

Information Brief

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STATE EFFORTS TO CONTAIN COST INCREASES
IN THE ACUTE HEALTH CARE SYSTEM

This Information Brief summarizes efforts by the state to control increases in the cost of health care in the acute care system, by using the state's authority as an employer, as a regulator and as a payor under assistance programs.

For related information on long-term care as distinguished from acute care, see Kathy Lamp, "Long-Term Care", Research Department Information Brief (1983).

The "acute care" system is that part of the total health care system which is concerned with diagnosis and treatment of individual occurrences of illness, trauma or recovery from surgery. Acute care services are usually provided for each occurrence in a hospital, physician's office or alternative site.

In January, 1985, the Commissioner of Health will present to the Legislature a report with recommendations for containing cost increases in the acute care system. The Commissioner, as directed by the Legislature, will propose:

- a) a mechanism to constrain expansion of the service capacity of the acute care system by means of specific and quantifiable prospectively determined limits;
- b) a mechanism to prospectively limit charges for acute care services; and
- c) any other related proposals the Commissioner wants to recommend.

Rising health care costs have been a legislative concern for several years. Public attention has been focused more on recent legislative efforts to constrain long-term care cost increases and efforts to address acute care concerns have been overshadowed. Repeal of the state's certificate-of-need legislation and the continuing escalation of acute care costs shifted public interest back to these issues and prompted the Legislature to require the report and its recommendations for deliberation during the 1985 session.

The remainder of this Information Brief summarizes actions already taken by the state to contain acute health care costs. These actions necessarily provide a foundation upon which any future legislation can build.

COST CONTAINMENT METHODS

The state sees the effect of acute care cost increases from several perspectives: as an employer, as a regulator and as a payor under assistance programs. Its response in each case is reflective of these three different perspectives, as well as the scope of authority available to the state to act in each role.

State as Employer

The state provides health benefits for approximately 47,700 employees. The Legislature has indirect involvement in the development of the benefit package by providing general guidelines for the collective bargaining process. The Department of Employee Relations negotiates the health benefits directly with the employee representatives and the insurance and HMO carriers.

Cost containment initiatives introduced by the state as employer:

- o The state's contribution to state employees' health and dental benefit plan is a flat rate based on the Blue Cross and Blue Shield or Delta Dental monthly premium rate. (1981)
- o State employees may select a health maintenance organization (HMO), a preferred provider organization (PPO) (which is a plan that limits the number of provider participants, and requires them to practice in a cost effective manner), and the traditional fee-for-service plan. (1983)
- o Employees choosing the fee-for-service plan are subject to the following conditions:
 - The medical/surgical benefit pays 90% of the usual, customary and reasonable charges as defined in the adopted reimbursement schedule.
 - Outpatient mental health and chemical dependency treatment requires an annual out-of-pocket cost of \$1,000 per employee or \$1,500 per family.
 - Employees have an incentive to choose hospitals participating in the Blue Cross AWARE program (a modified PPO) because they are responsible for any charges that exceed the charges that would have been paid for the same service at a participating hospital. This same incentive applies to a plan limiting physicians' charges as well.
 - Employees are covered for hospice and licensed birthing center services. (1983)

State as Regulator

The Legislature establishes health care policy for the state. Statewide concerns and the needs of special populations are balanced within the political process. Cost containment efforts reflect compromises between various interests with different approaches to solving a common problem.

The state has legislation to regulate the following areas:

- o A three-year moratorium has been placed on expansion of the hospital system by prohibiting construction of new hospitals, relocation of existing hospitals or certification of new hospital beds. (1984)
- o The Commissioner of Health has been given authority to analyze and disseminate price information related to the treatment of common diagnoses in hospitals and outpatient surgical centers. The Commissioner can also collect, analyze and disseminate information concerning the financial state of each hospital and outpatient surgical center. In addition, licensed health practitioners are required to post the prices for treatment of the twenty-five most common diagnoses seen by practitioners in each profession. (1982)
- o HMO development has been encouraged. (1974)
- o Legal barriers to PPO development were removed by allowing insurers to discriminate in reimbursement for enrollees who agree to receive services from specified health care providers. (1983)

State as Payor

The state pays for health care benefits for low income persons through two major programs: medical assistance, the federal-state-county financed Medicaid program, and general assistance medical care, a state-county financed program for people not eligible for the medical assistance program. Costs of these programs have increased 118.2% since 1977, primarily because of nursing home cost increases. Because these two programs represent almost 9% of the total state budget, the Legislature has made major changes in reimbursement policies and procedures to contain the cost increases and reduce expenditures that also affect acute care costs.

The state as payer has taken the following actions with respect to these programs:

Medical Assistance

- o Reimbursement for inpatient hospital services has been prospectively based on a rate per admission. A reimbursement system based on a diagnosis classification system appropriate to the service population is being developed. (1983)
- o The annual increase in payment rates to hospitals has been limited to a specified percentage (5% for the current biennium). (1983)

- o Outpatient hospital services have been reimbursed at the same rate as similar services provided in physician offices or by other non-institutional providers, except in the case of initial triage, emergency services and for services not provided or available from other providers. (1983)
- o A second medical opinion has been required prior to reimbursement for a list of elective surgeries specified by the Commissioner of Human Services. (1983)
- o Funding for a more effective statewide utilization review program, both pre-payment and post-payment, has been increased. (1983)
- o HMO enrollment has been encouraged through financial incentives for county participation. (1981)
- o The Commissioner of Human Services has been directed to apply for federal waivers to expand the availability of community-based, non-institutional services for the elderly, the mentally retarded, the disabled and the chronically ill. A waiver has been received and a program of alternative care is in place for the elderly and mentally retarded populations. (1981 and 1983)
- o The Commissioner of Human Services has been directed to participate in and/or develop demonstration projects involving the application of pre-paid reimbursement systems to care for the MA population. One project will limit the recipients' choice of provider to specific case managers and another will provide a continuum care that includes hospital and nursing home services. (1983)

General Assistance Medical Care

- o Eligibility has been tightened to decrease the categories of people who could qualify for assistance, and the medical services have been reduced from the 31 services available under medical assistance to a few considered most essential. (1981)
- o Payments for inpatient and outpatient hospital care for chemical dependency or mental illness have been reduced to 70% of the MA payment rate, and payments for all other inpatient hospital care have been reduced to 80% of the MA rate. (1981 and 1983)
- o County boards have been permitted to select and contract with organizations to provide GAMC services on a prepaid basis. For such contracts payments have been the same as prepaid MA services. (1981)