. The rationale for this is that if an employer were to make his contribution equal to the cost of the highest priced option, employees choosing the low cost option will receive savings reflecting their selection rather than efficient utilization of the health care system.

If an employer's standard contribution is higher than the lowest priced plan, then any rebates to employees should reflect only the actuarial value of the difference in benefits. The reason for this is that with a high contribution, employees with lower utilization will select the lowest cost option and the rebate will exceed any savings to the employee group as a whole.

Employers should work closely with insurance carriers (HMOs, Blue Cross/Blue Shield, conventional insurance companies) to design plans with incentives and penalties such that both employees and employers benefit from cost efficient use of providers.

If a resulting plan produces rebates for lower utilization, the amount rebated should not exceed the actuarial value of benefit plan savings.

Non-wage Benefits – In return for cost effective behavior employers could give such employees non-wage benefits such as additional days of vacation or shorter hours.

Another possibility would be to allow the employee to carry over the cost savings and apply it to the following year's premiums or future deductibles. If the size of the premium or deductible went up from one year to the next, the cost effective employee might be allowed to apply some of the savings against the increase.

Summary – How will these insurance incentives impact the health care system?

This approach, with incentives for using cost-efficient, high quality providers, puts the choice of cost-effective utilization squarely in the hands of consumers. When added to our earlier recommendations about the necessity of releasing price and quality information so that efficient providers can be more readily identified, this strategy contains the seeds of a virtual revolution in health care cost containment. If consumers use the health care system effectively they can benefit financially and may not, in some cases, have to incur the penalty of an across-the-board end to first-dollar coverage. Leaving the decision about provider utilization to the consumer will relieve both the employer and the insurer from tampering with the physician/patient relationship.

Moreover, it should also give the individual the ability (assuming that he is made aware beforehand of how various providers' charges compare to reimbursement schedule rates) and the incentive to challenge non-cost-effective physician decisions regarding hospitalization. In so doing, additional pressure will be placed on physicians to develop privileges at the more efficient institutions. Presumably, over time, both physicians and consumers will shift their utilization patterns (particularly if they are allowed to share in some of the cost savings or disincentives) to the most cost-effective hospitals, thereby placing serious market pressures on less efficient hospitals. (As underutilized providers incur even lower utilization, they will likely raise their rates. The more their rates increase, the more they will be distinguishable from the community norm with further utilization shifts then occurring by both consumers and physicians. (We could even envision situations where physicians would buy out hospitals.) Experience with HMOs continues to illustrate that given a choice between cost savings and loyalties to a given physician, more and more consumers seem willing to shift physicians if there are financial incentives for doing so. Finally, unlike the present system, this system would reward efficient providers.

In short, this strategy is based on a simple premise: Letting consumers know, in advance, how much they have to spend on their health care, will make them more careful about how and where they spend it. Thus, making individuals *provider-sensitive* can also make them *cost-sensitive* if there is a financial reward involved. And equally, if consumers are made to be cost-sensitive to the providers which they use, then providers, in turn, will become more cost sensitive in order to attract more consumers.

5. Both public and private employers should adhere to a "choices" strategy. But it is particularly important that the public sector do so so now, to set an example and contain costs.

It would be inconsistent for the public sector not to be willing itself to implement recommendations for cost containment when it has urged them upon the private sector.

While the recommendations below are directed primarily at the State of Minnesota as the state's largest public employer, they are equally applicable to city, county, and regional governmental entities.

a. The State of Minnesota and other public employers should give their employees choices among different levels of insurance coverage.

To a certain extent, the state has begun to do this. Recently agreed-to labor contracts limit the state's contributions for health care premiums, offering employees an incentive to pick cheaper coverage. However, the state's approach does not offer cafeteria style benefits, incentives to use lower cost providers or plans to redistribute resulting cost savings. Both the state and its employees could benefit under such arrangements and some tax dollars could be conserved.

Consistent with our recommendation to the private sector then, we would also urge the public sector to offer "fair market choice" to its employees. This can be achieved if the state would offer three levels of coverage (high, low and medium) and make an equal dollar contribution to the plan of the employee's choice. (Again, it would be best, if the state kept its contribution independent of the choices themselves.)

It should be noted that the Federal Employees Health Benefits Program operates along identical lines to what has been suggested here. That program, which covers more than 10.5 million federal employees, retirees, and dependents has received consistent praise from competition theorists. The program offers both conventional and prepaid plans to which the government contributes a set percentage of the six largest plans. In 1978, for example, the government contributed 60% of the premium cost or about $58 per family per month. Employees paid the rest out-of-pocket.

b. The State of Minnesota, and other public employers, should set reimbursement limits for given medical conditions. Such reimbursement determinations should contain some relation to a standard price for a given medical service in the state employee's community.

c. Public employees' out-of-pocket expenses should then vary depending upon whether they use providers whose prices are higher or lower than the reimbursement schedule limits.

If state employees are willing to use providers whose charges are at or below the established reimbursement schedule rate, they should be allowed to retain first-dollar coverage or get a reduction in their co-insurance. State employees who choose to use providers whose charges are higher than the reimbursement schedule rates should be required to pay a higher rate of co-insurance and all or part of the difference in cost.

d. The Governor's Task Force on Medicaid expenditures should consider whether these strategies are applicable to the state's Medicaid population. Specifically, the Task Force should determine whether the State of Minnesota should seek federal waivers that would allow it to impose a fixed budget on the Medicaid program. The program's free choice of vendor policy should be retained but a co-pay provision should be added in instances where care is

obtained from a provider whose costs are above reimbursement schedule limits.

With these kinds of changes, the Medicaid program could work in much the same way as our earlier strategies. The State of Massachusetts has already asked the federal government to let it impose a fixed budget on Medicaid costs. Under the Massachusetts plan and our scheme, the state Legislature would set an overall spending cap for the program.

Next, the state could apply the same reimbursement limits to Medicaid recipients' medical care as it would offer its own employees. Prices of area providers should be made known to recipients and they would be encouraged to "shop" for care. *Those who choose the less costly provider would experience no out-of-pocket costs and may even receive a direct cash benefit.* Those who choose to utilize higher cost providers would be asked to pay an income-adjusted differential between the negotiated rate and the provider's actual charges. The state might even consider establishing a special fund in which to deposit savings achieved under this strategy. That fund could then be earmarked to assist existing income transfer programs operating in the state.

e. The State of Minnesota should explore the feasibility of expanding the application of this strategy to other areas, such as Medical Assistance recipients and Workers Compensation cases.

6. To provide for ease of market entry, certificate of need for hospitals should be eliminated.

The certificate of need process was meant to be a rationalizing control mechanism which would limit new capital construction projects in the region's health care system on a selective basis.

However, the certificate of need process has only been selective in the sense of allowing existing providers to rebuild or expand while at the same time effectively barring all others from the market. Thus, certificate of need quickly became a franchising mechanism, protecting existing providers from competition from alternative providers such as for-profit hospitals and independent surgi-centers. It has not been very selective in its application to existing providers, as this report has shown. In by far the majority of cases, the certificate of need was approved as submitted or subsequently approved at a later date. About 94% of all certificate of need applications submitted to the Metropolitan Health Board or to the Minnesota Department of Health have been approved.

a. Minnesota should phase out certificate of need for hospitals by 1984 in order to allow new forms of competition to emerge.

The Reagan administration is proposing to eliminate federal funding for Health Systems Agencies by 1983. At that point, it will be up to the states, individually, to decide whether to continue health planning and certificate of need review.

As soon as price and quality information is released to the public and particularly to employers and insurers, they will begin to act on it with shifts in utilization then occurring.

At that point, whether it be sooner than the target date or later, certificate of need will no longer be necessary. It will, in fact, become a hindrance to the competitive system.

Certificate of need should be phased out for three basic reasons:

To expose hospitals to new forms of competition from for-profit institutions and free-standing surgi-centers.

It is apparent that the 1980s will be a period of major adjustment for hospitals, particularly the community non-profit institutions. These hospitals have been likened to America's "big cars" before the advent of competition from European and Japanese economy models.

A recent (June 15, 1981) editorial in the Wall Street Journal stated:

"Data on comparative costs of for-profit and not-for-profit hospitals are extremely thin. However, there is growing evidence that hospital management firms have been able to generate respectable operating margins and pay the taxes and higher financing costs associated with their for-profit status, while keeping their charges to the patient competitive with, or in some cases, even lower than their not-for-profit neighbors."

As for free-standing surgi-centers, the May 22, 1981 edition of the Federal Register cited a Health Care Financing Agency (HCFA) study showing that these institutions charge 55.3% less than hospitals and 18% less than hospital outpatient treatment. These institutions would handle patients who need only minor surgery and then go home later in the day. Such free-standing surgi-centers will also help to reduce inefficient and costly waiting time to use hospital surgery rooms. Waiting time often wastes surgeon's time and patient's money.

Proposals have been made to build free-standing surgi-centers in Golden Valley and Coon Rapids. In August, the Metropolitan Health Board denied a certificate of need for a proposed surgi-center in Golden Valley. Vigorous, organized hospital opposition accompanied each proposal.

To expose existing hospitals to competition following redistribution.

Many people have speculated that the elimination of certificate of need would lead to a spate of new hospital construction projects. We doubt that anyone can know now exactly what would happen were certificate of need to be removed. New hospitals probably would be built. Some hospitals might close. The end result would be more competition, less excess capacity, and better access to care for the region as a whole.

To increase the hospital's ability to succeed in a competitive marketplace.

The Summary Report of Roundtable Discussion at the Twin Cities Hospital Trustee Conference (Wednesday, May 6, 1981) made the following observation:

"If the buyers of services have price and quality information and are encouraged to make free choices, then hospitals must have the same freedom in deciding what services they will sell and how they are to be packaged. Hospitals will need the freedom they do not now have–to be able to compete at all levels."

This seems reasonable. Under the current certificate of need process, even the most efficient hospitals are prevented from adding new services quickly because of the prevalence of the belief that to allow them to do so would cause "duplication." At the same time, many less efficient hospitals are allowed to offer the same service at utilization rates that are often less than optimal. The current system then "props up" inefficient providers. Changing that would allow the more efficient provider to compete more readily with its less efficient rivals.

Because private practice physicians are currently exempted from the certificate of need process, eliminating that mechanism will help hospitals compete with physicians on an equal basis.

b. Minnesota's certificate of need law should be changed during the phase-out period to encourage a competitive system.

Although certificate of need should be eliminated by 1984, it should be redirected in the short term to encourage competition.

The following three recommendations can serve to facilitate that development:

- Ambulatory surgi-centers and all free-standing ambulatory programs, including birthing centers, should be exempt from certificate of need.
- The threshold limits for new capital expenditures (equipment, new services, etc.) requiring certificate of need should be increased.
- Any hospital or proposed facility able to demonstrate that it is operating or can be expected to operate at or below the 50th percentile of its Rate Review group should be granted an automatic waiver from the certificate of need process.

7. Some public body with an interest in regional health care cost containment ought to determine when and under what circumstances tax-exempt financing for new construction should be granted.

Some people fear a situation in which unrestricted capital investment would flow into the health care system were certificate of need to be eliminated. Clearly that would not be desirable. So there is a need, and a legitimate one, to put more risk into the capital acquisition process than is currently present. Therefore, we offer the following comments:

There has been a rapid trend toward the use of the state's industrial development revenue bond laws for the financing of hospitals. The tax exempt feature of these debt instruments means lower interest costs to the borrower. In 1978 Minnesota law was specifically amended (by Chapter 609) to authorize the use of these industrial development revenue bonds for hospitals and other health care facilities.

There is admittedly ample room for substantive debate over whether this practice should be totally discontinued or modified somewhat to continue to allow projects deemed to be in the public interest to enjoy the benefit of the tax exemption.

We do not now urge the State of Minnesota to repeal that 1978 amendment to the law, though this is an issue we believe could usefully be discussed in the community as a part of the growing interest in the potential for a "market forces" approach to restraining costs in the health care and hospital system. There might be some discussion with the federal government, as well, about the consistency of its effort to restrain expenditure on hospitals, and its encouragement of such investment through the tax exemption.

Our conclusion is that some more limited version of tax-exempt hospital revenue bond financing should remain. This conclusion was based on two potential impacts of outright elimination:

- Outright elimination of tax-exempt financing might prohibit an existing non-efficient provider from generating enough capital to change roles, thereby making it more difficult for that provider to leave the acute care business.

- Outright elimination of tax-exempt financing contains an implicit bias against all forms of new construction that could lead to serious dilapidation of needed existing facilities.

Thus, while some new hospital construction is not in the public interest, there is, at the same time, some that is. A regional public agency that is mindful of the need for cost containment should determine when the public interest can best be served by granting the tax exemption and when that privilege should be refused or qualified.

The use of tax-exempt revenue bond financing for hospital construction should be continued but the responsibility for authorizing its use should be modified as follows:

a. By 1984, Minnesota law should be changed to provide that industrial development bonds for (and only for) hospital projects be issued, within the Twin Cities area, not solely by a municipality but by, or with the approval of, the Metropolitan Council, on the recommendation of the Metropolitan Health Board.

The Citizens League first made this recommendation in 1980. It deserves even more consideration now, as an integral part of the competitive strategy contained in this report.

This change would simply create a correspondence between the jurisdiction authorized to issue tax-exempt bonds and the jurisdiction that is, both under state and federal law, responsible for health care and hospital planning. It would also open the way for questions about the financing of a proposed hospital project to be brought more fully into the discussion about its approval, including perhaps, the possibility that a municipality or group of municipalities seeking hospital construction or reconstruction might themselves provide funds to cover some portion of the total capital cost.

The effect of this recommendation would argue for the establishment of a regional Health Care Financing Authority. Unlike the certificate of need process, however, decisions regarding approval of tax-exempt financing for a project should be made more on the basis of financial feasibility of the project than on subjective "need" criteria. It should have staff capable of performing financial feasibility analyses which the current Health Board lacks. An additional advantage would be that, just as municipalities do now, the HCFA would have the authority to impose conditions on the granting of tax-exempt financing.

There might be occasions when the HCFA would find it necessary to refuse the request. There might be occasions when the HCFA would limit the use of tax-exempt financing to some proportion of the total project cost thereby forcing the provider to demonstrate market or philanthropic support for the rest.

The HCFA would have the authority to impose such conditions on the granting of tax exempt financing as it deemed appropriate. Such standards might be performance-related in order to reward the most cost-efficient providers or they might require a reduction or a redistribution of beds as a pre-condition to the awarding of tax-exempt revenue bonds. One obvious criterion would be whether a given provider's prices were unjustifiably higher than community norms.

With certificate of need eliminated, there will be nothing to prevent hospitals from remodeling, expanding, or even building or rebuilding so long as they can secure the capital to do so. However, informed observers appear increasingly convinced that access to capital will be the biggest single issue facing hospitals in the 1980s. This would seem to be even more apparent in light of trends, already emerging, which indicate that capital allocation will tend towards business and industry to stimulate greater productivity and employment opportunities and away from human services.

There will be nothing to force hospitals to seek tax-exempt financing from the Metropolitan Health Board. They will be free to raise that capital in the open market, if they can. Otherwise, they will be forced to demonstrate their competitive ability to the HCFA and abide by such conditions as may be imposed.

Although this recommendation only concerns who should decide whether tax-exempt financing should be granted, we believe the entire question of the use of tax-exempt financing needs further study.

b. The newly formed Metropolitan Council committee examining the Health Board's future role should consider these recommendations in its deliberations.

This report has maintained from the outset that the future health care system must contain a hybrid or combination of competitive and regulatory forces working together in

fundamentally new and different ways.

There needs to be a body which can serve as a catalyst in implementing the kinds of structural changes which need to occur if a competitive system is to develop. That body should anticipate the shortcomings of a competitive system and suggest policy responses to minimize them. In that sense what seems needed is some kind of an ongoing public oversight function to insure that competition occurs and is maintained over time.

Logically, this function is not one which the market could be expected to fill on its own. Logically too, the actor filling that role ought to be one which has a broader perspective of the health care system than the many private groups involved. Since the utilization of health care facilities transcends municipal governmental jurisdictions, the appropriate body to carry out these functions should be regional in nature. The Metropolitan Health Board should play this role. To do so, however, its philosophical perspective, its role, and its powers must be changed.

As the Metropolitan Council's committee examines the future role of health planning in our community, it should consider changing the role of the Metropolitan Health Board to reflect the responsibilities cited below:

- Collection, interpretation and dissemination/disclosure of health care data on price and quality. The Health Board should continue to help the community interpret the kinds of information which we have recommended be released. Its ongoing perspective is needed and useful but it should not provide the only perspective. Some provider group should be able to supplement the Board's comments with interpretive suggestions of its own.

- Encouragement of a competitive health care system and evaluation of the region's progress towards that goal.

- Authority to issue Tax Exempt Hospital Revenue Bonds. The Health Board might usefully take on this function basing its decisions on such competitive criteria as it will develop and on economic feasibility analyses. The Board would have the authority to grant 100% tax-exempt financing for a project, partial funding, or apply such conditions on the project as it feels appropriate in order to promote cost containment, and competition. Tax-exempt revenue bonds should also be offered to those institutions seeking to change their role and get out of the acute care marketplace.

In the context of these possible responsibilities, we encourage the Metropolitan Council committee to address some broader and more specific issues:

- The future of the Health Board in a competitive health care system.

- How the Health Board should be funded in the future.

- Staff requirements.

- How the Board's existing activities will fit with future activities.

- Whether the Board should play a proactive or reactive role.

- What kinds of criteria and conditions the Board should use in considering provider requests for tax-exempt hospital revenue bonds. Whether a regional goal figure for tax-exempt bonds should be set and, if so, what that limit should be.

- What the composition and representation of the Board should be.

HOW WILL THIS STRATEGY AFFECT EXCESS CAPACITY?

If all or even some of the changes recommended in this report are implemented, they will have profound effects on the Twin Cities health care system.

Once price and quality information is made known to the public and to employers, it may become evident that large price differences exist among providers. Given the incentives suggested in this report, utilization could then shift to favor the lower cost, efficient providers at the expense of more inefficient providers. As a result, it is probable that the prices of these more inefficient providers will rise. In a competitive system in which pricing information is available, that will be a clear signal to the community that an institution is in serious danger of becoming noncompetitive.

In addition to the potential for major utilization shifts to occur, hospitals and other health providers will have to meet the challenges of new forms of competition. If certificate of need is, in fact, eliminated, the barrier to market entry for alternative providers such as independent surgicenters, for-profit hospitals and others will have been removed. New kinds of providers may, and probably will, enter the system. The amount of excess capacity in the present system may very well be an attractive inducement for that to occur.

Finally, if this report's recommendations regarding tax-exempt hospital revenue bonds are implemented, there will be more competition for capital at a time when capital is likely to be scarce. Providers seeking capital need not submit to a mandatory regulatory process to obtain it. They may appeal directly to the market. If, however, access to a *public good* is sought, then providers must be willing to submit to a public process of review by a public agency. That is as it should be. Either way, more risk will accrue to providers.

If a provider is unable to secure access to the capital it seeks at the rate it desires, it will have little choice but to raise its rates. Higher rates should raise a "red flag" to potential consumers, providing them with incentives to seek care in other institutions.

In sum, creating incentives to shift consumers' utilization to the more efficient providers, forcing existing providers to compete with new market entrants and placing some restrictions on the availability of capital could stimulate market conditions that would, quite literally, place inefficient providers at risk of pricing themselves out of existence.

ABOUT THIS REPORT

CITIZENS LEAGUE PROCEDURES

Each year the Citizens League Board of Directors adopts a research program with several topics based upon their importance to the community and the potential contribution of the League studies. An ad hoc committee of the Board of Directors then develops a specific charge or assignment for a study committee, which is made up of members of the Citizens League who have been given an opportunity to participate through an announcement in the League's biweekly newsletter.

Under the League's constitution and by-laws, the Board of Directors approves all League reports and position papers before they become official League policy and are released to the public. However, the chairman and members of the committee are frequently asked to help explain the report to the community.

TASK FORCE ASSIGNMENT

Since its beginning in 1952, the Citizens League has been actively involved in health related issues.

In the early 1970's the League produced a report entitled "Hospital Centers and a Health Care System." That report eventually lead to the linking of Hennepin County Medical Center and the Metropolitan Medical Center as a means of containing costs and lowering excess capacity.

In 1977, the League's report "More Care About the Cost In Hospitals" proved to be a seminal document and spurred many efforts by the Metropolitan Health Board and hospital trustees to reduce beds and contain costs.

In the years following the issuance of that report the League became increasingly aware that the regulatory system did not seem to be having a significant impact on the health cost problem. So, in 1980, the League Board of Directors gave its Health and Hospitals Task Force the following charge:

"Specifically, the task force is assigned to design a market forces strategy for restraining spending in the hospital system as an alternative to the current reliance on certificate-of-need reviews. Pursuing this strategy represents a follow-up to the 1977 report which concluded that market forces are preferable to administrative regulation."

The task force viewed its task as answering essentially two questions: 1) Would a competitive system facilitate a greater degree of cost containment than the present regulatory system and 2) If so, what would a health care system controlled through market forces look like? (i.e., what kind of a strategy should be employed to bring such a system into being?)

TASK FORCE MEMBERSHIP

Thirty-four people originally signed up for this task force. The task force had the active participation of thirteen members. Professional staff assistance was furnished by David Hunt, with Judith Cavegn and Paula Ballanger providing secretarial and administrative assistance. The printing of this report was done by Joann Latulippe. The members are:

Charles Neerland, Chairman
C. Robert Beattie
Bill Blazar
Tom Galligan
Arthur Gillen
Marlene Grant
Glen Hendricks
Ron Johnson
Wilbur Maki
Belle Scott
James Shaw
Harry Sutton
Paul Zerby

TASK FORCE PROCEDURES

The task force met twenty-four times from September 23, 1980 to September 18, 1981. Each task force meeting lasted approximately 1½ hours. All task force meetings were open to the public and were well attended by Health Board staff and representatives of various community providers.

The task force spent the first phase of its work taking testimony from numerous community resource people whose names appear below.

In the second phase of its work the task force came to a common concensus on its definition of what the elements of a competitive system would be. (These competitive elements are listed in the Findings portion of the report.)

During the final phase of its work, the task force concluded that a system based on market forces would indeed attain a greater degree of cost containment than the present regulatory one and began to formulate a competitive strategy to recommend to the community. That activity culminated in the present report.

One member of the task force, Art Gillen, dissented from the task force's recommendation regarding tax exempt financing. Mr. Gillen believed that the evidence heard by the task force was inconclusive with regard to this issue and that, therefore, the issue should not have been further pursued. (Other committee members disagreed with that perception.) With the exception of that issue, Mr. Gillen was in fundamental agreement with the thrust of the report.

The names of the various resource persons from the community who met with the task force are listed below. Their participation and insights are gratefully acknowledged:

Gary Appel, President, County of Community Hospitals
Andrew Czajkowski, Senior Vice President for Underwriting, Statistics, and Membership Division, Blue Cross/Blue Shield of Minnesota
John Dilley, Director, State Health Planning and Development Agency, State Planning Agency
Charles Ego, Vice President of Finance, Health Central Inc.
Louise Forseth, Legislative Assistant, Senator David Durenberger
Richard J. Frey, MD, Chairman, Minnesota Coalition on Health Care Costs
Stuart Hanson, MD, President, Metro Physicians Task Force
Coral Houle, past Chairman, Metropolitan Health Board
Richard Keck, Director, Health Planning, Health Central Inc.
Professor Robert Kudrle, Hubert Humphrey Institute of Public Affairs, University of Minnesota
Walter McClure, President, Center for Policy Studies
Malcolm Mitchell, Executive Director, Metropolitan Health Board

The following people assisted in the research through private contact with staff:

Marion Adcock, Vice President, Planning and Special Projects, Council of Community Hospitals.
Marvin Borman, past President, West Metro Hospital Trustee Council, Senior Partner, Maslon, Kaplan, Borman, Brand & McNulty
Robert Christenson, past President West Metro Hospital Trustee Council, Sales Assistant Towle Corp.
Arthur Cobb, Consultant, Peat Marwick and Mitchell
Linda Ellwein, Vice President Corporate/Community Group, InterStudy.
William Flexner, President, Flexner and Associates
Phil Griffen, Committee Administrator, Minnesota House Health and Welfare Committee.
Pat Harger, Director, Corporate Planning, Fairview community Hospitals
John Harris, past President, West Metro Hospital Trustee Council, Partner, Briggs & Morgan
William Howard, Assistant Commissioner of Insurance, State of Minnesota
John Hurly, Senior Health Systems Planner Implementation, Metropolitan Health Board
Allan Johnson, Director, Research and Information Systems, Council of Community Hospitals
James Kenney, Executive Director, Minnesota Coalition on Health Care Costs
Lenore Kligman, Senior Research Analyst, Minnesota Hospital Association
Ted Kolderie, Senior Fellow, Hubert H. Humphrey School of Public Affairs, University of Minnesota
Katherine Lamp, Legislative Analyst, Minnesota State Legislature
George Lohmer, Director, Department of Health Planning, Minnesota Medical Association
Mara Melum, Vice President, Planning and Regulation, Minnesota Hospital Association
LuVerne Molberg, Staff Consultant, West Metro Trustees Council
Barbara O'Grady, Chairperson, Metropolitan Health Board
Robert Provost, President, Minnesota Insurance Information Center
Paul Riddle, Associate Director, Metropolitan Health Board
Kathy Tue, Associate Health Systems Planner, Generalist Metropolitan Health Board

SUMMARY

In 1977, the Citizens League published a report entitled "More Care about the Cost in Hospitals." That report concluded that the metropolitan area had too many hospitals and hospital beds for a community of our size and demographic characteristics and recommended that, both through voluntary and regulatory efforts, this excess capacity be eliminated.

These past four years have seen increasing attention to this issue. And some of the excess capacity has been trimmed. In the meantime, many interested observers, including the League's Board of Directors, began to wonder whether the problem really was excess capacity or more a matter of fundamental market failure. In 1980 a task force was commissioned to explore the potential for controlling costs through competitive market strategies.

Now, at every level of society, questions are emerging over limits. How much, as a proportion of total resources, should we allocate for health care industry? Clearly, few industries can compare with the technological advances made in the health care field in recent years. More machines, advances in biochemistry, breakthroughs in fundamental understanding–these have all combined dramatically to expand the treatment potential for disease. But it has also become more expensive. While inflation pushes prices of everything higher, the prices for health care have risen at even faster rates.

The Twin Cities metropolitan area is in 1981 at a crossroads in its policy debate over how to control health care costs. This situation is especially evident in the growing controversy between the Metropolitan Health Board and the hospital community. The Health Board, for its part, is suggesting numerous regulatory strategies for reducing the size of the region's hospital system. The hospitals, in turn, contend that the Health Board should refrain from making decisions which pre-empt the fundamental rights of the affected hospitals.

The 1981 League report contends that, while both regulatory and voluntary actions have been somewhat effective in reducing excess hospital beds, neither will, in the long run, be able to succeed in bringing health care costs under control. To do that, the report contends, our community must refocus its attention away from excess capacity and toward the larger problem of our essential failure to operate this industry as a rational market. Until now, the dominant means of dealing with market failure has been through various regulatory mechanisms which exerted pressure on the supply side of the health care equation. These mechanisms have focused, for example, on the number of excess or underutilized hospital beds in the community. If our community is to succeed in its attempts to control health care costs, a new strategy is needed: market reconstruction.

The report calls for controlling health care costs through strengthening the health care marketplace itself. It focuses on the demand side, rather than the supply side, contending that in the future the key to cost containment will lie less in affecting hospitals' and other providers' behavior than in affecting the environment in which they must operate.

Accordingly, the Citizens League recommends a new, demand side kind of strategy:

First, we would encourage real price competition through widespread dissemination of providers' prices. The fact that this is not done today has resulted in widely different charges for nearly equivalent medical procedures. Once prices are released, health care consumers will become better informed of what the community norm is for a given medical service and which providers offer comparable quality at competitive prices.

Second, the report recommends that the U.S. Congress place a limit on the tax exclusion of employee health benefits, to give consumers a true choice between additional income and additional insurance. Present methods of purchasing health insurance give consumers no such choice, a condition due principally to the tax free nature of insurance benefits. The more extensive the breadth of health insurance benefits are, the fewer the incentives for health care providers to deliver services as efficiently as possible.

Third, in order to provide incentives to employees to purchase no more health insurance than is needed, the report

recommends that employers offer different kinds of plans to their employees. Employers should offer plans with different levels of coverage and make an equal dollar contribution to each. If employees select plans with broader coverage, they should have to pay more out-of-pocket.

Fourth, because prepaid health insurance plans appear to purchase health care in a cost-effective manner, the report urges employers to offer employees a choice between prepaid insurance plans and conventional insurance. Recognizing, however, that 75% of the Twin Cities area population purchases care through conventional insurance, the report suggests several ways to structure these plans so that consumers have incentives to use the health care system in a cost-conscious manner.

Fifth, regardless of which conventional plan the employee chooses, his out-of-pocket costs should vary depending upon his willingness to use a provider whose charges are at, or below, community norms. For example, co-payment provisions could vary depending upon whether the consumer utilized a provider where charges were greater or less than community norms for a given diagnosis. If a lower cost provider were used, the consumer would make a lower co-payment or could receive first-dollar coverage. If a higher cost provider were used, he would face a higher co-payment. In order to promote price competition at the level of the prevailing community norm for a given diagnosis, the report urges employers and insurers to set limits on reimbursement systematically related to the median price for a given procedure by community providers.

The report also suggests two supply-side policy changes to complement the demand-side recommendations. First, it recommends that if consumers are to be expected to make more purchasing decisions themselves, they must be able to choose from many different types of products. To that end the report argues that consumers ought to be able to choose nontraditional or alternative providers, such as independent surgi-centers or for-profit health care organizations. In order for such choices to be made, however, it must become easier for these providers to enter the market. To facilitiate such entry and subject existing hospitals to these new forms of competition, the report recommends eliminating certificate of need by 1984.

The second supply-side recommendation concerns the flow of new investment into the hospital system. Over time, much of the risk of new investment has been removed through government subsidies and the availability of tax-exempt revenue bond financing. The report argues that limits should be placed on the use of tax-exempt financing by moving the authority to grant such requests from the municipal level to the regional level. Since this form of financing implies a subsidy judged to be in the public interest, the League report argues that it should be financed by a public body with an interest in cost containment. This recommendation would give additional powers to the Metropolitan Health Board, granting explicit authority to place conditions on the use of tax-exempt bonding and the authority to vary the percentage of financing that can be tax-exempt. For example, the Board could require that the requesting provider demonstrate private financial or philanthropic support for a certain percentage of the proposal, and award tax-exempt financing on some performance basis, or it might do so in order to facilitate the entry of alternative providers in the system for competitive reasons.

Taken as a whole, the report attempts to structure incentives into the health care marketplace that will reward efficient providers and introduce realistic financial risks for all providers. It encourages consumers to take a more active interest in their own health care costs and provides numerous forms of assistance and financial incentives to do so. It insists that if we are ever to succeed in arresting the growth of health care costs, we must be willing to put in place incentives for providers, insurers, and consumers to make cost-conscious decisions.

EMERGING POLICY ISSUES SUGGESTED BY THIS REPORT

1) How will and should we pay for medical education in this state? Should it be publicly funded or privately funded? At what level? To what extent should future health professionals be required to finance their own education? What will be the consequences to the public teaching hospitals under a competitive system if this question is not addressed in the near future? Would they be placed at a competitive disadvantage?

2) What will be the future of the public, county teaching hospitals? Will they be needed? Can we afford them? Should their roles change?

3) Is there a need for the State of Minnesota to determine what the minimum level of health insurance coverage should be? (i.e., what level of coverage is needed to provide an adequate floor?)

4) Is there a need for the Minnesota State Legislature to re-examine its current mandatory benefit laws in light of our finding that such laws fuel overconsumption of health care resources and deter consumer cost-consciousness?

5) Is there a need to make existing insurance laws uniform so that they affect all carriers in the same way and thereby contribute to a competitive situation in which no carrier has a competitive advantage? (i.e., so that both traditional insurers and HMOs are required to comply with the same basic regulations or restrictions.)

6) Is there a need to re-examine laws which prohibit firms from joining together for the sole purpose of buying insurance?

7) What kind of role should the physician be required to play in a competitive health care system? How should physicians be compensated for their services? Should substantial modifications be made in the usual and customary fee for service system?

WHAT THE CITIZENS LEAGUE IS

Formed in 1952, the Citizens League is an independent, nonpartisan, nonprofit, educational corporation dedicated to understanding and helping to solve complex public problems of our metropolitan area.

Volunteer research committees of the Citizens League develop recommendations for solutions after months of intensive work.

Over the years, the League's research reports have been among the most helpful and reliable sources of information for governmental and civic leaders, and others concerned with the problems of our area.

The League is supported by membership dues of individual members and membership contributions from businesses, foundations and other organizations throughout the metropolitan area.

You are invited to join the League, or, if already a member, invite a friend to join. An application blank is provided for your convenience on the reverse side.

WHAT THE CITIZENS LEAGUE DOES

RESEARCH PROGRAM

- Four major studies are in progress regularly.
- Each committee works 2½ hours per week, normally for 6-10 months.
- Annually over 250 resource persons made presentations to an average of 25 members per session.
- A fulltime professional staff of seven provides direct committee assistance.
- An average in excess of 100 persons follow committee hearings with summary minutes prepared by staff.
- Full reports (normally 40-75 pages) are distributed to 1,000-2,000 persons, in addition to 3,000 summaries provided through the CL NEWS.

CL NEWS

- Four pages; published every other week; mailed to all members.
- Reports activities of the Citizens League, meetings, publications, studies in progress, pending appointments.
- Analysis, data and general background information on public affairs issues in the Twin Cities metropolitan area.

PUBLIC AFFAIRS ACTION PROGRAM

- Members of League study committees have been called on frequently to pursue the work further with governmental or nongovernmental agencies.
- The League routinely follows up on its reports to transfer, out to the larger group of persons involved in public life, an understanding of current community problems and League solutions.

COMMUNITY LEADERSHIP MEETINGS

- Held from September through May.
- Minneapolis breakfasts are held each Tuesday at the Grain Exchange Cafeteria, 7:30 - 8:30 a.m.
- Saint Paul lunches are held every other Thursday at the Landmark Center, noon to 1 p.m.
- South Suburban breakfasts are held the last Friday of each month at the Lincoln Del, 4401 W. 80th Street, Bloomington, 7:30 - 8:45 a.m.
- An average of 35 persons attend each of the 64 meettings each year.
- The programs attract news coverage in the daily press, television and radio.

QUESTION-AND-ANSWER LUNCHEONS

- Feature national or local authorities, who respond to questions from a panel on key public policy issues.
- Each year several Q & A luncheons are held throughout the metropolitan area.

PUBLIC AFFAIRS DIRECTORY

- A directory is prepared following even-year general elections and distributed to the membership.

INFORMATION ASSISTANCE

- The League responds to many requests for information and provides speakers to community groups on topics studied.

Citizens League non-partisan public affairs research and education in the St. Paul-Minneapolis metropolitan area. **84 S. Sixth St., Minneapolis, Mn. 55402 (612) 338-0791**

Application for Membership (C.L. Membership Contributions are tax deductible)

Please check one: ☐ Individual ($20) ☐ Family ($30) ☐ Contributing ($35-$99) ☐ Sustaining ($100 and up) ☐ Fulltime Student ($10)

Send mail to: ☐ home ☐ office

NAME TELEPHONE

ADDRESS

CITY STATE ZIP

EMPLOYER TELEPHONE

POSITION

CL Membership suggested by

(If family membership, please fill in the following.)

SPOUSE'S NAME

SPOUSE'S EMPLOYER/TELEPHONE

POSITION