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CONSUMER HEALTH PERSPECTIVES

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NYS HOSPITAL RATE-SETTING THE ABUSE OF POWER

In past publications the Consumer Commission has explained, analyzed, exposed and criticized the State of New York's policy to starve out of existence hospitals in poor and medically underserved areas. Two important events have recently occurred which we feel our readership should be made aware of :

The Establishment Documents Our Case

First, Walter McClure and Lenore Kligman, established experts in the area of policy options aimed at reducing health care costs, have published "Conversion and Other Policy Options to Reduce Excess Hospital Capacity" (available from the U.S. Department of Commerce, National Technical Information Service) in which New York State is used as one case example. They documented what consumers have been saying all along: closing hospitals by manipulation of reimbursement rates is indeed a State policy and it is most, if not entirely, successful at closing hospitals whose constituencies are neither well-to-do nor politically powerful.

We have not been making it up! It is the policy of the State of New York (and others) to use the power of reimbursement to close hospitals and force consolidations which favor powerful institutions.

McClure and Kligman also found that:

First, since cutting back on reimbursement rates is done across the board to all institutions, the State can claim that it is an objective and equitable policy not targeted at any particular hospital, geographical area or people.

Second, McClure and Kligman discovered that since financial pressure most effectively works to close "weak" hospitals, it may in fact not *be a cost saving device. Patients who might have been treated in lower cost community hospitals are forced to seek care in more expensive, "intense," tertiary care facilities. Indeed, the authors concluded that* closing hospitals was a result of cost containment, not a cause of it. *Something we, and other consumer groups, have been saying for a long time.*

New York State Wants More Power

In August the Office of Health Systems Management (OHSM) of the State of New York made two requests of the federal government:

1. To grant OHSM the power to set Medicare rates at the state level, i.e. for the federal government (the Health Care Financing Administration,

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EXCERPTS FROM *CONVERSION AND OTHER POLICY OPTIONS TO REDUCE EXCESS HOSPITAL CAPACITY**

by Walter McClure and Lenore Kligman

Background

The State of New York has shown continuing concern about hospital capacity since at least 1964, when it became the first State to enact Certificate of Need legislation. This legislation was originally conceived more as a means of rationalizing the hospital system and avoiding duplication than a cost containment measure per se. But with the State's concern over increasing per capita hospital expenditures in 1970, it went on to implement hospital rate controls which remain among the strictest rate controls applied by any State. The New York rate controls permit Medicaid and Blue Cross per diem reimbursement rates to each hospital to rise no more than a specified percentage each year, based upon a formula pegged to the general cost of hospital inputs in the State and the specific costs of that hospital in prior years.

These rate controls were stiffened by legislative amendment in 1976. This formula has placed the hospitals of the State under severe financial pressure, and they have reacted with intense political pressure upon the regulators and the legislators to soften the formula. The State has shown exceptional commitment in refusing to budge. It also went on to pass legislation in 1976 allowing the Commissioner of Health to close any hospital deemed "unnecessary" after proper review. In response to the enabling legislation, the State and the City HSA developed a list of "unnecessary" hospitals in 1976 to serve as a guide for application of the closure authority. This list was based on a similar list compiled earlier by the HSA's precursor, the Health and Hospitals Planning Council of Southern New York, a voluntary, state-supported, area-wide planning council. However, so far ***the State*** has chosen not to use its statutory authority to close hospitals. Rather, it ***has used the financial levers at its disposal and public health inspections to apply indirect pressure to close hospitals. Its strict rate controls and the informal circulation of the list of unnecessary hospitals have been sufficient to close several vulnerable hospitals.*** The list remains unofficial and has never been formally approved or published.

By 1978, the State amended its reimbursement regulations to give the Commissioner of Health authority to temporarily grant higher reimbursement rates to hospitals with an acceptable plan to consolidate and reduce combined hospital capacity (including staff). . . . The State reviews each proposal carefully and uses its discretion so that it does not sustain in any form an institution deemed unnecessary from health and cost standpoints. One reason for the State's continuing tough stance may be the severe financial pressure upon the State generally, and the fact that Medicaid is one of the largest items on the State budget.

The State's concern appears to arise from general financial pressure coupled with high per capita hospital expenditures . . .

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[*Text which we wished to emphasize appears in bold italics.]

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HCFA) to waive its responsibility to establish the rates at which hospitals participating in the Medicare program will be paid;

2. To support a grant application funding OHSM to study how much more money it could save (translation: hospitals and beds it can close) when its current power to set rates for Medicaid and Blue Cross (50% of total inpatient days in New York State hospitals) is increased:

- *a) by 40% of inpatient days if the Medicare waiver (see #1 above) is granted, and*
- *b) by another 10% (making 100% of days) if the next State legislature passes OHSM supported legislation to enable it to set rates for commercial health insurers, labor-management welfare funds and self-pay patients.*

OHSM is moving on both the federal and the state fronts. Their goal is total control of rate-setting in New York State, with federal grant money supporting the operation.

Given the history of OHSM's use of reimbursement as a tool in its hospital-closing-by-administrative-fiat policy, the Consumer Commission has strongly opposed granting the Medicare waiver, funding a rate-setting project in New York State and the passage of legislation giving OHSM rate-setting authority over commercial insurers, union welfare funds and self-pay patients.

In this issue we have reprinted relevant, revealing excerpts from the McClure and Kligman study report, along with the Consumer Commission's letter protesting the Medicare waiver, an excerpt from the Committee of Interns and Residents' letter of protest and a brief discussion of the issues involved in the OHSM bid through the New York State Legislature for total rate-setting control. ■

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The combined effect of cost containment efforts in New York City is still somewhat uncertain... A reasonably careful evaluation of the rate control program in downstate New York by Dowling shows that it may be having some effect.[3]. . After four years of controls, he estimated that annual hospital expenditures were perhaps 5% lower than they would have been without the program (i.e., an annual savings of $50 million in annual hospital expenditures of $1.1 billion in downstate New York). However, the Dowling estimates of savings involve considerable data manipulation and must be regarded as tentative.

There is one significant sign that the rate control program may have greater impact in the future. Dowling found that ***hospitals were incurring significant operating losses and that hospital endowment funds in New York declined from 17% of total assets in 1970 to 5% of total assets in 1974.*** This implies that hospitals have preferred to use their endowment funds to subsidize losses rather than change their ways and become more efficient. ***Since endowment funds will eventually be exhausted, this means many hospitals are being pushed to the financial brink . . . (S)ome have already gone over the edge.***

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Observations . . .

1. *The principal cause that forced retirement of hospital capacity was financial pressure, not planning pressure.*

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2. *Planners and regulators were most effective in reducing excess* hospital capacity when they created and coordinated financial pressure and adverse publicity on hospitals they identified as unnecessary.* Delicensure has not been invoked, and the unofficial PSA list of "unnecessary" hospitals has never been formally stated or used. However, the State does reportedly use the list as a guide in applying the various financial levers at its disposal when the political climate permits. It interprets the rate control requirements strictly to avoid giving undue relief to such "unnecessary" institutions. It increases its surveillance of their medical and plant adequacy. It refuses to give the incentive relief. Publicity attending informal circulation of the list and leaks to the press have brought severe pressure on the identified hospitals; medical staff begin to place patients elsewhere, creditors demand payment and may refuse to extend credit, and there is a general reluctance to do business with them. In a climate of strong financial pressure, these effects are powerful and are accomplished with modest planning effort compared to fighting a delicensure action against a financially strong hospital through the courts. The impact of these actions has been successful in closing hospitals . . . and perhaps for this reason the State has yet to take a delicensure action.*

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3. *The hospitals closed were smaller, marginal institutions characterized by falling census, deteriorated programs, failing leadership, out-moded facilities,* and/or weak constituencies . . . (T)hree (of the) hospitals that closed in 1978 represent about 1.3% of the City's beds, but only about .8% of the City's hospital expenditures.** This suggests that bed rates are a poor proxy for expenditures. While the closure of marginal hospitals is undoubtedly useful from a quality standpoint if nothing else, the observation raises two questions. First, ***closing only marginal hospitals*** will not have much impact on expenditures, particularly if patients shift to hospitals with higher intensity.*** Second, can rate control pressure be maintained politically when it begins to force prestigious hospitals to retire excess tertiary capacity or even to close entirely? The Dowling report shieds some light on the first question. The report finds that while scope of services has increased in New York, total expenditures have been somewhat restrained. This suggests that int. nsity capacity has increased, but financial pressure has kept hospitals from fully exploiting it financially. Thus, ***hospital closure has been a byproduct rather than cause of expenditure containment.***

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4. ***Protracted financial pressure may erode the constituencies opposing closure.***

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It seems likely that when a hospital experiences continued financial troubles with no relief in sight . . . then the various constituencies begin to drop out by attrition. ***Medical staff begin to hospitalize elsewhere, employees look for more secure jobs, trustees grow tired of the constant struggle, and most crucially, it becomes increasingly difficult to attract able new people to replace those lost by attrition.*** . . . If delicensure is attempted on an unnecessary but financially secure hospital, these constituencies might be much more alive and kicking.

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Hypotheses (tentative findings)

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1. *Financial pressure, not planning pressure, appears to be the principal agent in retiring a hospital.* . . . Even in New York, where authority to close an "un-

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[*Please see "The Myth of Excess Beds" in *Consumer Health Perspectives* Vol. VI, No. 3]

*This and the above observations are consistent with Gottlieb's observation that the most effective use of public policy is to create a climate of pressure on hospitals, but to leave actual closure to the workings of the private sector in resonse to such pressure.[2]

**We cannot conclude that these closures reduced expenditures by even this .8% because we have no idea whether remaining hospitals absorbed the service areas of the closed hospitals without increasing use or intensity.

***By marginal we mean hospitals that are clinically, financially, and/or politically weak. There is reason to believe that these are concentrated among smaller rather than larger facilities.

THE CONSUMER COMMISSION PROTESTS

Mr. Howard Newman
Project Officer, HCFA, HHS
Washington, D.C. 21201

Dear Mr. Newman:

The Consumer Commission is writing this letter to strongly oppose the granting of the Medicare waiver requested of the Health Care Financing Administration (HCFA) by the New York State Office of Health Systems Management (OHSM).

By its own figures OHSM calculates that this waiver will increase its jurisdiction over an additional 40 per cent of patient days in New York hospitals. The OHSM has already proved itself to be glacially disinterested in patient care. To extend its sphere of power would be to do an enormous disservice to Medicare beneficiaries whose health care HCFA administers. Indeed, the Commission believes that the past practices of the OHSM with regard to Medicaid and Blue Cross rate-setting have led to results so inimical to proper patient care that Medicare beneficiaries, along with other patients, especially the poor and other minorities, have already suffered severely. A full blown study of the results of OHSM cost-cutting practices is long overdue.

Reading OHSM's "Proposal for the Development of a Hospital Reimbursement for 1981-1983," it is acutely apparent that nothing has or is about to change in State policy. Nowhere in this document is patient, population or institutional need; the effectiveness, safety or out- Costs and efficiencies are the gospel. This is old hat in New York. OHSM's increasing preoccupation with cost efficiency and cost cutting strategies has corresponded to its de-emphasis on providing care, and determining and meeting needs.

OHSM has sat by and calmly observed as poverty area hospitals (many of whose patients are the poor elderly) have starved and withered on the vine. With their Medicaid and Blue Cross reimbursement rates being kept far lower than the inflation rate, these hospitals have been forced to cut staff and services by 10, 20 even 40 percent. This, combined with slow Medicaid reimbursement policies, and arbitrary and capricious disallowance of payment for care rendered by hospitals to Medicaid patients (duplicating the work of the Federally mandated PSRO, but having a disasterous impact on patient outcome), has forced many hospitals into bankruptcy. It is inescapable not to conclude that the OHSM has supported the death of such facilities. Unfortunately, it is not just facilities that suffer and die. Patients continue to be "treated" as the money for staff, drugs, equipment, maintenance, and eventually morale and spirit, dry up. Is this policy to be given increased federal government support? Will it be condoned and extended making the agency responsible for it even *more* powerful? We sincerely hope not.

The Commmission, like everyone else, knows that when money is scarce, the poor, the under- or unrepresented, minorities without organization or influence, usually suffer the consequences in cuts to the benefits and services provided them by government. On page 18 of their Hospital Reimbursement Proposal OHSM states proudly that "(f)rom 1974 to 1978, the average annual increase in Medicaid expenditure in New York (6.4%) was approximately one-half of the national average (12.6%)." This might be admirable *if patient care did not suffer.* The data that we have indicates that since 1976, 25 hospitals have closed in New York City. Most of these have been in or near poverty and medically underserved communities, severely limiting the access of people in these communities to adequate health care. Cutbacks in services to remaining hospitals and threats of closures led HEW, as long as a year and a half ago, to indicate that potential violations of Title VI of the Civil Rights Act existed. HEW civil rights experts expressed a concern that minorities would be adversely affected by hospital closures or shrinkages in a way that would violate this Title. This finding, at the time directed at municipal hospitals, would be equally relevant for many voluntary hospitals. Although there has been glib talk of substituting ambulatory and preventive services for beds, the fact is that both have been cut back. State set eligibility criteria for Medicaid have become harsher, disenfranchising upwards of 2 million people in the last decade. There has been only a very slow development toward cutting back tertiary care services, such as cardiac invasive procedures and neurosurgery, and to consolidating them in regional arrangements.

New York State already enjoys federal funding sponsorship for at least two reimbursement related experiments. The Consumer Commission believes that any further federal money spent in New York should go toward evaluating the affects of the State's past and present cost-cutting policies on the ability of hospitals to provide decent, effective and safe care to patients requiring it, especially to Medicare patients who are HCFA's specific charge. Where hospitals no longer exist the affect on patients in the community should be studied. Is care accessible? Once someone gets to a hospital, what sort of treatment (staff, equipment, drugs, supplies, safety, timeliness, appropriateness, etc.) do they get?

There is another important reason why the Medicare waiver should not be granted. It is clear that OHSM has in the past, and intends to continue in the future, to use the power of rate-setting to circumvent the legally mandated health planning process. By their arbitrary use of reimbursement OHSM has made a mockery of the work of thousands of Health Systems Agency staff and board members to devise local plans to provide needed, adequate health services which attempt to meet the national health priorities, many of which do not have cost control as their sole aim. Cutbacks annd plans for cutbacks have been discussed and adopted by OHSM outside of the planning structure and without the

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knowledge or input from the affected communities. *De facto* consolidation of the health care system in the hands of the most politically influential (but not necessarily the best or most needed) health institutions has been promoted. OHSM's policies have served to legitimize the frightening notion that health planning is synonymous with cost-containment rather than with active planning to fill service needs. OHSM has made inappropriate use of nationally promulgated health resource guidelines and numerical standards as rationales for arbitrary or unexamined cutbacks in the health systems. This has led to disproportionately severe cutbacks in services to the least influential communities, resulting in harm to the health status of minorities, the indigent and the elderly.

OHSM's past policies can be summed up as health planning by administrative fiat with the poor, elderly and other minorities as the severest and most frequent casualties of its cost-cutting fever. The Consumer Commission urges HCFA not to grant the Medicare waiver and requests that until the outcomes of OHSM's past reimbursement policies can be studied in detail with a focus on the effects on institutions and patients, that no further rate-setting projects be funded for New York State.

Very truly yours,

Donald Rubin, President■

CIR JOINS THE FIGHT

The Committee of Interns and Residents (CIR) has also strongly protested OHSM's past policies and current request for the waiver of federal responsibility to set Medicare rates in New York State. From the unique position of physicians staffing hospitals as they are forced out of business by OHSM, CIR President, Dr. Jonathan House, observed in his letter to HCFA:

"OHSM has used its authority to set rates for Medicaid and Blue Cross as a vehicle to force hospitals serving low income communities out of business. Since the rate of increased reimbursement allowed to New York State hospitals by OHSM has been approximately one-half the national average and considerably lower than even the rate of inflation, financially and politically weak institutions have been the hardest hit. This policy has had a direct impact on patient care in at least two ways: 1) As a hospital is slowly starved, cutbacks are made to staff, supplies and services. The remaining staff is increasingly unable to provide decent medical care. Those hospitals which manage to survive are so constricted in staff and equipment that they cannot provide adequate levels of care. 2) Patients are not only denied access to the inpatient services of hospitals that have been forced into bankruptcy, but outpatient facilities and emergency rooms close as well. Private doctors, denied access to a community hospital, move out of the area, causing a further deterioration in medical care in communities, many of which have already been designated medically underserved.

CIR believes that in view of OHSM's past reimbursement policy, granting the Medicare waiver would further the deterioration in patient care in New York State by promoting the use of reimbursement to force additional hospitals into bankruptcy."■

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necessary" hospital was enacted in 1976, the Health Department has found it more useful to attack a hospital on or over the financial edge on grounds of medical inadequacy or abuse, rather than on grounds that the hospital is unnecessary. ***It seems doubtful that an attack on medical adequacy would succeed with a financially viable hospital . . .*** *Attempting to close an unnecessary hospital by delicensure in the absence of financial pressure violates the* ***basic tenets of regulatory behavior*** *identified by a large body of research on regulation.*[4,5,6] ***The first such tenet is that government may do no direct harm.*** A planning agency identifying and trying to close a hospital as unnecessary is obviously doing direct harm to that hospital and to all persons involved. Unlike a public nuisance, hospitals are charged with symbolic value, and this symbolic value will be used by hospitals to fight back. ***A second tenet is that Government must use explicit rules and due process rather than intuition and judgment.*** *But excess capacity is a characteristic of the hospital industry, not a characteristic necessarily residing in any one hospital.* ***There are objective ways to decide that a community has too many hospitals, but which ones should be closed is usually arbitrary.*** *There is no rule to identify this or that hospital as unnecessary, particularly if it is a healthy hospital.* Consequently it will be hard to make any such public decisions stand up in court. ***A third tenet is that governments respond more readily to focused interest groups than to broad diffuse consumer interests.*** A hospital under seige becomes a focused one-issue interest group, likely supported by other hospitals. But no equal counterforce of consumers is likely to crystallize supporting closure. ***A fourth tenet is that Government must be equitable.*** Closing one hospital while letting the others survive is easily construed as inequitable, particularly when there is no way to show it any more unnecessary than any other hospital. The usual outcome is that all hospitals are required to cut back an equal amount, an action unlikely to restrain capacity to generate expenditures . . . For all these reasons we suspect that direct delicensure will not be of great efficacy in retiring unneeded hospitals. On the other hand, there is reason to believe that effective financial pressure can drive out excess hospitals. ***A financially weakened hospital can be seen as inefficient rather than inequitably picked on by Government;*** after all, other presumably efficient hospitals are surviving. The weakened hospital . . . can be attacked on

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other grounds, such as medical inadequacy, and it will usually lack the human* and financial resources to fight back. Our hypothesis and the observed behavior in our cases are consistent with the above results and arguments. They are also consistent with experience in Canada and England, where planning efforts to reduce capacity have been marginal.[1]

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2. ***The most likely candidates for hospital closure appear to be financially marginal, older hospitals with weak constituencies.*** All the cases of hospital dissolution we observed fit this description. ***Unfortunately such hospitals contribute relatively little to rising national hospital expenditures.*** Nationally, 12% of hospitals account for 50% of hospital expenditures, and 50% of hospitals account for 90% of expenditures.[7] Under financial pressure it seems likely that the smaller, financially weaker hospitals will be pushed over the edge first, especially if they have no constituency that can rescue them. Under planning pressure— essentially a public process that must inevitably respond as much to political muscle as to technical merits—it seems especially unlikely that the larger, costlier hospitals will succumb. Thus ***no matter what tools are used, an emphasis on closing capacity is likely to force out the smaller, weaker hospitals. This will require much effort but will only make a small dent in the expenditures problem.***

3. *Even a reduction in hospital beds and patient days did not appear to slow the annual increase in hospital expenditures in the community; apparently, increased service intensity more than offset the reduction in bed use and bed capacity . . .* ***Indeed, in several of the mergers we observed, an underlying motivation was to consolidate in one strong institution the patient and financial bases that could support the acquisition of sophisticated technology. Even in cases where beds (or even patient days) were reduced, annual expenditures appared to rise at national average rates.*** (This observation is consistent with the results of Bice and Salkever.[8]) It thus apears that *the profligate growth of intensity capacity (i.e. the capacity to use labor and capital more intensively in a single bed or bed day) is as great or greater a danger to expenditure containment than bed capacity.* Attention to intensity capacity may be more vital than attention to bed capacity. *The best measure of capacity is exenditures. It is the capacity to generate expenditures tha we are trying to reduce.* It appears that *beds are a very poor measure of capacity.* ***It is not clear, for example, that closing two smaller hospitals, with no tertiary capability or aspirations, in favor of a larger hospital, with less total bed capacity but more intensity capacity, confers any net cost containment gain. (If intensive care capacity is already adequate in the community, there is no quality gain either.)*** Rather, the more intensive hospital can use the larger patient base to further incrase intensity capacity.

*i.e., the able people will likely have begun to leave.

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Major Conclusions and Recommendations

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1. . . . To make any significant dent in hospital expenditures, at least 10% to 20% of hospital capacity must be retired.[1] By capacity we do not mean just beds: we mean a 10% to 20% reduction in hospital labor, equipment and capital assets. Beds are the least significant aspect. Regarding financial inducements . . . there is simply no indication that 10% to 20% of hospital capacity can be retired by financial enticements. . . . Success will be marginal compared to the effort. Moreover, . . . ***the hospitals we succeed in delicensing will be the small and/or weak hospitals. They are very unikely to include the 12% of hospitals which account for 50% of expenditures, or even the 50% of hospitals that account for 90% of expenditures.*** Thus, even if many of the remaining smaller, weaker hospitals are closed, there will be little impact on expenditures; and there may be a growing trail of angry communities and legislators who will make further progress more difficult.

. . . If we actually wish to use capacity reduction as a serious means of containing cost, then we shall have to reduce capacity to the point where it retards utilization, especially intensive utilization. ***It is utilization, not empty beds, that costs money.*** The minute that physicians and elective patients begin to wait in line for admissions, it is doubtful that there will be any public tolerance for a program that expends public money to shut down hospitals. ***Thus, direct capacity reduction seems likely to succeed at best just to the point where it might begin to save some money and no further.***

2. • • •

(I)n New York . . . even this modest financial pressure [rate controls are now limited to Blue Cross and Medicaid] has been sufficient to force a number of weaker hospitals over the edge. Presumably more effective regulatory pressure on rates could further restrain expenditures, and as a by-product force out excess capacity even when it is less extreme. This use of regulatory financial pressure as an indirect strategy to reduce excess capacity appears more politically acceptable. The "do no direct harm" principal is less transparently violated. The hospital forced out of business can be viewed as inefficient, rather than as a target singled out for public execution. The "equity" principle is maintained, since all hospitals are subject to equivalent financial restraint. No arbitrary public rules nor due process are involved in a hospital financial failure. Of course it can be expected that a failing hospital may take the regulatory agency to court on grounds that rates are inadequate. But the agency can defend itself on grounds that it has no obligation to guarantee the costs of an inefficient hospital, and that other hospitals are successfully surviving under the rate

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NEW YORK STATE'S BID FOR TOTAL CONTROL

Legislation will probably be introduced in this year's New York State legislature to extend the Office of Health Systems Management's (OHSM's) rate-setting authority to cover commercial health insurers, self-insured labor-management funds and self-paying patients. Passage of this legislation will:

- give OHSM control over setting reimbursement rates for 10% of inpatient days (making 100% if the Medicare waiver is granted), thus making its policy of closing hospitals through fiscal harassment more effective,
- increase profits to commercial insurers (which now pay hospitals' posted charges), unless these insurers are required to substantially reduce premiums or pay a windfall profits tax (which policies are not a part of current proposals and would probably be blocked by the insurance industry if they were)
- cause government, Blue Cross and self-insured unions to cover hospital costs now paid for by commercial carriers.

The Revenue Cap Trap

OHSM wants to be able to set a "revenue cap" for all New York State hospital care, i.e. to predetermine a finite, total amount of money to be spent for inpatient hospital care in New York each year. If the legislation to extend its authority is passed and the Medicare waiver is granted, OHSM will have this power. It will control *all* payments for inpatient care in the State. It will be able to set the cap wherever it wants, limiting the amount of money in the system and, with a free hand, harassing and forcing cutbacks and closures on hospitals of its choosing.

If Someone Saves, Someone Else Loses

Extending OHSM's authority over the commercial insurers has been touted as a cost-saving device. This will only be true if OHSM decides to set the revenue cap lower than the total number of dollars now going into New York State's hospitals.

If the total number of dollars is not decreased, a cost-redistribution, not a cost-savings, will be achieved. It is estimated that reducing the amount of money that the commercial insurance companies now spend for hospital care by 30%, as is proposed, will result in a revenue loss of $120 million to New York hospitals. The burden of these costs will be shifted to:

- government—it could cost New York City and New York State up to $20 million per year more for their employees,
- Blue Cross subscribers (12 million)—the necessary 5%-8% increase in premiums will translate into an additional $100 million per year, and
- the self-insured labor management health and welfare funds with negotiated reimbursement rates.

The Bandits Make Out

No matter what is decided about the revenue cap, if it goes down or stays at current spending levels, the private commercial health insurance carriers stand to increase their yearly profits by $100 million! Their retention rates (overhead plus profit) are already three times greater than Blue Cross. They can not be considered needy for the proposed legislation which is the equivalent of State welfare for private insurance companies.

Amazingly, OHSM wants to give this financial boon and regulatory haven to companies which are not accountable to the public in any way; are subject to less stringent regulation than Blue Cross and other organizations operating under Article IX-C of the State Insurance Laws; and have demonstrated time and again that they are not interested in effecting cost control programs of their own.

As wih OHSM, the Commission wonders why consideration is being given to reward this history.

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controls. If the hospital can muster up sufficient political support, it can get its rates changed. But this is a vulnerability of all regulatory strategies.*

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In sum:

We conclude that excess hospital capacity reduction is more likely to be a consequence than a cause of effective cost containment.

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*For this reason we must not become over-optimistic about the ***New York experience. Presently only very weak hospitals with weak constituencies are being forced out by rate controls. When large prestigious hospitals start to go over the edge (the ones that generate the bulk of expenditures), it may not be so easy to maintain tight rates . . .***

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On Such Fertile Ground, New Companies Will Grow

There are currently about 190 commercial, for-profit insurance companies writing health and accident insurance in New York State. If OHSM's powers are extended as proposed, these companies will be guaranteed, by State law, extraordinarily high profit margins. Inevitably, more commercial insurers will be drawn into the New York market. These companies can be expected to focus, as have their predecessors, on signing up low risk groups, i.e. those whose members have a low chance of needing medical care. As a result, an increased proportion of Blue Cross and government beneficiaries will be people who are high utilizers of medical services and frequent benefit claimants. The burden of payment will be further shifted to government and Blue Cross. Government contributions and Blue Cross premiums will have to rise to cover this higher utilization.

Many of the commercial companies now doing business in New York have out-of-state central offices. Probably many of the new companies seeking New York business will also be from other states. In order to gather data and monitor compliance with State law, it is necessary for State inspectors to be able to conduct in-depth, on-site audits. By providing an incentive for new for-profit insureres to come to New York, the OHSM plan can only exacerbate the current regulatory nightmare and make the practical enforcement of any future regulations impossible.

Opposition The Only Course

Clearly, the power inherent in total rate-setting authority is too great, and the possibility and OHSM's history of abuse through dehumanized administrative decisions is too present and strong, not to protest. McClure and Kligman have called into serious question the effectiveness of a financial harassment policy in closing anything but politically and financially weak hospitals (indiscriminately without regard to need, quality or access concerns). Moreover, they suggest that such closures may not even result in cost-savings. Regardless of this, OHSM's intent is to use the expanded powers it is seeking to further pressure New York State's hospitals with reimbursement rates which do not meet the rate of inflation. It obviously wants to close more hospitals. The question is: Which ones? An obvious answer: the ones it can most easily affect, i.e. those in or near poor and medically underserved areas whose constituencies are neither wealthy nor powerful.

The special interest legislation which it, and the commercial health insurance industry, would like to pass in New York would complete OHSM's stranglehold on reimbursement. It will also grant exhorbitant profits to commercial health insurers and cause a shift in the burden of paying for the care of high risk patients to government and Blue Cross. It will probably increase the power and strength of the larger, financially and politically stronger hospitals by forcing poorer, lower cost community hospitals out of business.

OHSM is on the move to grab all the power it can. Its intentions are ill-conceived, costly and destructive to needed health services. The Commission stands in opposition to this power grab.■

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