THE REPORTER DISPATCH

Gannett Westchester Newspapers
Sunday, Feb. 10, 1980

Government pulls the purse strings

By BRUCE FRANKEL
and DOUG WILLIAMS
Staff Writers

When Peter Wade went before the board of directors of one of Westchester's most successful hospitals, he painted what has become in his industry an increasingly familiar and disheartening fiscal portrait.

The president of Northern Westchester Medical Center told the directors recently that the hospital in Mount Kisco is expected to fail to meet its 1980 expenses by some $250,000. After a year in which his hospital — at the crossroads of the county's most affluent towns — managed an estimated $150,000 surplus, Wade blamed the projected 1980 deficit on a new state policy.

"Whether government sits on our board or not," says Wade, "it's there. Its shadow is everywhere."

On the wards, that shadow second-guesses a doctor's decision to keep an 88-year-old woman in the hospital after an operation on a nerve in her hand.

"If she were young," says White Plains neurologist Kenneth Gang, "she would be out of the hospital in a day. Because she's 88, we waited two days before sending her home. It may end up that she will get charged for the extra day because some chart somewhere says only one day is allowed. I find it inhumane to say I don't care if there's no one home to take care of the patient.

"Patients suffer because clerical workers are deciding on their proper length of hospitalization."

The clerical workers are following federal Professional Standards Review Organization regulations. PSRO is only a small part of the government's arsenal of weapons in the war over who should control hospitals and to what end.

Of the 17 hospitals in Westchester and Putnam, 12 ran in the red in 1978. The accounts for 1979, when closed, are expected to look no better. Statewide, 80 percent of the hospitals reported operating deficits for 1978 exceeding $170 million. Many are fighting for survival. In Westchester, the 150-bed Yonkers Professional Hospital has just applied in federal court for reorganization to avert bankruptcy.

The figures in Manhattan are already like a body count: 25 hospitals forced to close and several forced to merge as a result of the stringent state guidelines.

Hospital officials accuse the government of initiating a deadly trade of taxpayers' dollars for lives. If government wins, they say, the public can expect low-quality rationed medical care.

If hospital costs are high — and Westchester's are among the nation's highest — hospital officials say there is a good reason: They provide vital services which increasingly require elaborate and expensive machinery and highly skilled staffs that no longer work for paltry wages (60 to 70 percent of their expenditures go for salaries and benefits, hospitals say), and they are burdened with the same inflationary spiral as the rest of the nation.

Not so, contend the government health planners who have been devising ways to force hospitals to cut waste, to stop duplicating services and to start running themselves with the efficiency of a business. Their goals, they say, are twofold: Enhancing the quality of hospital care and containing the already monumental financial burden shouldered by the taxpayer.

The hospital system has grown "obese," with more beds than are occupied, more services and equipment than are fully used, and a continually fulfilled desire to build and replace, say government fiscal experts who aim to change all that.

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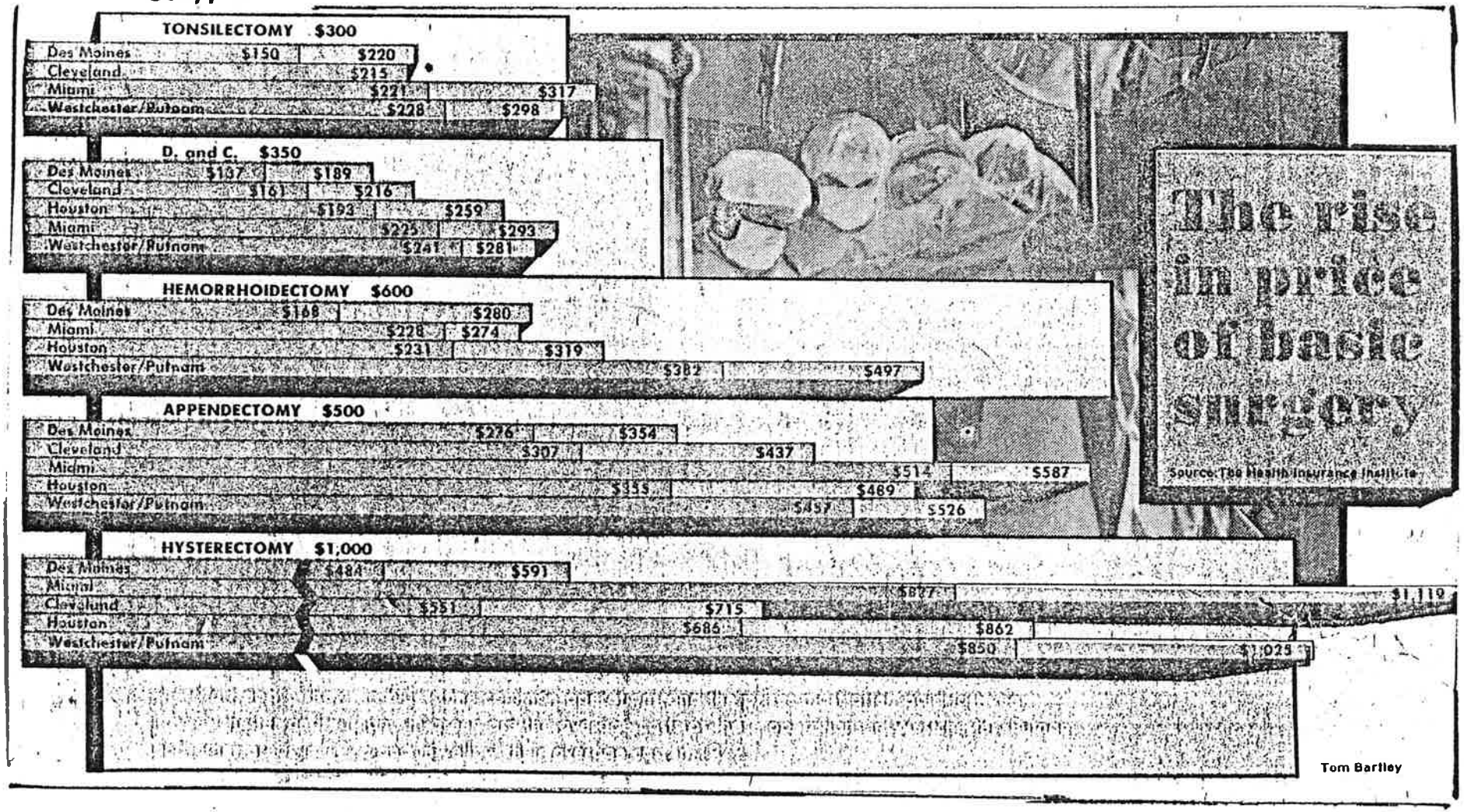
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Houston $335 $489
Westchester/Putnam $457 $526
HYSTERECTOMY $1,000
Des Moines $484 $591
Miami $827 $1,119
Cleveland $551 $715
Houston $686 $862
Westchester/Putnam $850 $1,025
The rise in price of basic surgery
Source: The Health Insurance Institute
Tom Bartley

The reason government has flung itself into the fray is that though only the sick go to the hospital, just about everyone pays the bill. And the bill has grown fearfully large.

This year, Americans will spend an estimated $229 billion on health care, 40 percent of it on hospitals. And taxes pay 55 percent of the U.S. hospital bill through the public insurance programs, Medicare and Medicaid. President Carter sought mandatory ceilings last year on hospital-cost increases as a "top priority" of his administration's inflation fight.

But the conflict has its origins in Congress' 1965 decision to pay for health care of the poor and the aged with tax dollars — a decision many now consider the first in a long line of ill-conceived government efforts in the health field.

It set in motion a spending spiral that by 1976 had reached a rate of 12 to 15 percent a year, nearly double the nation's rate of inflation in that period.

The same year, the state, beset by its own financial crisis, decided to try to cap the spiral. It ended what had been, in large measure, open-ended Medicaid rates. No longer would the state gauge its rates by what the hospitals spent; instead, it would base them on what the state could afford. This was but another plan that backfired.

At White Plains Hospital Medical Center, for instance, costs ran an average of $199.97 per patient-day in 1978 (1979 figures are still being audited). Blue Cross reimbursed the hospital at the rate of $189.30 per patient-day, Medicare at $193 and Medicaid at $175.95. The Medicaid rate left a gap of $24.02. That much was intentional, part of the government's design to cull from the hospital system the financially weak and underused institutions.

But the hospitals shifted the burden to the private-paying patients — the "charge payers." At White Plains, for example, the charge payers, who accounted for 12 percent of all patient-days in 1978, were charged $273.37 per day.

The difference between what the state was reimbursing and what private insurers and the occasional patient who pays out of pocket were being charged grew to 40 percent. The public, for the most part, was insulated from the cost gap and did nothing.

"If you were to expose the patient to the real costs of medical care," George Vecchione, president of the New Rochelle Hospital Medical Center, said in an interview, "they would be more selective in their demands."

Ellen Markowitz, a Yonkers woman who opted for 30 days of traction in a hospital rather than facing surgery which was eventually required, agrees that had she not been insulated from the cost by her insurance she would have chosen otherwise.

"The state was essentially throwing some of the burden of caring for the indigent back onto the private sector," says Morton Ganeles, director of health finance for the Hospital Association of New York State. The tactic was used, he says, because "it is very difficult for any elected official to take away something they have given to the people."

To rectify this situation, the state legislature in 1978 put a hold on increases to charge payers, freezing the difference between what they pay and Blue Cross rates at 40 percent.

In the latest battle, hospitals have won a temporary reprieve from what they see as another bureaucratic foray into their once impregnable citadels. Two weeks ago, the federal Health Care Financing Administration deferred the final decision on a state request to give it control of Medicare.

About 40 percent of all hospital patients are covered by Medicare; about 50 percent by the already state controlled Medicaid and Blue Cross; of the remaining 10 percent, seven percent are private payers and three percent are either working poor or illegal aliens with no medical coverage.

Hospital administrators lobbied fiercely against the state proposal. Much of the reaction came after hospital directors received a letter from Richard Berman, director of the state Office of Health Systems Management, telling them that the proposed change would not hurt hospitals. Simultaneously, Berman was telling the federal agency that bringing Medicare under state control would in its first year save the federal government an estimated $80 million.

"I'm turning a steak now," said Andy Foster, a spokesman for the state hospital association, from his Albany home. 'When I went to the butcher today and bought it, with some cold cuts, the bill came to $12.50.

"Now, if I had told the butcher that I was on a cost-containment program and could only afford $10, he wouldn't have given it to me. The state's cost-containment program doesn't cut costs; it just cuts money.

"What the state was asking the feds to do," he said, "was, 'Let us bring to Medicare the same control we brought to Medicaid.' Those controls have already brought deficits to 75 to 80 percent of the hospitals."

The state Office of Health Systems Management, however, is adamant about the need for Medicare control. "Having effective control over all sorts of payment is essential if we're ever going to get hold of rising costs," said Barbara Thomas of OHSM. Otherwise, "the institutions will seek relief on the uncontrolled portions of the population."

Medicare reimbursements are still retrospective — what they spend, they get.

Meanwhile, the results of state controls continue to be mixed: Cost containment is scaling down the hospital system and decreasing utilization on one hand, and creating a fiscal nightmare for hospitals on the other.

Assemblyman James Tallon, chairman of the Assembly's health committee, believes that they have proven successful.

"Our goal is to keep the rate of growth at a level we can afford," he said, "both when government pays and when we, private payers, pay. The goal for the 1980s is to keep rates of growth a little below the national inflation rate.

"Over the last five years, New York hospitals have kept in the 7-9 percent range. In states without cost-containment programs, the rate has been between 13 and 15 percent. I know of no panacea, but vigorous controls of capital investments and other measures should help."

Tallon's beliefs are borne out by recent reports from Blue Cross and Blue Shield of Greater New York. That agency reported last month that its subscribers' hospital utilization rate is 24 percent below the national Blue Cross average and that "dramatic reductions in hospital patient days, admissions and lengths of stays" were accomplished in the 10-year period ending in 1978.

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> *Assemblyman James Tallon*

In New York, local president Edwin R. Werner reported, patient days per 1,000 subscribers declined to 553 in 1978, well below the national average of 729. And hospital admissions for subscribers in the state's lower 17 counties fell to 80 per 1,000, the lowest in the nation. Werner attributed the declines to "careful monitoring of admissions and efforts by hospitals to become more cost-efficient."

But often, that "cost efficiency" is accomplished by dipping into endowments or depreciation reserves to pay operating bills. "We won't see the effects of that for many years," says Vecchione of New Rochelle, "but we are really holding the future in abeyance in order to pay for today."

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John Farmer, vice president of BlueCross/Blue Shield of Greater New York, is more blunt: "Hospitals are, in effect, competing for survival."

Donald Rubin of the Consumer Commission on the Accreditation of Health Care Facilities believes that state policy discriminates against hospitals serving the poor. One of the severest hospital critics in the past, Rubin is now defending the financially fragile ones against government policy: "In some ways cost containment has gone too far — the state is using reimbursement to squeeze out the weaker institutions" which generally serve poor neighborhoods.

The squeeze on the dispensers of hospital care — the doctors — is applied through the Professional Standards Review Organization. PSRO workers are peeking over the shoulders of the doctors to make certain that patients aren't admitted without cause and are discharged as soon as possible. Neurologist Gang is one of PSRO's milder critics. Dr. Charles A. Bertrand, president of the Westchester County Medical Society, warns of its danger.

"The central issue that affects me as a physician is whether I will retain control of patient care in the overall decision-making process," was his first message of the new decade in the January edition of the Westchester Medical Bulletin. "Will the system that has the power of the purse have the power to dictate procedures and treatment in contradiction of what I and my peers know to be good medical practice? Will the public tolerate the inordinate waits for service inescapable in a system of rationed health?"

But physicians are beginning to accept the federal scrutiny, says Dr. Frank Iaquinto, chief of medicine at New Rochelle Hospital Medical Center and of the hospital's PSRO.

"There are still some people who are vehemently opposed to it," he said. "They say it's no fun practicing medicine any more. But they don't understand the reasoning. The intent is not to waste days."

If the PSRO worker does find a discrepancy between a patient's length of stay or treatment and what the government manuals prescribe, he or she speaks with the doctor to determine if there are extenuating circumstances. If, after consultation with the doctor and with the head of the hospital's PSRO committee, it is decided that the length of stay is excessive, the patient's coverage is disallowed from the day discharge should have occurred.

"Years ago, there was a guy here who used to put his patients in for five days for a bowel preparation," said Iaquinto. "That doesn't happen any more."

Next: Patients as a captive market.

REPORTER DISPATCH
SUN. FEB. 10, 1980

THE REPORTER DISPATCH

Gannett Westchester Newspapers
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Hospital costs: Few questions asked

By DOUG WILLIAMS
Staff Writer

Ellen and Mitchell Markowitz of Yonkers, Fred Rossi of North Tarrytown, and George and Viola Nelson of Rye Town are caught in the eye of an economic hurricane.

Covered by comprehensive health insurance, they are riding within the relatively calm center of the hospital-cost tempest swirling around them.

• Yet, unknowingly, they all play major roles in escalating the conflict between government and hospitals over how much hospital care should cost.

As taxpayers and voters, they have harped on the government to do something about soaring inflation and rising taxes. In response, government has begun to clamp down on hospital costs as a major contributor to the spiraling cost of living and public expenditures.

As potential patients and citizens of prideful communities, Markowitzes et al support their community hospitals' ambitions to provide a full range of services and high quality and technologically advanced care in a comfortable, modern setting. The hospitals respond with alacrity.

Finally, as consumers of hospital care, they neither control what they "consume" nor budget that consumption on the basis of ability to pay.

Hospital patients are a captive market with an almost unlimited ability to pay and an almost absolute faith in the "seller' or provider of care — the doctor.

A few months ago, Ellen Markowitz was in great pain from a herniated disc. She wanted the pain to vanish, and the price tag on that disappearance was not a major concern. After she spent 30 days in a New York City hospital in traction, the pain did not ease, so she opted for surgery which required eight additional hospital days.

"Cost affected our decisions not a bit," she said. "My good health insurance is why."

Ellen agreed to try traction because she and her husband Mitchell were leery of surgery and, unlike most people, aware of the need to prevent unnecessary surgery to hold costs down. But it was their health insurance that made that option possible.

"If I had to pay myself," Ellen explained recently, "I would not have gone into the hospital for traction which I did not think would work. I would have had immediate surgery."

Control over decisions such as this is usually placed in the hands of the doctor. Health-care experts say that nearly 80 percent of cost-incurring decisions in hospitals are made by doctors. Few patients question doctors' statements of what is needed, and of those that do few base their questions on costs.

Mrs. Markowitz, as a hospital clerical worker, is more knowledgeable than most patients. For example, she was able to spot during her second hospital stay two simple actions by doctors that state officials say contribute unnecessarily to rising costs.

"The doctor said I couldn't be scheduled for surgery until I was in the hospital," she said. "So I was admitted on a Saturday and waited three days for surgery. If I had to pay, I would have waited at home."

Also, she said, although medical procedures did not require it, she was told she would have a battery of diagnostic tests upon her second admission —she had had a similar battery only weeks before. Had she had to pay for those extra days and extra tests out of her pocket, she said, she would have questioned the need more closely. As it was, she refused a second chest X-ray, mainly out of awareness that unnecessary radiation should be avoided.

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Unnecessary utilization of hospital beds and equipment has been a target of a state crackdown in recent years, mainly through financial penalties. Doctor "utilization review" committees in hospitals have been monitoring test orders and admissions so as to pressure their peers to consider cost and need.

But Ellen Markowitz saw evidence that even those efforts may not be effective without patient support.

"At one point," she said, "the doctor came in and said he was ordering a traction device because he was getting pressure for not ordering anything to justify keeping me there. He said the traction equipment could just be placed on the bed. It didn't have to be used."

Even though they were knowledgeable about costs and procedures, the Markowitzes did not scan their "purchase" of hospital care as they would have the purchase of auto repairs.

George Nelson spent two shorter periods at United Hospital in Port Chester for twin hernia operations. During each, unbeknownst to Nelson, a second surgeon stood by in case the main surgeon became ill.

When the bills came in the mail, the Nelsons questioned the need for a stand-by surgeon, only to discover it was hospital policy for some surgical procedures. Although their major medical insurance covered this expense, the Nelsons queried the main surgeon about it.

"The surgeon said, 'What do you care? The insurance will cover it,' " Mrs. Nelson said. "That's true. But we pay — eventually."

All state residents pay in full eventually, through payroll deductions for insurance premiums or through taxes or both, because government and Blue Cross pick up 90 percent of all hospital bills.

The premiums for employees' health insurance also represent a hefty part of the overhead costs for industry, ultimately resulting in higher prices for goods and services. In the final analysis, people like the Nelsons pay for hospital care in the marketplace as well.

But all these levies for health care are hidden from the insulated consumer and the isolated taxpayer.

For the people whom Fred Rossi represents in Tarrytown as vice president for insurance of the local United Auto Workers union, the costs may be hidden even deeper.

General Motors, the firm Rossi's men work for, pays the entire premium bill for hospital insurance, dental insurance and major medical insurance.

"This doesn't affect the workers directly," Rossi said recently. "No part of the health-care premium is paid by them. They don't feel the costs of a doctor or a hospital bill. All they pay is the bill for an office visit, and they know that has gone up a lot."

But General Motors feels the costs of a health-care premimm bill that nationally has gone up in the last 10 years from $365 to $2,162 per worker. Some of that increase is the result of improvements and expansions of benefits, but much of it is the result of premium hikes made necessary by soaring health-care —and hospital-care — costs.

That 10-year hike affects GM workers through the paycheck and consumers through the cost of GM cars.

"The first thing our national negotiators hear in sessions with the company is that they want us to absorb the increased costs of premiums," Rossi said. "But that never gets i..to the contract, and I know that if those increases didn't exist from year to year, we would have more money that we could use in other programs. I'm sure that if the premiums didn't go up, we would see a little more in the paycheck, too."

Russell Schuck, an IBM executive who is president of the newly formed Fairfield-Westchester Business Group on Health, confirms Rossi's assumptions.

'If the costs of doing business have risen, and health care benefits have been a major cause of such a rise," Schuck said, "then the employer has fewer dollars to spread around for other things, employee salaries being one of those things."

Much of the tax money spread around each year by people like the Markowitzes and the Nelsons and Rossi goes for health care, too.

For the Nelsons, a portion of their Blind Brook School District, Rye Town and Westchester County property-tax levies goes to pay health insurance premiums for teachers and other government workers. Fifty-seven percent of the county budget is gobbled up by the 25 percent share of Medicaid costs that the county government must bear.

The Nelsons' payroll taxes help foot the federal budget of which seven percent goes to health care outlays of one sort of another and the state budget of which about five percent is used similarly.

Of the Nelsons' total annual tax payments of $10,400, more than $860 is used by governments at various levels to pay for health care; about $287 of that amount goes for hospital care.

"Inflation is totally out of control," Mitchell Markowitz laments. "Taxes —they have to revamp the whole system, and government must balance its budget. The way things work out now, in the last few years we have doubled our combined income. But with inflation, and moving to a higher tax bracket at the same time, we are in no better shape now than we were before.

"Hospitals are a needed service," he said, "but they have to come to grips with the doctors."

But the person in the best position to place a grip on a doctor is usually the patient. Yet the patient is not likely to be in circumstances allowing much pressure with such a grip.

Next: The cracks in the cost-containment dam.

REPORTER DISPATCH
MON. FEB. 11, 1980

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How the role of government has expanded

In the last 50 years, the nation has drawn ever nearer a legislative declaration that everyone has a right to health care — particularly hospital care — and that the government should be the insurer of that right.

In the last five years, the government has also begun to realize that it cannot do everything for everyone and to re-examine its commitment of taxpayers' money. One such area of commitment is hospital care.

As John Farmer, vice president for reimbursement of Blue Cross/Blue Shield of Greater New York, said recently, "For years, the whole atmosphere was expand, expand — more, more — better, better, and there were massive hikes in costs along the way. Well, now the chickens have come home to roost."

Here is a chronology of how those "chickens" found their way home:

1933 — The aftermath of the Great Depression focuses national concern on the plight of the poor, and medical care comes to be recognized as a basic right. The federal Emergency Relief Administration begins a program of home medical care with doctors paid on a fee-for-service basis.

1945 — Post-war military studies reveal that one man in three called for service had been found physically or medically unfit. Prior to his death, President Roosevelt is preparing a compulsory health insurance plan, after declaring in his last State of the Union address that all citizens should have "the right to adequate medical care and the opportunity to achieve and enjoy good health."

1946 — The Hill-Burton Act is passed by Congress. It funds hospital construction and research into medical care. The funds spur building of hospitals in suburban and rural areas, research at medical schools, and specialization in the training of doctors. Community hospitals in affluent areas like Westchester compete for the best facilities, and for the finest specialists with promises of the latest equipment and of services on a par with the large metropolitan hospitals. Community hospitals are transformed into scaled down full-service institutions, each controlling its territory like a "medieval fiefdom."

1965 — After more than 20 years of debate, Congress approves Medicare, insuring the aged through Social Security, and Medicaid, aimed at insuring the indigent. The money from these two programs begins to pay hospitals for the care given the aged and the poor — patients who had been bad debts become a fresh source of funds. A second hospital boom period ensues.

In New York, the state adopts extremely liberal benefit packages for Medicaid recipients on the assumption that the federal government will pay the bill. Hospitals are reimbursed for care on the basis of costs incurred.

1969 — The federal government changes the Medicaid legislation, and the state faces a bigger portion of the bill than anticipated. County governments, which pay 25 percent of Medicaid bills, begin to howl. Property taxes reflect the new burden.

In an effort to save the state from bankruptcy, the late Gov. Nelson Rockefeller pushes for hospital cost-containment, first seeking to limit the Medicaid benefit package. The effort is altered to reduce the amount the state pays hospitals for those benefits, without scaling down the package. This arrangement is passed by the state legislature as the Hospital Cost Containment Act.

1975 — New York City teeters on the brink of bankruptcy, its incredible costs for the Health and Hospitals Corporation a major contributor. New York State begins to follow the city toward the brink. The cost of Medicaid alone is feared to be enough to plunge the state over the financial precipice. The federal government sets up a network of regional Health Systems Agencies to foster regional approaches to sophisticated specialty care in place of duplicative local approaches.

1976 — Gov. Hugh Carey introduces a Medicaid reduction bill to coerce hospitals to run more efficiently. Ceilings are set on hospital costs and penalties imposed on hospitals that exceed the ceilings or have chronically empty beds.

1978 — Hospitals faced with penalties for empty beds move to keep them filled, keeping patients in beds longer than necessary and admitting patients marginally in need of hospitalization. Hospitals threaten to cancel Blue Cross coverage so patients can be billed directly and revenue losses minimized.

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1979 — President Carter unveils a package of mandatory hospital cost-control legislation, predicting savings to the federal, state and local governments of $84 billion and to employers of $25 billion in health care costs by 1984. The bill is defeated by the House in November.

1980 — New York State removes financial penalties for empty beds, opting instead to reward hospitals for keeping beds empty.

1984 — A hospital stay averages $400 a day?

REPORTER DISPATCH
SUN. FEB. 10, 1980

THE JOURNAL OF COMMERCE, Thursday, February 14, 1980

Sheeran Approves WC Rates

Journal of Commerce Special

TRENTON — State Insurance Commissioner James J. Sheeran has approved a new manual of rates for workers compensation filed by the Compensation Rating and Inspection Bureau that will increase premiums by $97 million, or about 18.5 percent.

The new manual reflects the substantial increases in benefits mandated by a reform act adopted unanimously by both houses of the Legislature and signed on Jan. 10 by Governor Byrne. Its effective date was retroactive to Jan. 1.

Among the increased benefits provided by the act are a weekly minimum benefit of $49, up from $15, and maximum benefit of $185, up from $156; a death benefit of $2,000, up from $750; an increase in the maximum duration of benefit payments from 300 weeks to 400 for temporary total disability and from 550 weeks to 600 weeks for permanent partial disability.

THE NEW YORK TIMES, THURSDAY, FEBRUARY 14, 1980

New Study Suggests Running Curbs Heart Disease

BOSTON, Feb. 13 (AP) — A comparison of blood samples taken from marathon runners, joggers and inactive people provides new evidence that exercising may help prevent heart disease, researchers say.

The study found that the more people run the higher are their blood levels of high density lipoprotein cholesterol, or HDL, a substance that is associated with a reduced risk of coronary heart disease.

The researchers said it was the amount of running, not what people ate, that determined whether they had high or low levels of this blood fat.

Unlike low density liproprotein cholesterol, which is suspected of causing hardening of the arteries, the high density substance is believed to provide protection from heart trouble.

The study, conducted at Methodist Hospital in Houston, was published in the The New England Journal of Medicine.

The researchers took blood samples from 59 marathon runners, 85 joggers and 74 inactive men, all between the ages of 35 and 66.

HDL levels were 65 milligrams per deciliter in the marathoners, 58 in joggers and 43 in nonexercisers.

There have been reports that HDL levels go up if people drink alcohol moderately or lose weight.

"The marathon runners and joggers did not differ substantially from the inactive subjects in their reported dietary habits, although they had significantly higher HDL-cholesterol levels," the researchers wrote.