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MAINE STATE LEGISLATURE
COMMITTEE ON HEALTH AND INSTITUTIONAL SERVICES

Public Hearing on Hospital Cost Containment

30 June 1982

Participants

Committee Members:

Rep. Alfred Brodeur
Sen. Beverly Bustin
Sen. Barbara Gill, co-chair
Sen. Walter Hichens
Rep. Harriet Ketover
Rep. Mary MacBride
Rep. Peter Manning
Rep. Richard McCollister
Rep. Merle Nelson, co-chair
Rep. Susan Pines
Rep. Edwin Randall

*Presenters of Testimony:

Maine Hospital Association
Voluntary Budget Review Organization
Maine Health Care Association
Maine Committee on Aging
Maine Medical Association
Blue Cross/Blue Shield of Maine
Hospital Insurance Association of America
Union Mutual Life Insurance Company
Maine Association of Life Underwriters

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[Transcript prepared by Cyrille White]

MAY 23 1988

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COMMITTEE ON HEALTH AND INSTITUTIONAL SERVICES

Public Hearing on Hospital Cost Containment
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GILL: We want to give everyone ample opportunity to testify. We will not get into the specifics of the final draft of the legislation as we saw it last time. I would just ask you to testify on prospective reimbursement and how it would affect you, so that in future meetings the committee can sit down and have you back in and continue to ask any questions. What I would like the committee to be well-versed on is prospective reimbursement and how it affects everybody in this room, so that when we do get a bill--however it reads--we will be well enough informed to make some decisions on legislation that will be before this committee.

NELSON: I just wanted to welcome you here and to tell you how much I am enjoying the leadership and participation of all the people in the health industry in Maine. This is very important. Certainly what we heard last time is that, in order for anything to work, you need that voluntary leadership and participation of all parties. I think we have it. I think that's the spirit in which we are moving. And I think it's extremely important. Who's going to get hurt? We're all the victims and I'm sure we'll all work very hard so that no one gets hurt, if that's possible, in the best of all possible worlds.

GILL: We'll start with the Maine Hospital Association. We have a program for today, with the Maine Hospital Association scheduled to start. We'll then go to the Voluntary Budget Review Organization. Then the Maine Health Care Association. Then the Maine Committee on Aging. Then we're going to break for lunch. When we return from lunch, we'll hear from the Maine Medical Association, Blue Cross/Blue Shield, the Maine Association of Life Underwriters, Union Mutual, and the Health Insurance Association of America. Is there anyone here who doesn't fall into any of those categories? ... Then we'll proceed. The first speaker for the Maine Hospital Association is Grant Heggie, who is President of the Maine Hospital Association.

HEGGIE: My name is Grant Heggie and I am the President of the Maine Hospital Association. I am speaking here this morning on behalf of our forty-three member hospitals and some two hundred personal members. We certainly appreciate the opportunity to speak with you today on the subject of hospital costs, with reference, of course, to the Health Facilities Cost Review Board's report and possible future legislation aimed at controlling hospital costs.

With me this morning are five individuals: four hospital executives and the chairman of a hospital board of directors. Each of them will talk about a facet of hospital operations, development, legislation, or regulation.

To set the stage for their presentations, I'd like very briefly to describe what it is we are talking about when we talk about Maine's hospitals in the aggregate, or Maine's hospital industry. At the present time, we are forty-three hospitals providing something in excess of $420 million worth of patient care per annum. We are, additionally, experiencing more than two million outpatient visits to our Emergency Rooms and outpatient clinics. This care is being provided by nearly 26,000 hospital employees, whose wages and salaries amounted to better than $207 million in 1981. These 26,000 employees are comprised of over two hundred identifiable professional groups, making the personnel mix of hospital employees an extraordinarily complex one. The 26,000 employees also make Maine's hospital industry the largest single employer in the state, impacting, according to U.S. Labor Department estimates, directly upon approximately 78,000 people. And if one wants to take extended families and friends beyond that, you can see the impact which the employee group does have.

Completing the people portion of the hospital equation, Maine's hospitals enjoy the fruits of the labors of some 4,000 volunteers and 7,000 auxiliarians who, in 1981, rendered in excess of 400,000 hours of free service to our hospitals. Add to this the nearly 800 members of hospitals' boards of directors

who contribute untold numbers of hours, and one can readily see the impact which hospitals have upon the state.

Finally, Maine's hospitals purchased nearly $200 million worth of goods and services in 1981, an estimated 85 percent of which (or approximately $170 million) was spent here in Maine.

Now, as you consider the matter of hospital costs, I urge that you not be misled by simple arithmetic or ratio comparisons of what hospital costs were five and ten years ago and what they are today. For, in truth, we are not talking about the same product. The automobile of ten years ago and the automobile of today are essentially the same product, with some design changes and a few engineering modifications for fuel efficiency and safety. So, too, with a loaf of bread or a gallon of gasoline, there has been little essential change to either one of these products in the last ten years. Yet I am certain that each of you has some feel for what it cost to purchase these commodities today versus what it cost to purchase them ten years ago. A day of hospital care, on the other hand, is a wholly different product, vastly improved over what it was ten, five, or even two or three years ago.

I would strongly urge that you keep this in mind as you hear various statistics which purport to show that hospital costs are out of control and that hospitals need to be greatly more regulated than they are at present.

Finally, let me emphasize that hospitals are acutely aware of their costs and are probably more concerned about them than are their critics. Unlike many of their critics, however, hospitals--specifically, their managements and community boards of directors--are also aware of the complexities of hospital economics, and recognize that easy answers and quick fixes like cost caps, socializing health care, or putting doctors on salaries, won't work. The Health Facility Cost Review Board's report itself admitted that hospitals are more victim than villain of a reimbursement mechanism which was forced upon them

largely by government.

Maine's hospitals, through the MHA, will work with this committee and/or any other appropriate body to arrive at sensible and workable solutions to the cost problem which concerns us all. We will not, however, willingly accept the imposition of restraints which ignore the elements contributing to higher hospital costs, such as an aging population, inflation, service intensity, entitlements, third-party discounts, technological advances, over-regulation, medical practice patterns, access, and public and community expectations. We recognize that this committee is faced with an extraordinarily difficult and complex task. I want each and every member of the committee to be aware that the Association and its hospitals will stand ready to work with you and any other appropriate body to deal in a rational and sensible and workable manner to address these various complex problems.

Our next speaker will be Robert Marden, who is chairman of the board of directors of Mid-Maine Medical Center. Mr. Marden is also a past president of the Maine State Senate.

GILL: Are there questions from the committee for Mr. Heggie? ... Thank you.

MARDEN: I'm Bob Marden from Waterville... For just a few moments I'd like to give you my perspective as a trustee of a hospital. I'm one of twenty-five with Mid-Maine Medical Center. We merged the Thayer Hospital with the Seton Sisters Hospital and we own and control Jackman Hospital and the Greenville Hospital and have working relationships with several others.

I don't envy you your task. I served on your committee twenty years ago and the burning issue then was the proper commitment law for people going to the state hospitals in Bangor and Augusta. At that time, there was standing room only in both institutions. So a lot has happened over the years.

We trustees are "bugged" daily by members of the community--our best friends--about two things. One is hospital care itself, the quality of hospital care, the convenience of hospital care. And, in the same breath, the awful cost of hospital care. That's point one. Those two issues, I think, cannot be separated: the quality of care and the cost. Even our official corporate policy now at the medical center uses the phrase "quality care within our means," because we are sensitive to this issue.

Our budgeting process is almost unfair to ask any volunteer to get involved in. It involves three-hour sessions each evening for ten weeks every year and going through, line by line, with department heads, full scrutiny by the board, then back for another look. We fight for economies of scale. We recently had a trustees' retreat on the subject of cost containment. We go to regional seminars. We force our management people to abide by the MBO system.

In spite of all these efforts, we're still frustrated by the very same problem you're facing. We've cut clinics, we've closed out clinics, we're reviewing others. We still hear it on the street. Because in spite of our efforts and our budgeting process, we don't know what the government is going to allocate for reimbursement purposes, either state or federal. Even worse, we don't know what the bed census will be for the ensuing year. People still say on the street: the cost is awful and, by the way, why did I have to wait thirty minutes in the Emergency Room?

So, if I may take just a couple of minutes to reflect... When I first became a trustee, the Hill-Burton Act was king. And why not build that new wing? There's the money. Mental health was king. And any time you wanted a grant to start a community clinic, it was there. And the big move, of course, was in 1965 with the passage of the Medicare Act, when it became national policy that every person in this country was entitled to good medical care, regardless of their means.

Excellent philosophy. And the root of our problem today.

So you know what's happened. The twenty-four-hour Emergency Room, clinics of all kinds, ICUs, CCUs, an ambulance service second to none, CAT scanners, linear accelerators, dialysis--saving countless lives, extending countless lives, based upon proven need before a government agency, but enormously expensive.

So point two is this. If we, the people, and the government created this marvelous system, regardless of its cost, we should be proud of it and we should not apologize for it. But we do have a problem. The figures are staggering and the solution, as many will say after me and have said before me, is not simple or easy. And I don't think the solution will lie with one legislative document, however well-intentioned. It seems to me that we've got to face that essential, basic, fundamental public policy which the Congress faced in 1965 when it adopted that public policy that all people in this country are entitled to quality health service, regardless of their means. And this is a tough one. In other words, we have met the enemy, and it's us.

In all your lives, in my life, and the people I know, especially these days, people are saying: We don't need to buy steak tonight, or we won't go out to eat this week. Or, don't buy the shoes in the shoe store, there's a discount place down the road. Or, we don't need to trade in the car this year. Everyone is talking that way. But, if Aunt Suzy gets sick, she gets the best. Nobody says, when it comes to health care, I can't afford it. Nobody. We have a big problem in mass education as part of any solution we're going to discuss, which contains very important moral and legal issues.

Shall we ration expensive medical procedures? If a ninety-five year-old person with terminal cancer wants an organ transplant at a hundred thousand dollars, should he or she have it? Is it true that five percent of the Medicare patients use fifty percent of the Medicare budget for the last year of their lives?

I do some probate work as a practicing lawyer. In the last couple of years, I have offered to people--not suggested, but offered--something called a Living Will. All it says, in the form of a letter to your doctor and your family, is, if I'm kept alive only by artificial means, pull the plug. Just showing it to people, I have yet, in two years, seen one person who said, no, I don't want to sign. Every single one says yes. We've got to take a new look at this great system.

But one thing we must beware. In our efforts to cure what we perceive as a real problem, please don't do what may result from solutions. And that is to bring us back to a system of two classes of care: one class for the people who can pay and the other class for the poor and the elderly for whom the government pays. We trustees, who are citizens like you, will be glad to help.

GILL: Bob, as chairman of the board of trustees, what have you done in your facility in working with physicians to try to tighten things up. I know you said you have dispensed with some of the clinics. But are you suggesting that they look at their behavior and how they have practiced medicine in the past, as far as lab tests, diagnostic tests?

MARDEN: We deal through a committee system. And several of the committees are emphasizing that very thing at the present time. We can't interfere with the doctors' private practice of medicine outside the hospital, but insofar as it applies to hospital practices, the answer is yes. And the newest and the busiest committee of the hospital in compliance with the accreditation people request is quality assurance. We meet monthly and we review each department's quality assurance, which has to do with the subjects of risk management and efficiency. As a matter of fact, at the last meeting the medical staff was in a very cooperative mood with our

concerns and expressed deep concern about the series of charges which they saw come out of the lab. So we've got people thinking that way. It's a long, hard process. In terms of the total problem, and that is the extremely high cost of health care, the cost of hospital operations other than salaries is a fairly small percent, but we're still looking at it.

NELSON: Mr. Marden, what do you see as important incentives for the hospitals to try to contain their costs?

MARDEN: The most important incentive to the board of trustees is public awareness and the fact that our operations are in a glass house. Everybody in a town like Waterville, which is only 18,000 people, knows most of the physicians or knows many of the employees. If they're loafing and so forth, we're the first to hear about it. Anybody walking through the hospital can get a feel for whether or not it is a brisk, efficient operation, or looks kind of sloppy and lazy. Management by objectives, which is a document of forty-fifty pages, outlining the goals against which the performance of management is judged in terms of salaries for the next year, contain many items involving efficiency and cutting of costs.

NELSON: But what are the incentives for a hospital to cut costs? Are there any incentives, as you see it right now?

MARDEN: I don't know. With the crazy financing system that hospitals operate under... with the type of legal restraints they have as to what is reimbursable and what isn't... the traditional kind of incentives aren't there as in a business.

NELSON: Could you envisage any non-traditional incentives, then, to encourage hospitals to cut costs?

MARDEN: The pressure that this board is constantly putting on our president in terms of our own operation--not to compare the cost of our product with other similar institutions but with straight dollars.

NELSON: Do you believe that there is a free marketplace in the health industry?

MARDEN: I don't think the way our health industry is composed that it could be compared at present to a free marketplace, no.

NELSON: Do you believe that everybody should have the best medical care possible?

MARDEN: I think that's too broad. I think you should separate necessary health prevention procedures and life-saving procedures from cosmetic surgery and other types of procedures which you might, indeed, in a review of the whole system, say, some things people can afford and some things people can't afford.

NELSON: But the quality is the best?

MARDEN: The quality must remain high. Whatever we do, it must be first-class, the best.

NELSON: So that everyone is entitled to the best eye surgeon in the State of Maine?

MARDEN: No, I don't think, for example, that specialized surgery needs to be located everywhere in the State of Maine. Whether a person should have the services of the best eye surgeon would depend on whether or not he were willing to travel to a place where the economy would support an excellent eye surgeon. In

other words, the certificate-of-need process which we have should continue, particularly in a state like Maine which is so spread out.

NELSON: Could certificate-of-need be thought of as an incentive?

MARDEN: I don't feel the certificate-of-need process is part of an incentive.

MANNING: Mr. Marden, earlier you had indicated that the way the budgets of the federal and state governments have been going, and the uncertainty of what will be reimbursable... Wouldn't it be easier to know ahead of time how much money you're going to have?

MARDEN: Absolutely. No question about it. It would produce a significant improvement in our budgetary planning.

MANNING: So you would be in favor of prospective payment?

MARDEN: Very much

BRODEUR: You mentioned prevention efforts. I'm wondering what is being done in the Waterville area in the area of prevention? And is that adequate?

MARDEN: I don't think it's adequate, but there is a beginning. And it's beginning from a base of zero, other than the traditional school health programs. A recent organization has been established involving local industry and the Chamber of Commerce, working with our hospital leadership in terms of preventive medicine, identification of areawide health problems. We're really at the beginning stage, but we see that as one of the changing roles of the hospital system in the future, to do some preventive medicine.

BRODEUR: It seems to me in your answers to questions and some of your comments that you seem to favor the concept of prospective

reimbursement. Is that correct?

MARDEN: Yes, that's correct

GILL: Bob, do you find that you've got people who are waiting for placement in ICFs, who are spending time in the hospital waiting for a bed to open up?

MARDEN: I'd leave that question to Dr. Beaupre. Generally, our hospital census is declining. As for specifics, I'd leave that up to him to answer.

NELSON: As a trustee and a businessman and lawyer, and so forth, what do you think the role of the trustees--the business part of the community--should be in this problem of hospital cost containment? What is their responsibility?

MARDEN: Just the day before yesterday, our board of trustees amended their by-laws to change the designation from "trustees" to "directors." This may be partly symbolic, but I think it's significant because it represents the changing responsibility and the increased responsibility on the part of the board--more to that of fiscal accountability. We see some really big economic problems ahead. In our case, we're in the process of construction. And with the challenge and duty to repay some $20 million in bonds, we have to think seriously about efficiency, about costs, getting the best bang for the buck. That falls directly and legally in the laps of the board of directors.

McCOLLISTER: Earlier you said that changing the reimbursement system could create two classes of patients. Do you honestly believe that we don't have a two-class system at the present time, with government-pay and private-pay patients?

MARDEN: Everything is relative. But, compared to my memory of what the system was like back in the Sixties and Fifties--compared to that, we have an admirably equal system, I think. I'm sure there are some inequities, but comparing the two systems, we're in good shape now.

McCOLLISTER: We have not overcompensated?

MARDEN: In those days, some little old lady with no money had a hard time just to get an appointment with a doctor. After the Medicare Act, she seemed to be right in there with everybody else.

MacBRIDE: Do you feel that a prospective method of reimbursement would put a cap on hospital care?

MARDEN: I don't know. I'd like to see the specific language of the legislative document before I could comment on that. But, from the information and comments made by Gerald Fuller, our controller, he is very upbeat and positive in terms of helping the cash-flow problem and the budget system of hospitals by having prospective payment.

GILL: Thank you very much. We'll go on to Donald McDowell, Executive Vice President and Treasurer of the Maine Medical Center.

McDOWELL: I have come today to represent the business side of hospitals and to talk a little about the reimbursement system that has been referred to this morning--the way hospitals fund and finance themselves presently, and talk about the inequities in that system or the problems in that system. If, over the next year or so, we're going to be dealing with changes in that system, certainly our board of trustees and Bob Marden

had to know how the system presently works in order to know how to change it.

First of all, I think you must understand the hospital cost reimbursement is complicated a great deal by federal and state laws, regulations, and with historical contractual relationships with Blue Cross and Blue Shield. Hospitals attempt to recover costs. We don't pay dividends out of profits. There has been some discussion in the past year or so about excess hospital profits. I think most people think of that in a corporate sense, that those profits are going to somebody. If hospitals do make a profit (we like to use the term "excess of income over expense"), but if hospitals have a bottom line, there is a reason for that bottom line, and we'd like to explain that today.

Going back a few years to the days that Mr. Marden was talking about, prior to Medicare and Medicaid, hospitals (non-municipal or non-state) did their accounting much differently than they do it today. They really did cash-flow accounting. Income was what they took in, expense was what they paid out. You didn't hire accountants that understood accruals, because accruals didn't mean anything. Accounts receivable were important only in that some of them you were going to receive. Depreciation was not accounted for whatsoever.

Today, seventeen years after the advent of Medicare, I think hospitals have become rather sophisticated in their accounting practices. And reimbursement specialists have been the name of the game in hospitals--hiring people who understand the federal and state regulations, and working those regulations to the best advantage of the local hospital. And I think you have to understand a little of the hospital accounting conventions to understand how the system works.

So what I would suggest we do is that we look at a fictitious hospital and go through the process of determining how a hospital budget will be put together and how it will operate, and the kind

of financial planning that must be done by the hospital and by its board of trustees. First of all, you have to understand a few of the ground rules.

Hospitals must charge all patients the same thing. That doesn't mean they're all going to pay the same thing. But we must start out by charging all patients exactly the same for a day's care, for operating room use, for a laboratory test--everybody has to be charged the same. Also, another interesting convention in hospital accounting is that bad debts... where in most businesses, bad debts are considered to be an expense, in hospitals bad debts are considered a negative revenue. You just never get to consider it and you never get to count it as an expense of doing business. If you don't collect a bill, it's just foregone revenue; it can't be part of your expense base. We also must depreciate on a historical cost basis, not on a cost-of-replacement basis. And we must integrate the federal and state regulations into our accounting system, so we can accommodate those.

So let's take a particular hospital, and let's say that in that hospital the operating costs, after all of the budget hearings that Mr. Marden's or any other board of trustees or board of directors in this state would go through, looking at the budget, looking at what part of that budget can be constrained or cut--and understand that a hospital has a certain critical mass, being a twenty-four-hour-a-day, seven-day-a-week operation, providing at least certain basic services. There are certain areas where there is very little opportunity for cuts. You've got to have people there twenty-four hours a day. You've got to have somebody in the laboratory and in radiology at certain times of the day. So there are certain given, critical-mass costs which can't be cut. And then there are some where there are some options. But in a given budget, when you look at a fairly large or medium size hospital, you may be talking about three to five percent maximum of discretion each year in terms of the budget--if you're

going to continue the same level of service. So let us say, in this particular hospital, that the operating costs are a hundred million dollars. That's a big figure. We could use thousands or hundreds, but let's say that the operating costs are approximately $100 million. That is a lot of money, but that just covers the day-to-day operating costs.

Now, what else does a hospital have to have money for? If it has any debt, it has to have money to repay the debt. The principal payments are not part of the operating costs. So it must generate dollars to pay off the debt. It must generate dollars for capital equipment. Included in this $100 million is a bit of depreciation expense. But I think historically, given that you're depreciating assets that are five or ten years old, and you're replacing them with assets that are bought in 1982 dollars, you must have dollars for capital equipment.

When we talk about capital equipment, people immediately think about a CAT scanner or some radiation therapy equipment. It's not all that exotic. I went to the capital budget of MMC last night and looked at some of the things that were included in last year's. We had to buy 50 replacement stretchers. They cost $1600 apiece. We bought wheelchairs at $750 apiece. We bought examining tables at $5000. A crib, $500--stainless steel. The Joint Commission on Hospital Accreditation requires that. A stretcher scale to weigh people that cannot stand up, $3500. A routine, regular bed, without mattress, $200. A defibrillator to use on a "code" cart, in case somebody gets into trouble, $6500. Those are not exotic things and things we have to replace every year. Certainly, you get into some of the newer technology--monitoring equipment, $8000 a bed for a CCU; an EKG monitor, $2500; an echocardiograph, $100,000; a balloon pump to use in cardiac surgery, $22,000; a fetal monitor, $9000. Those are the kinds of things we're dealing with in capital budgets. And they're not all the exotic CAT scanners that go through certificate-of-need. If you add

up enough of those, you come to a great deal of money in just keeping up with the replacement of equipment. At the Medical Center, we have to replace a hundred mattresses a year. That allows us to replace every mattress every five years. A mattress gets a little raggedy in five years in a hospital. So I think we must have dollars for capital equipment. We must have dollars for debt. And you must have dollars for working capital.

We carry accounts receivable. We don't collect every dollar we bill. And each year, the accounts receivable, as the hospital budget grows and as the charges grow, the accounts receivable grow. And since we have to pay a payroll every Thursday afternoon (employees get a bit testy if you don't make that Thursday payroll), we have to have the money in the bank to make the payroll. So working capital is certainly a need, just as in any other business.

So we have to add all those things together and we have to determine what this bottom line needs to be very early in the game. So if we have a requirement for $2 million in capital equipment, $2 million in debt, and $1 million in working capital, we can fill in this line rather quickly as needing $5 million in bottom line. That's the "profit" in hospitals that people are talking about: working capital, capital equipment, and debt repayment. That's what we're getting at.

The other thing we need to look at is, what do we have in terms of non-operating revenues available to meet that need? Gifts, interest income (if you happen to have any money to invest), endowment fund return. Certainly that is available to meet these needs and the operating costs needs. So let us say that in this particular institution we have non-operating revenue of $2 million. That then means that the income from operations is $3 million. If $2 million is going to be made up by gifts and interest income, then you need to make up $3 million from the results of operations.

That then says that the total operating revenue has to be $103 million. You've got to have a total operating revenue of $103 to cover operating costs of $100 million and have $3 million left to add to the non-operating revenue (the gifts and interest income) to come to the $5 million you need to take care of capital needs, including debt. Then you can say, What other operating revenue that is not going to be billed to patients? Talking about cafeteria revenue, revenue from parking lots, and that sort of thing, that you don't bill to patients. How much of that is available? You can make an estimate of that. In this case, we'll say it's $2 million. That means, then, that you have to have net patient revenue of $101 million, to add with other operating revenues, to make up the $103 million. So, in order to make this equation work and keep this hospital financially viable, we have to get from patients $101 million.

Now, how do we get that with the present reimbursement system? I have to move now to what we call the "hydraulic" chart and talk a little about how the reimbursement system works. Let's assume that this box represents the total revenue for a hospital. And let's assume that the dotted line represents the total operating costs of $100 million, minus the other operating revenue which offsets some of that cost. So this line is really $98 million that we have to recover in terms of cost. We also have to recover, as I've said, not just the costs but the $5 million of excess. ¶ Let's assume that this group here is 50 percent. They are Medicare and Medicaid patients as a portion of the total. Medicare and Medicaid patients pay on a cost reimbursement basis. The government tells you what cost is. It's not what you pay, it's what they say you pay.

As an example, we pay malpractice insurance in hospitals based upon our total patient population and our physician population. Medicare decided several years ago that only thirteen percent or so of the malpractice claims were from Medicare patients. Therefore, they were only going to pay

thirteen percent of the malpractice insurance bill, even though Medicare patients were forty percent of the patients in the hospital. So somebody else is going to pick up the rest of that portion. There are a whole series of things that Medicare has decided, in their wisdom, not to pay their portion of. So, in terms of Medicare and Medicaid making their portion of that total, they will reimburse the hospital just slightly below cost. In terms of this operation, let's say that's one million dollars less than cost. Fifty percent of this cost would be $49 million. They reimburse us $48 million for the care of Medicare patients. And that's what we can expect. Somebody else has to make up this $1 million. We have to bill that to somebody else.

We have another segment of our patient population--about 25 percent in this hospital--that is Blue Cross patients. Due to historical contracting relationship with the Blue Cross, we pay them on a sort of modified cost basis, something slightly more than cost, with allowances for a portion of the bad debts and that sort of thing. Blue Cross patients would pay something slightly above costs. Let's say, in this case, it's one million dollars above costs.

Now, there is another group of patients in this hospital, about four percent, who pay nothing. Absolutely nothing. They're not covered by Medicare, Medicaid. They just can't pay. They're not entitled. And nothing is more difficult in a hospital, as you may realize, than to deny care to somebody who can't pay. So hospitals provide free care. And that free care, in this case, would be about four percent. So that total amount is uncompensated and somebody has to pay that portion of the bill.

So we have a million dollars here [in the Medicare population] that has to be paid just in meeting costs; a million dollars here [in the Blue Cross population] that is paid above; about four million dollars here that is not being covered at all; and we only have one group of patients left from which to collect:

private insurers and private pay. And those people pay charges. And they're the only people who pay charges. Everybody else is either cost-reimbursement or no-reimbursement. And they pay up here at this level. In this case, we have a $4 million deficit here. And in this particular instance, these people will pay $7 million above the cost. Here, the cost is about $20.5 million, and the payment will be $27.5 million.

So that when you complete this equation, and go back and put this in on the corporate income statement, you've got to generate $130 million in charges, (remember that we have to charge everybody the same thing) because we have $5 million in bad debts ($4 million that is costs plus the inflation up to charges); we have $17 million in Medicare and Medicaid disallowance--because we will bill Medicare and Medicaid $65 million to recover $48 million; and we will have approximately $7 million in Blue Cross allowances below charges. So, in order to generate the $101 million in net patient revenue, a hospital must bill $130 million--knowing full well that $5 million will not be paid at all, $17 million will be deducted immediately by Medicare and Medicaid, and $7 million will be deducted by Blue Cross contract, netting $101 million.

A great deal is said about the rising charges for health care. The cost of a room at our hospital (semi-private) this year is $192. Only 21 percent of the patients ever pay that. A lot of people are paying 80 percent of that, or are being paid for at 80 percent. This is the type of reimbursement system that we are now presently working with. It's difficult for those of us who work with it every day to understand. It's more difficult for our trustees to understand, because when we come with budgets and we talk about the fact that we need to raise another million dollars down here... In order to raise that million dollars down here, you have to add five million dollars to your charges, because only 21 percent are paying charges. So if you have an excess need for one million dollars

of capital in a given year, you don't add a million dollars to charge; you add five million.

You asked what incentive hospitals have to save. I think this says, on the one hand, one may look at this and say, no matter what that cost line is, you're going to get reimbursed almost all of it from Medicare, a little more than the cost from Blue Cross--so why save? Somebody has to protect the private-pay patients. And how long can that continue to go up? I think that hospitals have realized for the last few years that the private-pay or the private insurer has a limit to what part of this burden they can absorb. So I think there has been on the business side of the hospital, certainly on the trustees' side, a concern for what we call cost-shifting.

This is the sort of process one goes through when one budgets. It is exactly the same process one goes through in the accounting. If you're explaining an interim financial statement to your board of trustees and you say that you have decreased operating costs and increased gross patient charges, you may still be behind budget. It looks like you should be ahead of budget when you increase revenues and cut costs. But this reimbursement formula can work in such a fashion that you end up not meeting your budget because, by decreasing your costs, you decrease your reimbursement.

This is Economics 101 in Hospital Finance. Believe me, the graduate course is very similar. It's just this complicated and just this simple. I think that you as a group need to understand this. Maybe some of you already did, but it seemed that we should at least present this.

GILL: The reason that Medicare/Medicaid don't pay their 50 percent share--is it because they don't deal in bad debts?

McDOWELL: Yes. Remember, one of the conventions we started with is that bad debts is not a cost. So bad debts is part of the revenue. Medicare/Medicaid will pay almost their share of the direct costs, not counting bad debts and not participating in capital needs. They say that's somebody else's worry, and the bad debts are somebody else's worry; we're just going to pay the operating costs.

GILL: If there is statutory authority to recoup that, why hasn't that been done?

McDOWELL: Are you referring to the Texas case where they allowed Hill-Burton free care as a cost of the hospital doing business for Medicare and Medicaid?

GILL: What I'm talking about is that, traditionally, Medicare and Medicaid have not participated in bad debts. But there is statutory authority that allows us to try to recapture that. And apparently there has been no attempt in Maine to go after that.

McDOWELL: I'm sorry, I'm not familiar with what you're talking about.

BUSTIN: Let me ask the question a different way: How do you handle your bad debts? Does it get written off on your income tax statement? You've got to write it off somehow.

McDOWELL: It's a revenue foregone. We don't pay income tax. We're a tax-exempt organization. So it's not a matter of a tax deduction. It has no advantage to us. We try to collect these bad debts. We go through all the collection processes that one can go through. And we hold them to four percent of total revenue by doing that. But eventually, if you carry somebody down to the

point that they just can't pay, you write them off as foregone revenue.

BUSTIN: But you get no credit for that?

McDOWELL: No. Since we don't pay taxes, there's no advantage. In a corporate sense, those bad debts would be part of your tax relief. But in a hospital, not paying either federal or state income tax, there is no advantage in having bad debts.

BUSTIN: Could you go into how you handle the Hill-Burton?

McDOWELL: The Hill-Burton is a portion of this uncompensated care. I think most hospitals that have been around since the Fifties have some requirement to provide a certain level of free care under Hill-Burton agreements signed for capital dollars in the Fifties and Sixties. Our Hill-Burton requirement is about $300,000 a year. Hill-Burton requires some of the most godawful collection of paperwork that one can imagine. But we must notify every patient who comes into the hospital, in writing, that they may be eligible for free care. And if they wish to avail themselves of that, they should sit down with one of our people and fill out the forms. We then sit down and fill out the financial statement forms for that person to determine whether their income level and their number of dependents make them eligible for free care. And if they are eligible for free care, and we have not met our $400,000 limit for that year, we will not send them a bill.

BUSTIN: What are your benefits under Hill-Burton for that?

McDOWELL: The benefits were received years ago when Hill-Burton provided some amount of dollars for construction funds. I believe that at the Maine Medical Center some Hill-Burton money was used on the Richert wing, for instance. You have a requirement, dependent

on when you did it, for ten or twenty years of free care after that. There have been a lot of court cases in the past few years about exactly how that free care was to be calculated. A lot of hospitals were saying, We're providing four million dollars' worth of free care. For goodness sake, don't bug us about four hundred thousand. But Hill-Burton said, We want to know specifically which $400,000 was Hill-Burton, and did you tell them in advance that it was going to be free. And that's much of the litigation that is going on now.

GILL: I want to go back to my question, because I want to find out whether I am misinformed. I'm asking the question because of what Carl Schramm wrote in his article that he presented to the Health Facilities Cost Review Board. He said: Medicare and Medicaid generally do not participate in funding bad debt expenses although statutory authority exists to permit their participation.

McDOWELL: Statutory authority permits them to do it; they just don't. It has never been funded. There are no funds for Medicare and Medicaid to participate in bad debts. It's not against the law; they just don't do it.

GILL: But why hasn't something been done from the hospitals' point of view in trying to get that statutory authority in the works?

McDOWELL: I guess Mr. Heggie would know more about the number of suits that have been filed by hospitals in the United States over federal participation in bad debts. They are legion. It's not that hospitals have not tried. Hospitals more recently have tried to get the Hill-Burton portion of it that we were talking about, which is required by the federal government, considered as a bad debt. And that, in a Fifth Circuit Court case in Texas, was agreed to. It has not been carried forward to any other Circuit. And I think it has been denied on appeal, if I'm not mistaken. So it

is not from lack of trying to get the federal government to participate in this. But you can imagine that, in a year in which the federal government is cutting the Medicare entitlement by $3.5 billion, they probably are not going to move to pick up a new cost. At least we don't think they will.

GILL: We are in the same bind that they are. And if they have been responsible for the inflationary costs in the last ten years, and they're not paying their fair share, and yet we're squeezing everybody else, I think they have to look at themselves and say: If we're going to participate, then either we're going to cut services that we're going to participate in and pay up to the full, or we're not going to put the burden on someone else. It just seems that they're putting the burden artificially on the State of Maine, the hospitals in this state and other states.

McDOWELL: I think that has been said so many times to the federal government in so many ways and in so many legal actions, in terms of their participating. They started out in 1965 by saying, We want to pay our fair share. And from 1965 to 1982, there have been a series of regulations which have said, We don't quite want to pay our fair share; we just want a little less. And this is diminishing. And what that does is to put the pressure on the other categories of patients. It is part of the system that we deal with every day.

MANNING: Getting back to Medicare/Medicaid, you're saying that if $65 million is billed to Medicare and Medicaid patients, you only recoup $48 million?

McDOWELL: That's right

MANNING: You don't bill the patients any more?

McDOWELL: We can't... You can bill the patient for any items that are not covered by Medicare and Medicaid. If they have a television

in their room, or if they have a private room rather than a semi-private room at their own request--something like that, you can bill the patient. But you can't bill them for any of the costs covered by Medicare.

MANNING: What about costs that are not covered by Medicare? Do you bill them?

McDOWELL: Certainly, if they're things that are not covered by Medicare. There are very few things that are not covered. As I said, the cost of a television in the room, they would pay themselves.

MANNING: So, basically, Medicare covers everything more or less, but it just doesn't cover it to the full extent?

McDOWELL: That's right. There is a deductible amount when a person comes into the hospital--the first so many dollars, and that has recently changed. They pay the deductible amount, which we collect. Past that, it all goes into the Medicare/Medicaid pool. And we cannot collect from the patient.

NELSON: To get back to the payment of bad debts, if indeed there is statute that demands the government to pay--this was the implication?

McDOWELL: I don't believe there is any statute that demands that. I'm getting into some legalities. I don't believe there is any statute that demands the payment. I do not think the statute forbids the payment of bad debts by Medicare and Medicaid. There is no statute that demands it; it just is not forbidden. And they have chosen, in the operation of Medicare, not to pay it.

NELSON: And there is no litigation, in this litigious society, that hospitals have gotten beyond the first district court in this kind of case? The hospitals of America have never won a case?

McDOWELL: Never that I know of

NELSON: Is someone going to address that?

GILL: Warren [Kessler], could you do that briefly now?

KESSLER: There is no such statute on the book that demands, or even allows, the federal government to pay for bad debts for uncovered people. The law is very specific in saying that Medicare will pay for costs of Medicare patients. Period. And not the costs of other patients. What is on the books is that if these deductibles, co-insurance, and non-covered services are billed by Maine Medical Center to those Medicare recipients and are not paid for, they will pay for those. It's a very tiny amount. But when Don talks about the $4 million, or the four percent, of bad debts--there is no statute which either allows or permits the federal government to pay for those. And that law has been challenged in many courts around the country. And the hospital industry has lost all the time.

McDOWELL: Not to disagree, but I don't believe there is statutory prohibition in the description of costs that would preclude the costs from being in there.

KESSLER: There is such a prohibition. Medicare may pay for the costs associated with Medicare recipients only. At least that has been the interpretation of that law, every time it has been challenged. And of course it ends up being the Feds' definition of costs. Interestingly, Medicaid is not allowed to pay more than Medicare. So the State of Maine is in the same basic position.

GILL: Evidently I had the wrong information

KESSLER: You had the piece of information that says, if one of those uncovered services or deductibles ends up being a bad debt, Medicare indeed will stand behind that. One has to keep a separate log of that and separate documentation on it. And all of us do.

NELSON: How would prospective reimbursement work with this formula? Where would you then plug in prospective payments?

McDOWELL: In prospective reimbursement, you would assume that everybody would be paying the same. You'd like to think that in a prospective reimbursement system everybody getting a service would pay the same amount for that service. So I think what hospitals would do, going to the prospective reimbursement system, they would try to set their patient revenues at an amount to cover their operating costs plus their capital needs, without having to go through the Medicare and Medicaid allowances and Blue Cross allowances, and spread the cost evenly to all payors, and have front-end agreement what the revenue per unit of service would be, and build one's budget within that, and live within that, based on the unit of service times the number of units of service offered.

NELSON: Then the gross patient revenue is the area which would be negotiated by some judicial review board that would determine that factor? And then the rest would follow?

McDOWELL: I think you have to have agreement on what those financial requirements are. And I think you have to have agreement on what the operating costs are. And that is basically what we've done here. We've agreed on the operating costs and the needs above operating costs, and just worked backwards to a gross patient revenue figure. Now, if you know the volume involved, and you know what the needs are, you can make a calculation. The discussion in a prospective system would be, Is this the right figure and is that the right figure? And we have some discussions now about

that with the VBRO, which you'll hear about later--about whether those are the right figures.

NELSON: In Rochester, they talked about a contingency fund of some money that they then used for other services within the hospitals. Is there room in this whole plan for that so-called contingency fund?

McDOWELL: I think every hospital, in terms of their operating costs, will have a small contingency by board policy. At the Maine Medical Center, I think that's 0.3 percent of the total budgets. It is there in case something goes awry during the year--something we hadn't anticipated. But that's within the Medical Center. What I think they have in Rochester is a group contingency that they all can call upon. We have nothing like that right now.

NELSON: And what is the basis-of-payment formula? Is this what you're talking about? Or is that something that somebody else is going to address? That was talked about at great length at our last meeting. They worked in the cost of future wages. They used the term often. Is that just another phrase for it?

McDOWELL: I think that's just another phrase for how one determines the financial requirements of the health care institution, and then how that is translated into who pays and what percentage.

MacBRIDE: You mentioned the cost of equipment that a hospital nomally has. We in the public hear a great deal of criticism of the hospital suppliers having equipment, for example, that would take a special light bulb that has to be ordered only from a hospital supplier, that will cost something like three dollars whereas perhaps you would be able to run out and get it for fifty cents. Perhaps the hospital suppliers are driving up the

cost of hospital care. What can be done about that? Or should the marketplace be taking care of that? Or does it not take care of that? Or is there something the hospital can do to control that to a degree?

McDOWELL: I think the hospital suppliers are getting a lot of help from the regulators. I think Mr. Kessler is going to talk a little about the various regulations that hospitals operate under. But many of the things that we use in a hospital have to be perfectly safe, absolutely safe. And the cost of that... If you realize that an electric bed that is used in a patient's room, where the patient has a pacemaker--if you could imagine the complexity of the electrical system that is required to make sure that that electric bed does not interfere with that pacemaker, you pay a lot of money for that bed. We use mechanical beds in those rooms, the old crank type, because it really is not worth it to pay for the type of electrical bed required. I think the requirements of the Joint Commission and, in some places, the state, and OSHA, and a lot of others, have raised the cost of what may be considered a rather minor item to a great amount of money. I think Warren Kessler can give you an idea of how many of those regulations there are and their impact on the hospital.

BUSTIN: If you had your "druthers," how would you rearrange that hydraulic block?

McDOWELL: I think one would develop a system where we could come to agreement as to what the hospital operating costs and revenue would be through the local participation of the board of trustees, with a review, as we do now through the VBRO, or some mechanism similar to that. And have those costs then translated into equitable charges to all payors.

BUSTIN: As a member of the public, how can I be assured that you are monitoring your expenses well enough to keep those costs down?

McDOWELL: On the one hand, I think we've got pretty good regulation of hospitals with boards of trustees. Believe me, they are tough. I think Mr. Marden made that clear. They are very tough on hospitals in terms of their running away with budgets. Also, I think the whole system now requires that hospitals really review the budget and make absolutely sure that all the economies that can be built in, are built in. I believe there is public participation. Certainly there is public participation in the certificate-of-need process. I think there is participation in the VBRO. I think there are so many levels at which hospital activities are reviewed that there is little evidence of runaway hospitals in the State of Maine. During the Health Facilities Cost Review Board hearings, I think there was little evidence that hospitals were running away with the treasury.

BUSTIN: Because you're in the field, it seems to me that you might have come up with some innovative ways that you could readjust those figures. Have you thought about something that might possibly work?

McDOWELL: It really isn't that difficult. What you need to do is to get the government to cooperate. That's really the problem. It doesn't take much to realize that this system is inequitable, and that if everybody paid the same, our $192 room charge at Maine Medical Center would be around $160.

BUSTIN: But what we're talking about is taxpayers' money

McDOWELL: We're talking about taxpayers' money everywhere. The private insurer is taxpayers' money, too. They end up paying for that through the insurance they pay for.

BUSTIN: What I'm trying to get you to say is, How would you re-adjust those figures. And the only answer I get is: more taxpayers' money.

McDOWELL: In terms of the reimbursement system, that's true. I think that in terms of what one does about the total cost of health care, in terms of the public policy issues that Mr. Marden was talking about, I believe that's outside this. This is how you pay for it. A day's care for a Medicare or a Medicaid patient is as expensive in a Maine hospital as one that is being provided by Blue Cross or Union Mutual Insurance. And there is no reason they shouldn't pay the same amount. Now, the public policy issue as to who gets care, and how much care, and how many people you put in the hospital, and for what--I think that's a different issue. But in terms of paying for it, there is no rationale for this distribution that I can think of, outside of the fact that the government swings a fairly heavy hand in this.

BRODEUR: One of the areas where you have bad debts is in Medicare and Medicaid. What is the method of determining payment levels? How does the federal government go about doing that? Is it a certain percentage below cost? Is it a certain level of cost that they allot per service?

McDOWELL: Right now, the amount paid by Medicare--and then subsequently by Medicaid--is the result of a very lengthy cost report, where one documents the cost of each department in the hospital, then measuring that against the percentage of patients served by Medicare and Medicaid by that department, and allocating the costs of that department to Medicare and Medicaid, removing those costs that Medicare and Medicaid say they will not participate in. So the cost in each department is pro-rated, after a rather elaborate step-down of overhead, depreciation, administrative costs, laundry, parking, to each one of those departments. They pay their percentage of the cost of each department in the hospital.

BRODEUR: Then why is the payment two percent below the cost?

McDOWELL: There are certain costs they exclude. As I said, much of the cost of malpractice insurance is excluded. The cost of patient telephones are excluded. They say that telephones in a room are not necessary. If you're a nurse on a unit, having a patient telephone is pretty necessary, because that nurse is going to do a whole lot more work running back and forth to the desk if the patient doesn't have a telephone. So, from our point of view, a telephone in a patient's room is a necessity. In the government's view, it isn't. So there are a number of those issues where the government has said those are not costs they will reimburse for Medicare patients. The major one is malpractice.

BRODEUR: On the other hand, Blue Cross/Blue Shield will pay above costs because they are concerned with getting quality care and making sure the hospital is a viable institution. So it seems to me that the only incentive you have to cut down costs is in the private-pay area and the free-care area, in terms of economic incentives.

McDOWELL: If everybody were in the other part of the system, there would be no incentives whatsoever. There are some incentives in terms of Blue Cross/Blue Shield. They have several financial incentives in their formula. If you do certain things efficiently and effectively, there are ways to qualify for certain financial incentives.

BRODEUR: Senator Bustin asked, How does the public trust the hospitals to be able to cut costs. And your answer was that, basically, the board of trustees will do it because they're tough. It seems to me that your hospital... What are the operating costs?

McDOWELL: Last year, it was $82-83 million

BRODEUR: That's in the same ballpark. The $100 million is about one-tenth of the state budget. It seems to me that if you make that analogous to legislators who pass the state budget, considering that we spend about nine months every two years looking at the state system, when you consider a board of trustees that spend much less than that in terms of time, it seems to me that they will not have a complete handle on what is going on. Basically, the trustees will be going along with the administrators (which is not necessarily bad). But, in other words, the trustees are just supervising administrators who are actually going to set those costs. Most of the information is in the administrators' hands. And the trustees are not necessarily accountable to any elected group. It seems to me that that is not exactly a system that you can actually count on to cut costs.

McDOWELL: I think you also must remember that presently we go through the VBRO with that same budget, after passing the trustees. And I think Mr. Bourne is going to talk about how those budgets are compared, and the analysis they do, then coming back to the hospital to point out areas where there appear to be discrepancies in their figures. I think they are reviewed really twice. And I guess I'd disagree with your statement that hospital trustees do not have the time to give as close a scrutiny to a hospital budget as state legislators have to give to the state budget. Your state legislators are looking at an awful lot of different budgets. Hospital directors or trustees are looking at one. And they sit on that board for years. And they know it pretty well. I don't believe they are uninformed. Believe me, at Maine Medical Center, they are informed.

McCOLLISTER: Under the reimbursement system that we're discussing, how will Medicare and Medicaid bring their reimbursement up to equal everybody else? Why would they?

McDOWELL: I don't think they will. I don't know why they would. I was asked about the Utopia and I was speaking from a utopian viewpoint.

McCOLLISTER: Then there is no way we can bring about everybody paying equally for equal service?

McDOWELL: The report from the Health Facilities Cost Review Board had, as one of its mainstays, equity among payors. Now, if that means true equity--everybody paying the same amount--it's fantastic. I'm not too sure how we plan to get this participation at a time when the federal (and I suspect even the state) government is wanting to reduce that participation. I think it would be difficult to expect them to expand, to take their appropriate share of uncompensated care and participate in whatever financial requirements for capital and debt.

McCOLLISTER: How would you react if the future bill required you to print upon each patient's bill the various amounts that he would have paid if he'd been under the other systems? In other words, say I'm a private payor. Your bill also has to state that you would have been reimbursed so much if I'd been a Blue Cross, or so much if I'd been a Medicare or Medicaid patient?

McDOWELL: If the person is paying the bill himself... of this 21 percent, there is a very small category of people who are writing the check themselves... that statement would be persuasive to that group. To the rest of that 21 percent group that is being covered by a private insurance company, I believe he may be as blasé as the rest in saying, Somebody else is paying the bill. I think you get down to a very small number of people who write a check and send it in for payment of their hospital bill.

McCOLLISTER: You don't think the full 21 percent would be upset over their premiums?

McDOWELL: I think the employers of that 21 percent would. Whether the patient himself would or not, I don't know. As a nation, I think we've become a little blasé about the cost of health care because somebody else generally is paying: the government, Blue Cross, or a private insurer. Obviously, a good deal of that is being paid by a good deal of business and industry and by us. They take a certain amount out of my paycheck every week that goes to support this.

BRODEUR: From what we're hearing about Congress and from what we're seeing at the state level, the government share is getting less and less. Where can you see keeping hospital costs down?

McDOWELL: As I said, I think there is in every hospital a certain critical mass of costs that you have to have. I also think that hospitals must respond to the volume of patients that come in. We have to accommodate them. As Bob Marden said, people don't want to wait thirty minutes in the Emergency Room. Now, if you really want to start cutting back from where we are, I think we can start talking about cutting back on some services. There are statements made that there is great fat and waste in hospital budgets. I don't think there is. I think we can cut some things. We can cut services. We can close clinics. Clinics in hospitals are rather expensive. You can do that. You can decrease the amount of coverage in Emergency Rooms. You can begin to draw back some of the other outpatient care facilities, family practice units, and that sort of thing. And then, when you get down to the floor--the Intensive Care Unit or the patient--there is not a whole left that one can do. I don't think hospitals would be in favor of cutting the nursing staff in half. I don't think we

would decide to go with pharmacists who were not trained. When somebody talks about paying ninety percent of costs, so you cut back ten percent, I don't think somebody wants a ninety-percent-trained nurse, or a ninety-per-cent trained pharmacist, or a ninety-percent-trained lab technician. I think they want a hundred percent trained, once you get down to bedside patient care. I think there are some ancillary things in a hospital. If you start cutting, you could cut back services. And if the dollars are not there, I think that's what will happen in hospitals in Maine. You will see some service cutbacks. I think you're already seeing some.

BRODEUR: So those would basically be services that would not for the inpatients but more or less outpatient?

McDOWELL: I think that would be one of the easier things to start cutting back. I think it would be very difficult to cut inpatient services. It would be very difficult to say, We just don't have a respiratory therapist available today to give you your respiratory therapy treatment, because we can't afford one.

BRODEUR: How is that new medical building on Lowell Street in Portland affecting Maine Medical Center?

McDOWELL: You're talking about the ambulatory surgery unit? As far as that is concerned, if approved (and I don't know if it has been approved yet or not), I think it will attract some of the ambulatory surgery cases. Our own analysis is that we do ambulatory surgery now in such limited numbers that it's not going to be a great deterrent to the hospital budget. We don't anticipate any.

BRODEUR: There's a certain amount of money needed to run the hospital every year anyway?

McDOWELL: I read the transcript from your last meeting and they were talking about cutting lab tests. The idea being, if you cut lab tests in half, you'd cut the costs in half. That's baloney. If you cut the lab tests in half, you may cut the costs ten percent, or maybe less, because you're still going to have the equipment, you're still going to have the personnel. And in most hospitals, you don't duplicate much of that; you've got one of everything. So if you cut back the lab tests, except in a hospital where you have so many of them that you have a whole cadre of people doing the same thing--what you may do, in cutting back lab tests, is to increase the cost per lab test and cut the total cost back some fraction. You're dealing with a critical mass of people that provide patient care. Don't get me wrong. I'm not advocating broad laboratory testing. I'm just saying that you've got to get away from thinking that if you cut the lab tests in half, you're going to cut the cost in half. The cost is not going to be halved.

GILL: I'm going to ask you to hold your questions because we have three other speakers representing the Maine Hospital Association. We'll hear next from Warren Kessler.

KESSLER: This committee is gathered to join in examination of a problem which is nationwide: the problem of rising hospital costs. I think the increase in hospital costs is viewed as a problem throughout this nation and certainly within this state. It's a problem in terms of national priorities. I think you heard testimony at your last meeting in that regard. It's also, by the way--and very few people understand this--an international problem. The cost of health care is rising throughout the Western world at very similar kinds of rates, no matter what the system--wheter it is government-sponsored, or socialized, or government-controlled, or private enterprise. So we are really gathered to talk about that problem and whether, indeed, the State of Maine,

through its legislature, should have a role in solving that problem.

The Board's report was very clear, I think, on some of the reasons for hospital cost increase. Clearly, inflation itself is paramount. Clearly, we are not going to solve that in this room today. Inflation, no matter what it is in the economy, is going to find its way into health care costs on about an equal basis. And there are some people who would argue that maybe it will be a little bit more. So, in short, if there is a five percent inflation rate in this country, hospital costs are going to increase at least five or six percent. There is no way to single out this industry and make it less inflationary than others. However, it has been more inflationary.

So the real question is whether this legislative body wishes to get into the business of controlling what is controllable in hospital costs. And over recent historical times, that clearly has been the number of inputs to hospital care and the numbers of people receiving hospital care. Therein lies the great change in hospital services over the past two decades--decades of high inflation in health care. The reason, indeed, is that hospital inputs are increasing. What we do to a patient gets to be more intense. And more patients are demanding more care. What role should the state play in solving that particular problem?

I would like to go through with you some historical perspective of what increases in input have meant in Maine hospitals in the past fifteen to seventeen years. I use that time frame not because it happens to be the time frame for Medicare, but it's the time frame that I've been in the business of hospital administration. I've been running a hospital in the State of Maine now for eleven years--two different hospitals, the latest one for ten years. And so my historical perspective is very similar to the historical perspective on Medicare and Medicaid, whose programs were created at the time I graduated from graduate school. I'd like to give you some feeling for the kinds of

changes in inputs to the health care system that have happened over that time, and ask you to imagine which of these you might wish that we hadn't introduced. I am using for my frame of reference the hospital I run now, which was the Augusta General Hospital and is now the Kennebec Valley Medical Center since its consolidation with Gardiner General two years ago.

Over that fifteen-to-seventeen year time frame, approximately 30 to 35 percent of its current budget was created in new services offered to patients. The first obvious change in service was the inauguration of Intensive Care Units and Coronary Care Units. One of the main reasons for the increased life expectancy of the American public has been its decreased death rates from coronary artery disease. ICUs and CCUs at the Kennebec Valley Medical Center cost $506,000 a year. The second change was the advent of psychiatric services at the Kennebec Valley Medical Center--not, by the way, as a coincidence, the State of Maine was cutting back on the amount of money it was allocating to psychiatric care through its state budget, forcing many hospitals in this state (I think eight or nine) to go into that business with a vengeance. The cost of providing these services in the Kennebec Valley Medical Center is approximately $500,000 a year. A third area of major impact was when the hospital decided to have a full-time covered Emergency Room. We have a physician in our ER twenty-four hours a day, seven days a week. We made that decision within three months after my arriving at KVMC, because I was spending the better part of every day answering complaints from the public about the lack of speed with which they were being served in the Emergency Room, and because we had obvious opportunity to save some lives there which were being lost. The cost of covering the Emergency Room, twenty-four hours a day, seven days a week, with a physician (in this case, after many years, physicians trained in emergency care) is approximately $400,000 a year--a cost, by the way, which is not being made up with patient charges at this point.

The next major item of new input to our budget was the creation of an ambulatory care center: $531,000 a year, providing 22,000 patient visits a year. That ambulatory care center was partially created to deal with the indigent patient population that the hospital was dealing with and also as part of a larger program in support of what was then the Central Maine Family Practice Residency, which is now the Maine-Dartmouth Family Practice Residency. By the way, the cost of that program is an additional $350,000 a year to my institution.

From there, we drop down to some more mundane items. The inauguration of rehabilitation medicine services, $93,000. The creation of speech and hearing services, $78,000. The development of a more sophisticated oncology system for treatment of cancer (by the way, the leading cause of death in the State of Maine), $80,000. CAT scanning. My hospital does not have a full-body CAT scanner, although we're about to ask for one, but we have a head scanner. And the cost of that service is approximately $73,000 a year, which is tiny compared to the cost of a body scanner, but nevertheless a cost. Radio-therapy cobalt treatment for cancer, $90,000, which did not exist in 1965. And on and on it goes.

The numbers I have just outlined are approximately $3 million per year out of a $21 million budget at the Kennebec Valley Medical Center. If those costs also included indirect costs at the same ratio as other services, we're dealing with approximately 28-29 percent of the KVMC's budget which did not exist in 1965, but which does exist today. Those are the documentable costs of what did not exist. They leave out the costs in every department where service has been changed to the point where it is almost unrecognizable. The cost of monitoring deliveries, the cost of providing education for new parents, the cost of supporting natural childbirth in a variety ways which are currently fashionable. The cost of providing community health education. The cost of providing a pharmacy service which

includes almost a hundred percent of drugs unknown in 1965 and an almost hundred percent new methodology of delivery. For instance, almost all drugs are currently administered by IV therapy, because it's much more accurate and the dosage can be controlled to a much greater degree. That service is about $450,000 in my hospital.

When all these services are added, the Kennebec Valley Medical Center budget is approximately 50 percent greater than it was in 1965, purely from new services being offered to this area's population. The question which I think we all have to ask ourselves is: Which of those services would we not have offered if the state were controlling the cost? There may have been some. But I would invite any appropriateness review that this state cares to generate into my hospital to see if they could identify services which we are providing which are unnecessary for our patients and which are not benefitting them in a positive way. Which of those inputs would we have avoided, had we had rate control in the State of Maine? My answer to that is: probably none of them.

So we must turn our attention to the possibility of limiting those people receiving care. Which parts of the State of Maine's population would we like to disenfranchise? I happen to be a Republican, but I have to tell you that the Republican Administration in Washington right now is clearly providing us with an answer for which parts of the population will be disenfranchised. It clearly looks like it's going to be the elderly and the poor. I must disagree with that perception. But I, of course, am a product of the Sixties. I was educated and trained and my motivational structure was formed in the Sixties. And I find it impossible to choose whether a poor person is going to get care or not. They come into my hospital and, whether they have those resources or not--and we don't know whether or not they have resources until after their admission generally... but it makes no difference and it has no part in the admitting process per se.

So the real questions here are: What parts of a hospital's inputs are we going to do away with, or are we going to prevent from happening in the next ten years? And what parts of our population need to be served less completely? If we haven't got answers for that question, my suggestion to this committee is that we may not be ready to be in the business of putting global limits on hospital budgets.

Clearly, Don McDowell has presented a strong case for some kind of prospective payment system. There is no question in most people's minds that it's better than the mess we're in now. But if that system--and I submit it does--implies a global limit on hospital budgets, then one must understand clearly what that means. There are some economies to be had in hospitals. There is no human endeavor that cannot be done more efficiently, more quickly, and better. And I do not pretend to be administering a hospital where economies are impossible. On the contrary, I spend a good deal of my professional life trying to get those very economies. But I don't believe those numbers are large. And I don't believe it's going to solve the basic issues underlying the rise of health care costs in this state and in this nation. Simply stated, we have an aging population and we have a burgeoning technology which can do more and more. And people want that done. If the State of Maine intends to have a major impact on hospital costs, it is going to have to deal with those two questions.

I do not mean to be pessimistic over the long haul about hospital costs. I think there are pressures afoot now which are going to have some kind of braking effect on hospital costs. One is that it is clearly becoming less affordable. And I honestly believe that there are going to be economic pressures brought to bear on the hospitals that are going to force less and less latitude in the decisions they make in terms of adding inputs to the quality of care. That may be a tragedy. Professionally, I think it is. But I think it's going to happen.

There is almost a revolution underway now with the way people are dying. I honestly believe that is going to change dramatically in the next ten to twenty years. I think the population will choose not to die in my hospital's Intensive Care Unit, with tubes extending from every orifice, and a major barrier to communication with loved ones during the process. People are going to choose to die differently. A Supreme Court justice already chose that, when he denied himself kidney dialysis for an incurable kidney problem, and paid the penalty some months later, but in fairly short order.

So there are some reasons to be optimistic. But I am pessimistic about the state's role in putting on universal caps. I am pessimistic about anyone's political ability to stop the march of technology, to deny people inputs to developed care patterns. And by the way, Maine usually doesn't develop those; we usually use those developed by others. I can't picture the State of Maine deciding not to allow a major improvement developed, say, in California to be implemented in Maine hospitals. I can't picture the political process which does that, and does that well over time. Instead, what I think we're going to find is a political process which essentially, over the short run, will destroy the hospitals' ability to function, or economic viability--something like what New York State has put in with a vengeance--and which we will all spend money in ten years to correct.

So I urge you to think carefully. And the last thing I would say to this committee is: Is the problem in Maine so acute that the legislature needs to take action today? The bed per population in the State of Maine is lower than the national average. The cost per stay in Maine is lower than the national average. The increase in hospital costs in the State of Maine is lower than the national average. And our days of care per resident is lower than the national average. Is there any evidence that you have before you that Maine hospitals are somehow destroying the state by their greed or poor management? My answer to that is, No; but yours may be different. At any rate, I'll be delighted

to participate with you in the debate as it goes forward.

GILL: Something you didn't mention, Warren, but that I have read is that ten years ago people had only one fatal illness in their lifetime, and now they could have up to four or five.

KESSLER: There is no question but that that is true. Since Medicare was put into place, the average life expectancy in the population has gone from somewhere around 67 years to approximately 73 years--almost a ten percent increase. There is no question but that if you save an automobile accident victim at age 25, he's going to live to have four or five chronic diseases and have a lot more hospitalizations. There is no question about that. He also, however, may live for forty years to pay taxes. And that is the positive side which no one seems to wish to document. There has been a major positive impact of people living longer and living weller.

NELSON: I want to address the matter of waiting time in the Emergency Room. If I could wait thirty minutes in an Emergency Room, I would consider that very swift care. You also mentioned in passing that when people enter a hospital, you don't know whether they can pay for their hospital care or not. That's absolutely not true. The first thing they ask when you come in is, Do you have any medical coverage? I know of children who were literally dying, and the first thing they asked was, Do you know your Blue Cross/Blue Shield number? Do you have any insurance? Now, this may be one particular hospital. Perhaps it doesn't happen in your hospital. But I think you have to become realistic. I understand that you are a hired hand. That is to say, you are the professional president of the board, as opposed to a volunteer.

Another thing that we heard at our last meeting is that the important thing about looking at the cost of hospital care

per day is the percent of that change. What does that mean? What is the cost of living in Maine as it relates to that? And that we have to look at those figures and percentages in another light. It may be less expensive in Maine than somewhere else, but then there are other factors that make up the difference.

You paint a terribly gloomy picture. It sounds as if there is nothing that can be done. Clearly, you don't believe that prospective reimbursement is an answer. And you're not sure that the legislature should be doing this kind of thing, that perhaps it isn't such a great problem. What do you recommend, in a positive way, that will help the rising cost of hospitals?

KESSLER: I guess I'm not as positive that there is going to be a simple answer to that question, in terms of what I can recommend in the way of changes to what has been the greatly expanded cost of hospital care. I'm not positive that the answers I would have. There are only two ways, or maybe three. The old way, of course, was not to pay hospital employees very much. But the federal government has decided that we should come under minimum-wage laws now, and they've also decided that we should come under the National Labor Relations Act. So hospital employees now can organize. And the days of deciding to economize on the nation's health care bill by not paying hospital employees is over.

The second thing is lowering the amount of inputs to patient care. I do not think that is a politically viable solution, over any period of time. You might get away with it for a couple of years. But I think it's not going to be politically viable over time. There are simply too many illnesses which we can treat positively now. If you are arthritic and cannot walk, you may now have a new hip to eliminate that disability. You can also have a new knee. And I think it's not going to be very easy to tell people they can't have that, if the technology is readily available to do it. If you have a bad heart, you can have a new heart. I'm not sure that's going to sell in the marketplace.

But you certainly can repair the old one more and more effectively. And that looks like a winner. We don't happen to do that surgery in my hospital, but it's done in the State of Maine at the Maine Medical Center.

So I'm not at all sure that there are direct interventions that are reasonably politically possible that are going to bring a screeching halt to the rise in hospital costs. There are some that can mitigate those. People's lifestyle changes, I think, are going to do that. People's attitude toward health is going to do that. The American public will get what it wants. And they'll set the priorities over time. As they find that the cost of hospitals is impinging upon their ability to do other things, they're beginning to make different kinds of decisions. They're making different kinds of decisions about dying. And many people are making different kinds of decisions about the way they live.

So I am clearly optimistic that lifestyle changes will show up in lowering the increase in hospital costs over the long haul. It is, incidentally, very clear that alcohol plays an incredible role in the cost of health care. There was a study done at Mass General last year that indicated that something like 40-45 percent of their patients (and that's a tertiary hospital) were there for alcohol-related illnesses. So the use of alcohol and drugs in this country, if it is going to be endemic in our population, is going to show up in hospital costs. If the American public's lifestyle moderates, that should eliminate a major cause of health care expenditures. I think there are things you can do about those kinds of things. There are things that government can do. There are things that people can do. And there are some things hospitals can do.

NELSON: Let me be specific. One recommendation we heard last time was to eliminate so many tests. What is the cost in your hospital for the laboratory?

KESSLER: Approximately two million dollars

NELSON: And if they were to cut perhaps two or three of the blood tests or whatever for a simple appendectomy, and say there was a cost saving of two percent... What is two percent of your budget?

KESSLER: Two percent of the lab's budget would be around $40,000

NELSON: Then perhaps by cutting down some of the tests that are now being given, you could save $40,000. Is that correct?

KESSLER: That's absolutely true. No question about that. But I've got to tell you that there is another $40,000 out there that we might be able to cut, and maybe another $40,000... and I grant you that. And the entire bill that I could probably, if I were king (and not in a political system of my own), cut might amount to a couple of percent of the hospital's budget. Any system that you impose is going to get that two percent out the first year. Then what do you do? No one is looking to create a system that is going to cost $5-700,000 per year for the State of Maine to cut that first two percent out. Because after you've cut out that two percent, you've lowered your base a little, but you haven't done anything to the rate of increase in hospital expenditures. And that two percent is going to be eaten up rather quickly. It's worth doing. But I have to tell you that there is management in those hospitals that is attempting to do that every day. And they're successful in doing that. But that's like whistling in the wind, in terms of the staggering overall problem, which is that people are living longer and needing more care, and we have the technology to deliver it. In the face of those pressures, that two percent, or five percent, or (if you're a real critic of hospitals) ten percent--that's a one-time saving. And it doesn't do anything to lessen the increase in longevity of the

American public, or to lessen the march of technology which allows hospitals to do more and more, to both increase that longevity and to increase the quality of life during the years allowed.

There is probably an upper theoretical limit to the age of the population. And we may be approaching that. Some say that 81 years is par for the human body, which wears out after that. Of course, we all know 95-year-olds, but they may be on the tail end of a bell-shaped curve. If that's the upper limit, white female Americans are very close to that now, with an average life expectancy of something like 79 years. And that's not going to increase beyond the theoretical limit, if there is a theoretical limit out there. So we can expect that the aging of our population will slow down. Now, maybe that theoretical limit is false. If that is so, I don't know what happens to that argument. But many people think that the human body simply will not last more than an average of 80-81 years. If that's true, we're getting to that point. And that pressure for increased care will be off when the population levels out to that age expectation.

BRODEUR: Mr. Kessler, in your earlier remarks, you said you didn't think there was very much that the state legislature could do. Does that mean that you don't think the idea of prospective reimbursement is a good one?

KESSLER: No, I think prospective reimbursement is a good idea. I question whether it should be state-mandated. We're going to have prospective reimbursement in the Medicare program within a year, it appears. At last week's meeting of the Maine Hospital Association, Assistant Secretary of HCFA indicated that it would be a policy to have a prospective system for reimbursement of Medicare in place by October of 1983. By the way, that piece of information may have some bearing on the way you think about all this. It is clear that we are going to have prospective reimbursement from Medicare. It would be my hope that hospitals

and Blue Cross could work out such a system also, although we have not been able to as yet. It is clear that we probably could negotiate with the state for a prospective reimbursement system on Medicaid. It is possible. The question is, Are you going to have a global prospective reimbursement system, with global budget limits for Maine hospitals? I think there are going to be various answers to that, depending on who is talking to you. And I think the process by which you arrive at that is going to be extremely difficult. That's the question. Prospective reimbursement is not simple. And there is not just one option in terms of prospective reimbursement. It can be a multi-faceted program as well as a uniform one. ¶ My statement to you is that what is proposed by the Board is not workable, because it assumes that Medicare will go into a prospective reimbursement system on a par with Blue Cross and the insurance companies. And there has been no indication that that is true. There is one experiment in this country (Maryland--and I think you heard about that at some length) that was done on that basis. But HCFA is not willing to sign waivers on the basis they did in Maryland any longer. That was a one-shot waiver. There is no indication that Medicare, under any system, will pay the same as other patients. The evidence before us is that the federal government is going to cut and slash the Medicare budget for as long as it is politically possible to do so. And they're going to be paying less and less of their costs, as opposed to other patients. There is documentable evidence for that.

So I maintain that the system proposed by the Board cannot be implemented in the State of Maine. That does not mean we have to give up on prospective reimbursement. That does not mean we should cease trying to rationalize the mess of reimbursement that Don outlined earlier. But I think we should be realistic in our expectations. And if the federal government is going to cut back on reimbursement, there is no reason in the world why

we should expect them to be willing, or politically able, to pay for the indigent care they are not paying for now, or even major portions of the real costs which they are not now recognizing.

BUSTIN: I hate to diagree, but I just read in the Sunday paper a couple of weeks ago that the human mechanism is designed to last 125 years.

KESSLER: I read the same article. When I read it in the New England Journal of Medicine, I'll be more enthralled with it. What I have read so far has been in the scientific literature. And until I see evidence to the contrary, I'm still going to expect not to live beyond age 80. And in this business, my life expectancy is less.

BUSTIN: The other thing I would say is that I look on your comments as very positive. I fully agree that it is a public policy question. We do have to make a decision on what kind of resources we want to allocate to keeping ourselves alive and keeping ourselves well. And I think that's a very real question, and one that we've got to get hold of.

KESSLER: That's not an easy question, though

BUSTIN: No, it isn't. But when I'm in the hospital, I want the best care. And I'm sure everybody in this room does. And I want the best care for all of my family. But what I would like to ask... It seems to me that one of the costs that drives up the cost of medical care is the cost of insurance. It really isn't leveled out on all segments of the population. And that brings us to the question of national health insurance. How do you feel that would impact on hospital costs and services?

KESSLER: If history is our guide, national health insurance would be a major push to increasing hospital costs. One wonders, however, if you insure the population, whether certain inequities and inefficiencies in the system might be ironed out to offset that. I would have been interested to participate in that. My own guess is that it is a moot question, because I don't think our government, with its current priorities, is going to entertain the possibility of national health insurance for at least a decade, and perhaps two decades. I don't mean that in a partisan way. If we elect Ted Kennedy in 1984, you still wouldn't see national health insurance. You're simply not going to have a Congress that's going to buy into a major new entitlement program in this country until inflation is under control and until someone is comfortable with our defense posture.And until a variety of other things happen in this country, we're not going to turn back our attention to national health insurance for a long time.

GILL: Next on the agenda is John McCormack, who is executive director of Cary Medical Center. I'm going to ask John and Gene Beaupre to abbreviate their testimony because of time constraints.

McCORMACK: My name is John McCormack. I'm the executive director of Cary Medical Center in Caribou. Perhaps the most important point I could try to make is the small hospital perspective. Looking at it from the perspective that Maine is different... I worked for nine years as the chief operating officer of a 325-bed hospital in the Greater Boston area. Massachusetts, particularly the Greater Boston area and some of the more populous states, like Maryland and Connecticut, are loaded with 200- and 300-bed hospitals, seven or eight miles apart. It's a completely different system. The majority of Maine hospitals are small, rural facilities, physically isolated from many of the services and many of the major centers that

would normally be considered a typical referral pattern, an easy access process, in many other states. The point I'm trying to make is that we can't come up with a boilerplate package. The Rochester situation, or the one in Massachusetts, or in Maryland, is not going to apply to Maine.

I am the executive director of a 65-bed hospital in Aroostook County. In The County, we have seven facilities. Under certain multi-institutional arrangements and a couple of cooperative situations, we have some working together. I think there are five independently licensed hospitals. But we have a facility in Fort Kent, one in Van Buren, one in Caribou, one in Fort Fairfield, one in Mars Hill, one in Presque Isle, one in Houlton. The largest individual facility has 100 beds. As a 65-bed hospital, we're considered one of the largest facilities, one of the two central hospitals which take somewhat of a lead.

Economies and quality issues affect us differently. I'll talk about Aroostook County because I know it best, but I think there are a lot of isolated rural hospitals throughout the state. Reference was made to Greenville and places of that nature. We do not have the economies of scale that would apply to many of the larger facilities. We have dramatic shifts, or potential shifts, in occupancy and usage, depending on any given number of things--not the least of which would be the loss of a physician.

The loss of a single physician in a hospital such as ours, a single active physician, can put our budget into a tailspin. Two months after I came to the hospital, we removed (for some very legitimate reasons) two physicians from our staff. One of them was a very big admitter. He admitted 700 patients a year and probably provided us with $2 million in gross revenue, if you're looking at it from a financial perspective. We labored for almost two and a half years to recoup, from a financial perspective. In fairness to VBRO, they rode us pretty hard relative to our projections of usage and related costs. But we had difficulties. The second physician didn't have quite

the impact, but that single physician's removal had a major impact. Swings such as that in any hospital have significant effects that have to be considered.

For example, we have a busy obstetrical service and it's growing fairly rapidly. But we only have two obstetricians. If one of them should walk away today, or should be disabled in any way, we will have budgeted and staffed and prepared for a census that is going to take a dramatic nosedive. We're very busy right now. Our census is up and we're going along in a reasonably busy fashion and we're realizing a few of the economies of scale that we didn't even see a couple of years ago. But that happens.

We also have a lot of related expenses. Let me give you just a few examples. Travel and education programs. Many of the better education programs, particularly in the clinical areas, are offered in Bangor or Portland or sometimes in Augusta. When we have nurses from our newborn nursery, or from our operating room, that need to go to Portland, that's a very expensive proposition. They have to fly, they have to stay overnight, there are meals involved. They can't just go across town, they cannot jump in their car. I worked in Lewiston for a while and most of our people could drive anywhere to any of the education programs. But this doesn't apply in Aroostook County. You have a couple of legislators from Aroostook County on the committee and they know the problem...

Also, based on our population base and the distance between our communities and our hospitals, we can't provide the same number of services that are provided in the major centers. We certainly refer a lot of patients to Bangor, to Portland, to the major centers. However, we do try to provide a quality of care, acceptable by standards in any given community, in our community. One of the things we've done in recent years is to develop a number of clinics. Some of the people who spoke earlier were talking about cutting clinics. We are going the opposite way. We cannot recruit and retain specialists in a number of areas; specifically, pediatric allergy, pediatric

cardiology, dermatology, pediatric neurology, etc. So what we do is to bring those specialists, once or twice a month, to our community. We pay them a day's wage, we pick up their expenses. But what that means is that, while our budget is inflated perhaps significantly by the number of clinics, on any give day, eighteen or twenty people from Aroostook County do not have to fly to Bangor or Portland, do not have to stay overnight, and can have a service provided in their own community. That does appear to inflate the health care budget. Perhaps, if it were not there, it would inflate somebody's travel budget or somebody's expenses out-of-pocket that wouldn't even show up in the health care statistics. But we have tried over the last two or three years to expand that service. And we have twelve or thirteen different programs of that nature, that have been reviewed, approved, and endorsed. But that's an expense.

The smaller hospitals also have chronic recruitment problems. The recruitment of professionals is an ongoing, everyday process. Aroostook County has traditionally consistently had the highest vacancy rate in budgeted positions for RNs in the state. We also have the highest recruitment costs in the state. What you'll find, as you look at the rural hospitals, is that it does cost more to recruit, to retain. We're constantly looking for physicians, nurses, physical therapists, occupational therapists. It is a chronic problem. So it impacts on us in a different way.

We have had to support two local universities. Otherwise, we would lose the nursing programs they offer. We support, in a variety of ways, the University of Maine at Presque Isle and Northern Maine Vocational-Technical Institute, in order to assure that they will keep nursing programs going. Because, if we lose those, we're going to be in terrible shape. Our particular hospital is very dependent on Loring Airforce Base. And the cycles and flows of military personnel in and out of that base gives us significant problems. So we've had to support those programs.

There has been some discussion throughout this meeting on the role of the trustee and how significant their role is. Let me assure you that in our facility, and from what I can see in Aroostook County, trusteeship is a very significant and meaningful responsibility. When I testified before the Health Facilities Cost Review Board as they were doing their studies, I referenced the State of Colorado. At that time, they had just repealed their rate-setting process. The same legislature that had introduced rate-setting legislation had moved to have it removed. I did talk with them in Colorado, because I was interested. The major reason was that it was felt that it was destroying voluntary trusteeship. It removed their fiscal responsibility. It eliminated the incentive for the grass-roots, local community leader to take a real interested role in the hospital and take an intense look at the fiscal situation. Whatever we do, before we do something that will destroy the incentive for the local community leaders to participate and take a key role in the hospital, we should look at that. Certainly our trustees are very active. They're in on a regular basis, several times in a given week. There is an intense budget review that they put us through. And it's not superficial. It's a line by line, item by item, detailed budget review. And we're already into it for our Fiscal Year 1983, which begins on January first.

We have made every effort--and I think you'll find this is true of hospitals throughout the state--in our small hospitals in Aroostook County to join in whatever cooperative ventures we might. I think that while we lose the economies of scale, we certainly have tried to make use of those areas. We have a cooperative education program. It's called Project Raise. It's a shared hospital education program to see if we can offset some of the problems of the lack of education in The County. We have an Aroostook County planning consortium. We work with the Maine Hospital Association in their group purchasing and in their shared insurance programs. The administrators get

together, the personnel directors, the nursing directors, and the various department heads, to see if there are any ways that we can be cost-effective while not reducing quality. We have had to make a significant effort to improve quality. I think there were some real quality questions in many of the rural hospitals. We have put intense effort into that. Obviously, you've got some conflicts between the cost and quality issue. But we have had to work very hard to improve the quality. Those measures have cost us money, but they have also assured people in those communities that, other than the tertiary levels of care and perhaps secondary that have not been offered in rural areas, we have been able to provide a high quality acute care, out-patient care, ambulatory care, etc.

The VBRO process has been very constructive for us. There are no small hospitals that I'm aware of in the State of Maine that are without fairly intense budgetary process. They can't get by VBRO without a meaningful budgetary process. That did not always exist. Our process has been fairly stringent. And I think that a strengthening of the VBRO process has some real merit. I would hate to see that lost by the wayside, because there have been some good aspects to that.

I was a little concerned by Representative Nelson's comments concerning the data collection prior to treatment in reference to a critically ill child. Most of us sincerely try to treat those patients who are seriously ill. Certainly the policy at our facility is that if someone comes in with chest pain, if they are bleeding, if they are in obvious distress in any fashion, we treat them. We worry about it later. However, there are an awful lot of abusers of the emergency system. And if they walk in ... and I'm not being facetious because I had somebody call me just recently about somebody who six days ago had a burn and it's starting to cause some problems and they walk in. Sure, we ask for the information, because if we don't, that four percent figure that Mr. McDowell showed you as bad debts

is going to increase. And it's going to become eight or ten percent, or whatever. And the cost to private insurers is going to go up even higher. But we make a sincere effort that if anybody is in an acute situation, they are brought right in and treated. Then we try to get the information because otherwise there's a fiscal problem.

Our feeling is that we do need to change the incentives inherent in the current health care financing system. I think the most likely proposal is a prospective payment system. Right now, every incentive to consumers and providers encourages increasing quantities and increasing expenditures. There can be some incentives built in. I listened very closely to what Warren Kessler said, because it has been my experience that he has not strayed very far from accurate projections. He is a bit of a pessimist and he admits to that, but there is an opportunity, with some incentives. We have to emphasize cost containment. And we have to emphasize cost consciousness. But not only by the hospitals, not only by the providers, but by the patients as well. There has been a lot of talk about whether there should be some coinsurance and some deductibles. We certainly see people who abuse the system because it is fully paid for and reimbursed.

I think we have to reduce the regulatory burden on hospitals, whatever system we adopt. We have to reduce the size and the cost of the governmental administration of the programs. We have to provide incentives for effective and efficient management. We have to provide a reasonable financial predictability for both the hospitals and the government. The system should contribute to introducing more market forces into health care. There has to be avoidance of arbitrary decisions and a fair payment for services. I think the key is an adequate determination of reimbursement.

Finally, don't make the hospitals--the management or the boards--decide who does or does not get health care, based on economics. Those are really ethical issues that somebody has

to face. And they shouldn't be dealt with on a day-to-day basis, in terms of does our budget allow it. I certainly am not prepared... We all have our personal feelings of an ethical or religious nature. And I certainly am not prepared to start denying people care because the budget doesn't allow. I think that's not something we should be faced with.

We're certainly willing to work with you in any fashion to come up with a reasonable system. I believe that prospective reimbursement, with the appropriate incentives, to get away from spending to get reimbursed, is the most logical direction to move in. I think we should have a stringent VBRO process, with equity among payors, and some incentives built in.

Somebody made reference to malpractice insurance. How do we get around the fear of not providing everything to everybody? The malpractice crisis has a major impact on us. Malpractice rates for phsycians are starting to skyrocket again. And the concern is about massive settlements. We've seen what happened in Florida, where the doctors canceled elective surgery. Our own physicians are starting to feel the real impact of the rates going up again. And there is a real fear. Somehow that has to be addressed in the process, if we're going to cut the lab tests. Fine, but don't leave us totally open and vulnerable to be served with a million-dollar suit because we didn't provide those lab tests. We need some protection.

Hopefully, we'll see some emphasis on less-acute care. I have some very strong feelings about family responsibilities when it comes to the aged. That's not the hospital's business but it is a concern with me. I think that's a very significant issue. Public expectations that you turn on the faucet and you get health care and there is no cost related. The buffering effect of no-deductible. Where can we cut? Sure, we can cut lots of things, many of which have already been mentioned today.

GILL: Are there any questions of John McCormack?

MANNING: You mentioned that if one doctor leaves... Then what happens to those other women who are having babies? Do they move to Presque Isle?

McCORMACK: I don't have an easy answer for that. That's the problem we face in the isolated area. We have two physicians in that specialty, but there are hospitals in rural areas that have a single specialist. And when that person leaves, they may go to Bangor. In our situation, they would probably go to Presque Isle or to Fort Kent. From Caribou, Presque Isle is a half-hour, depending on which side of town; Fort Kent is an hour away. They have to go elsewhere. Certainly many of the specialty services we provide can be provided in Bangor. But that's a three-hour drive at a minimum, or $125 round-trip air fare plus a cab to the hospital. So there are alternatives, but that's the nature of the rural area. I don't think there is any single answer. Maybe they're treated by someone who isn't a specialist. And that may be all right to a certain point.

NELSON: You might be able to do it through creative staffing of midwives and other people who are well trained who might not be obstetricians. But then you get into the problem of how the medical profession feels about doing that. But there are other ways, it would seem to me, in this particular area.

McCORMACK: As Warren said, we have staffed our Emergency Room twenty-four hours. There is a real hazard if you walk in and there isn't a physician there. We have done it, though not totally with physicians. With our volume, which is very different from Kennebec Valley Medical Center's, we do have physician assistants that work the night shift and the odd shift.

And we have a nurse practitioner working with us. I don't disagee with you at all. But we have to constantly watch that we're not vulnerable. One of our physicians came back from a national meeting and said we're really at risk with the physician assistants... Yes, there are exciting staffing alternatives that we could look at. But there are some licensure, JCAH, and legal reasons why we can't do it. Some of the small hospitals, by the way, are thinking about potentially not participating in the Joint Commission on Accreditation of Hospitals, not seeking accreditation. It is voluntary. The requirements perhaps are stringent. Secondly, the costs are significant. But what does that do to quality? That's a concern we have.

GILL: Thank you very much. Next we'll hear from Gene Beaupre, who is president of Mid-Maine Medical Center and also chairman of the Maine Hospital Association.

BEAUPRE: I'm here this morning to talk on behalf of the Hospital Association. I'm going to do it very quickly. We, on our side, are just as frustrated about hospital costs as you are. And I hope we come across that way. But, as you heard this morning and from other testimony, it's a very complicated series of issues that we face. It's not a simple one and there is no easy fix in terms of solutions. I think you're all aware that Maine is not Rochester, New York, and it's not Maryland. And what's the solution for the problems there probably is not the right solution for the hospitals in Maine.

Between now and the time of the next legislative session, we're going to put together a series of alternatives that we can discuss with your group and with the legislature, in an attempt to cut the inflation of health care costs. I don't have a quick fix this morning, but we're committed to working on it over the next six months. And we'd like to share it

with you. Something I'd like to see evolve is a system that is not adversarial, but a system in which we work together to carry out what I think we all want to do. I hope a system comes out that we're all contented with.

NELSON: It seems as if the club that the Hospital Association is holding over our heads is that, if you do that, you're going to cut services, and you're going to disenfranchise people. That seems to be the alternative, if you do this. I think that's unfair, I think it's unreasonable. I think to use the threat that if we're going to do this--you in the legislature--the elderly are not going to get served, and that we're going to have to cut out the important new programs that are supposedly making people live longer... I've heard that a lot. Could you please address that?

BEAUPRE: Let me speak for myself now, not for the member hospitals. I think hospitals are well-run. I'm on two or three commercial boards, and I think the idea that hospital administration is responsible for the problem is wrong. I think there are some things we can do better. We're committed to do that. I've heard it said that the doctors drive the system, and they're responsible. To me, it's not who is to blame. As Mr. Marden explained, if you look historically, the boat we're in at the moment, we've all created. And I hope the new boat we create will be able to provide the same quality services and keep the inflationary rate down to something we can come up with. I think we want to say that it's a very complicated issue. And please don't try to come up with quick fixes. Prospective payment... As I see the economics of hospitals, it costs us a certain amount of money each year to run those hospitals. Whether you pay for it before, during, or after is not going to greatly influence the total cost of running the hospital. If we want to reduce that cost, or reduce the inflationary spiral of that cost, let's look at

the financial underpinnings of what's happening, and work together to preserve as much quality product as we can and should, and yet be publicly accountable in a way that you're happy with. Whether or not we can do that, I don't know. We'd like to work with you to try.

NELSON: I didn't hear anyone address specifically Rochester and Maryland. We heard a lot about that at our last meeting. I want to know if, indeed, in the course of the day, or now, you can address that. We are not Rochester and we are not Maryland. But we did learn something certainly from what they have done. I wonder if you could be a little more specific in your negative feelings about those things which, in reading, seem to make sense--at least to me at this time.

BEAUPRE: I have no negative feelings about them. I don't know Rochester well and I don't know Maryland well. But I was in Pennsylvania a long time. I heard the Number Two man from the Health Care Financing Authority speak last week about the federal government's intent, by cutting Medicare. He said very frankly, We expect the inefficient hospitals to close. They don't really see a whole lot of slack in the way hospitals are run. It's the federal government's espoused policy to close some inefficient hospitals in the country. Now, having worked in Philadelphia, where there are some sixty-odd hospitals in the Greater Philadelphia area, I almost feel you probably could close a significant number and probably not compromise the quality of care. Nationally, that may well be a good way to eventually cut costs. We voluntarily have closed 55 beds. We've done all kinds of things to try to keep our costs down. And they get lost in the inflation that we're all trying to manage. But in the State of Maine, the so-called inefficient hospital is going to be the one that John McCormack talked about. They look inefficient because little things cause profound impacts on both the cost side and the

potential revenue side. Maine does not have a great many redundant hospitals. We don't have four hospitals on four corners. We don't have eleven hospitals in a small area, as Rochester apparently does. My point is, if the intent of the federal government, through its rate review commission, is to close hospitals--and that's a potential in this state--we all ought to go into it with the idea that, yes, that's what we're going to do and it makes sense as public policy. I don't see a whole lot of hospitals in this state that ought to be closed. I think the ones that have closed probably are about all that we could afford to sacrifice through cost containment.

NELSON: Do you feel that the information we got from Rochester and Maryland is that they did indeed close hospitals? Is that what you feel comes out of that information we got at our last meeting?

BEAUPRE: I was not here and all I read was an abbreviated transcript, so I'm really not in a position to say. The only point I'm making is that the Rochester experiment was quite different from the Maryland experiment. What I'm saying is, in the State of Maine, let's devise and create something that's right for the hospitals of Maine and the people we serve, rather than trying to translocate a solution into the State of Maine, because I'm fearful that it won't work.

MANNING: From what I hear now, and from what I heard six-eight months ago, it's two different stories from the hospitals. First, the Hospital Association was saying that there were some problems, but it wasn't that bad. Now you're saying, there are some problems and we're working on it. I'm just wondering, if the legislature didn't push the hospitals into doing something, how far down the road would it have been before hospital costs really went to the point where the average person could see it, rather than just

the person dealing with it on a day-to-day basis.

BEAUPRE: We're part of a national inflationary problem. We recruit nurses and doctors according to national norms. And the inflation rate countrywide is very high indeed. I'm not sure there is going to be some simple fix for the hospitals in Maine. There is the implication that we're not accountable. We feel very strongly we should be accountable. I personally am very accountable, with Mr. Marden and a very good board. Every year, through a series of objectives, we do things to cut costs. We've closed beds. We've had four energy grants. We've done all sorts of things that are proposed in the management literature as ways of containing costs from a management perspective. And we feel that we've done that well. But when you look at the aggregated increased costs over the last ten or twelve years, they're appalling. But I think we've done a pretty good job. What I'm saying is, Work with us, rather than push us, to see what kinds of changes we need to make to achieve what you think we ought to do in terms of public accountability.

GILL: Thank you very much. That concludes the presentation by the Maine Hospital Association. We will hear next from the Voluntary Budget Review Organization, from David Bourne, who is the executive director.

BOURNE: My prepared remarks really did not discuss the issue of a prospective reimbursement system, but I hope what I plan to say is still relevant. A budgeting process is a form of prospective system. It is a financial plan that is based upon many inputs: what the volume will be, what kinds of resources are required to meet that volume, and what price you'll have to pay to get those resources. So when we talk about the Voluntary Budget Review Organization and we talk about hospital budgeting, we are talking about a prospective type of system.

I want to cover the following few points, which I think will be helpful in your factfinding efforts. First, the development of the organization; second, the quantitative results to date; third, the non-quantitative effects, from my perspective, that the VBRO has had on hospital cost containment in Maine; and, fourth, some possible improvements to the current system.

The current Act, which you have just extended for one year, was passed by the legislature in April, 1978, and was effective beginning July 6, 1978. In April, 1979, nine months later, the VBRO received approval of its budget review methodology from the Health Facilities Cost Review Board, as required under the Act. The VBRO then began reviewing budgets for hospitals with fiscal years beginning on July 1, 1979--one year after the effective date of the Act. During the past two months, we have completed the budget reviews for all Maine hospitals for the third time and have begun reviewing hospitals with July 1st fiscal years for the fourth time.

You heard testimony from the Maryland people that they did not begin reviewing hospital budgets until the fourth year of their program. And even in that fourth year, they reviewed only one hospital budget. By contrast, in the same amount of time, we in Maine have developed a state-of-the-art system and reviewed every hospital budget in the state three times.

Further, in the report to the Governor, the state Board indicated that the VBRO has a sound and manageable information system. That system has been developed and computerized internally over the short history of the organization.

The second point I want to cover are the quantitative results, for which I have a short handout. I believe it is extremely importnat you realize that all the figures you have heard to date, and those included in the report to the Governor, are no more recent than 1980--which essentially is prior to the VBRO. Dr. Gaumer, in his presentation to you earlier this month, indicated that

the national study on rate-setting programs has figures only through 1978. I will deal with the rate of change only, which you were told is the most important indicator. Representative Nelson mentioned that earlier.

In 1980, the rate of change in total operating expenses in Maine was 15.0 percent, as was indicated in the state Board's report to the Governor. What that report did not indicate was that the rate of change nationally was 17 percent. In 1981, the rate of change in total operating expenses in Maine was 14.5 percent; but the rate of change nationally was 18.7 percent. That 18.7 and 17.0 national figures are the same as those reported to you by Dr. Cook in his discussion of the Rochester system. For 1982, the Maine hospitals are estimating a rate of change of 14.1 percent, while the national figure is estimated at 16.0 percent.

These are the most current figures you have received to date. And the Maine figures are available from the state Board, as well as from the VBRO. I believe these figures should indicate to you that the current system is having a positive effect. In fact, it may be accomplishing much, if not all, of what we want to accomplish in Maine.

The third point I want to cover is the effect, from my perspective, the VBRO has had on cost containment, which probably cannot be quantified. There is little dispute that the hospitals in Maine are doing better budgeting than they were prior to this program. This better budgeting leads to better planning and better control. It provides the trustees of the hospitals with more sound information upon which to base the decisions they must make to meet community needs. Through our information systems, we provide ongoing reports to hospitals, comparing various elements of operations among similar institutions. In addition, we receive frequent requests from hospitals asking how they compare to others. Through this give-and-take process involving the VBRO staff, the panel, and the hospital, there is a continuing awareness of the

importance of cost containment.

One more way to look at the non-quantitative effects of the current system might be to look at the hospitals that have received an unfavorable opinion from the VBRO. In each of the first three years, the VBRO reviewed 45 hospital budgets. Over that period, 16 budgets involving 13 hospitals were found to be unreasonable. Three of those hospitals have sought and obtained shared management assistance from other hospitals or organizations. We know of one more that is in that process now, or in the process of merger. One hospital has merged with another, resulting in a reduction of total beds of the two hospitals. One hospital was closed. One hospital sold part of its operation, resulting in an improvement in the productivity for the remainder of the operation. Five of the hospitals resubmitted their budgets. In every case where an opinion of "unreasonable" by the panel has been rendered, corrective action has been taken by the hospital. In addition to the merger and the one closure mentioned already, there have been three other hospitals closed and several mergers since 1979.

The final point is changes or improvements that we can make in the current system. These are not all-inclusive but are some that I offer today. First, I'll ask a rhetorical question: Is there room for improvement? And the answer is: of course. You heard testimony on the Maryland and Rochester programs indicating that they have been under constant revision. One of the criticisms of the current program is a lack of accountability and disclosure. The current law provides for hospitals to file annual reports with the state Board and with the VBRO. The review methodology provides for the VBRO panel to report its findings and comments on the budget thirty days following the review. These provisions have apparently not produced what would be perceived as adequate public accountability. Therefore, additional reporting and/or disclosure requirements could be placed on the state Board, or directly on the VBRO.

A second criticism is the lack of adequate public representation in the current process. The budget review panel is currently composed of three consumer representatives, three payor representatives, and three hospital representatives, as required by the current law. These nine panel members, along with an alternate consumer and an alternate provider, are appointed by the VBRO board of directors. A change here could provide for the appointment of public members by the state Board, by this committee, or by the Governor. A safeguard that would be needed to be incorporated with this change would be the assurance that those public members could and would be willing to invest the time in this process. Through the current selection process, we have been able to assure the active and significant time commitment of most of the panel members, which is essential to this process.

A third change or improvement could involve a modification of the methodology to provide for mandatory compliance with approved budgets. This would require the development of criteria, identifying controllable and non-controllable elements of variations from budget. Progress can be made in these areas.

In conclusion, I would simply say that we collectively--the state, the hospitals, and the payors--have four years invested in this program, which has developed a methodology that is Maine-specific, demonstrated quantifiable results, witnessed other non-quantifiable benefits, and we know we can improve this system. I believe it would be unfortunate to totally dismantle this system and start with something brand new. A good beginning has been made. New knowledge has been gained through this experience. Let's incorporate the new knowledge as our next step.

MANNING: It sounds as if you're saying to us that you don't want us to do away with your Board. Am I right in saying that?

BOURNE: I'm not sure I understand the question

MANNING: It sounds to me as though you just made a pitch to keep your Board.

BOURNE: I made a suggestion that the consumer representatives to the budget review panel be appointed by someone other than the VBRO board, to provide that additional input from some other source, rather than the VBRO board of directors. Some of the positions on that budget review panel are specified by the law. One is a designee of the Commissioner of Human Services. Some of the positions are essentially designated in the law. The VBRO goes through a formality of appointing those people, based upon the individual who is recommended. Essentially, the VBRO board of directors has the authority to choose the consumer representatives and the payor representatives.

MANNING: The way I just heard you speak, it sounded to me as if we're back in the legislature and somebody is fighting for their own board, like the Health Facilities Cost Review Board, or the Maine Health Systems Agency. If we went with prospective payment, I don't see that we'd probably do away with your particular Board. It would seem to me, if we went with prospective payment, we'd still want somebody reviewing.

BOURNE: I think I was saying that, but I did not direct my comments specifically to a prospective system.

GILL: I think I heard you say that you were giving an evaluation of what you thought the effect of your Board had been.

BOURNE: We have a budget review panel and a board of directors. Maybe that's a problem at the moment. The budget review panel is the group that is actually responsible for the review of the budgets. I also have a board of directors that is responsible

for the administrative matters of the corporation and has the responsibility for appointing the panel members. The gist of my comments this morning were that the program has been effective, and I think the numbers demonstrate that.

NELSON: What I heard is that you are saying, in effect, that you are doing and, given a little more clout, you will be doing all the things that a hospital cost containment piece of legislation asks to do. You are already doing that. And you feel you're doing it well, that you have a strong data base. I think it was mentioned last time how important that is and they even complimented Maine on the fact that you had this. And you feel that what you're doing is, in effect, exactly what is supposed to be done to contain hospital costs. Is that correct?

BOURNE: Yes

NELSON: Are you saying also that if you were strengthened as a Board, given maybe more consumer representatives, etc., that you really don't need another piece of legislation?

BOURNE: Yes

MANNING: It just seems to me that we're back in the legislature...

GILL: Their Board was set up for a purpose. And what he's saying here is that he feels that they have performed and have shown some results.

MANNING: So did the Maine Health Systems Agency's board feel the same way. And we did away with that. We didn't, but we will.

GILL: No, we didn't

BRODEUR: It seems to me from your generalized comments on your reviews and determination of unreasonable budgets... is that for overall budgets of hospitals, or do you get into specifics, such as high lab costs and things like that?

BOURNE: At the present time, if we find a budget unreasonable, we will certainly give the hospital the basis on which we found it unreasonable.

BRODEUR: So it could mean that a section of the budget is unreasonable?

BOURNE: That's correct

BRODEUR: So basically you're doing some of the things that are being done in the Rochester area in terms of looking at costs under the prospective reimbursement system that they have?

BOURNE: Absolutely. And I would like to submit that we're doing it better. It is a voluntary program. That is a fact. But I believe, from a process standpoint, and a methodology, we're doing it as well as it's being done anywhere.

BRODEUR: You mentioned that the hospitals that were given determinations of unreasonable budgets by your organization... in each case they acted in some way so as to close or merge--in a positive way that did result in a reasonable budget. Is that what you're saying?

BOURNE: Yes. What I said was that in every instance where an "unreasonable" opinion was rendered, some positive action was taken.

BRODEUR: The biggest discrepancy is on another level in terms of the Health Cost Facilities Review Board saying that the VBRO is

not being effective in reducing hospital costs. I don't know if that's the way they said it, but in some way that's not enough. Could you respond to that?

BOURNE: Obviously there were several criticisms of the current program in that report. One that you may be referring to was a comment that the VBRO did not appear to be having any discernible influence on compliance with budgets. The last suggestion that I made to you this morning for change was that there be mandatory compliance with budgets. That requires determining what the reasons are for variations from budget. Are they controllable reasons, or are they non-controllable? And before you can put things into those two categories, you really have to determine, are they controllable and by whom. Who controls volume? Do the doctors control volume, or do the hospitals control volume? Or is it uncontrollable? So there are subcategories. I won't go on, but we can talk lots more about that at some other time.

McCOLLISTER: If you had the power to force the budget, then it no longer becomes a voluntary _________, right?

BOURNE: That would depend on how that was structured. That's very possible.

MacBRIDE: I talked to the personnel at the Aroostook Medical Center before I came down about the VBRO and its effectiveness. They were most enthusiastic. They thought the VBRO was doing an excellent job and that it should be expanded. They said they had decreased their budget and they were really very much pleased with the results.

MANNING: Would they go along with mandatory compliance, do you think?

MacBRIDE: I didn't inquire about that

NELSON: I received some information from your office which is a VBRO staff summary of the hospital cost containment in Maine with comments. It's very valuable. I wonder if all the members of this committee could have a copy of that. In it I read, "The present program mandates participation, but ~~not~~ compliance by the hospital is not required." Could you explain that?

BOURNE: The current law says that all hospitals must submit a budget for review. That is mandatory participation.

NELSON: Then what's the voluntary part? Why is it called a voluntary program?

BOURNE: They are not required to comply with the findings of the Voluntary Budget Review.

NELSON: The 108th Legislature did that, didn't we? Yes, that I know we did.

BOURNE: The point that I made to you was that, where we have found unreasonable budgets, in all cases corrective action has been taken. That may be some indication that total mandatory was not essential.

GILL: Thank you. We'll go on to the Maine Health Care Association. Ron Thurston is director.

THURSTON: My name is Ronald Thurston. I am the executive vice president of the Maine Health Care Association, a position I've held since August of 1979. Prior to that, from 1969 to 1974, I was director of provider relations and utilization review for Maine Blue Cross/Blue Shield. And from 1974 to 1979, I was the executive director of the Pine Tree Organization for Professional Standards Review, Inc.

I am going to talk from the nursing home perspective first and then talk about some comments I have on public policy as it relates to hospital reimbursement.

First, with regard to the nursing home issue, there is a great health economist by the name of Uwe Reinhardt, who works out of Princeton University. From time to time, he writes papers that are entertaining and educational at the same time. He has written one that I have shared with a couple of the members of the committee, called "Table Manners at the Health Care Feast." The subtitle is, "Regulation versus Market." He says if we're ever going to understand the issues involved in health care cost containment, we've got to have new terminology. And instead of talking about containment of health care expenditures, we have to start talking about containment of health care incomes. And instead of talking about health care cost containment, we're going to talk about containment on the income provided per unit of health service.

So, with that as a perspective, the nursing homes in Maine, as of July first, will have their incomes contained at a limit of 7.9 percent. The system will work roughly thus. Nursing home costs will be divided into fixed and variable. Fixed costs will include depreciation on buildings, depreciation on land improvements, real estate taxes, real estate insurance, interest on long-term debt, rental expense--costs over which nursing homes have no control. And they will be reimbursed for those at a hundred percent. Those costs will be passed through. All other allowable costs will be lumped into a variable cost category,

and will be subjected to a 7.9 percent limit. This limit is based on last year's variable costs, with a 7.9 percent cap.

So the incentive is obviously to operate within that 7.9 percent cap and make a profit. The negative incentive is not to exceed 7.9 percent, because if you do, you're not going to be reimbursed. If you do make a profit, then there are other incentives built in, such as increasing the number of Medicaid patients, etc., that allow you to keep much of it, while at the same time sharing some of it with the Department. I should point out that this is strictly a Medicaid reimbursement system, but since Medicaid applies to 80-85 percent of our patients, then it is obviously far and away the biggest share of our income.

So that is essentially the nursing home reimbursement system. Each quarter, as different nursing homes begin different fiscal years, they will receive a different incentive limitation, depending on a market basket forecast of what inflation is going to do in the coming year.

I am not suggesting that the same reimbursement system be used for hospitals. They have problems we don't have. The first, of course, is that they have a variety of payors. You've heard discussions all morning about problems that those pose. They also have other problems. I'd like to go ahead and comment on some of those and make some suggestions as to public policy issues.

I applaud Gene Beaupre and the Maine Hospital Association for saying that we're all now in a boat that we built ourselves. And if we're going to get out of it, we're going to have to build a new boat. I think that's something we're all going to have to help in. And I offer the support of the Maine Health Care Association to do that. I also offer the following comments.

Another problem that hospitals have, that nursing homes don't, is the volume question. Physicians control not only the volume of admissions but the volume of services delivered within those admissions. I suggest, as public policy issue Number One, that any reimbursement scheme to limit increases in hospital costs

ought to include a positive incentive for physician review and control of the quantity of medical services--a share of the profits, a piece of the action, whatever you want to call it. Remember again what Reinhardt said: We are controlling health care incomes.

Number Two Public Policy Issue. There was a study done in Maine when I was with the PSRO that documented significant differences in the quality of medical care delivered in Maine hospitals between hospitals. Poor quality medicine is not only poor economics; it is hazardous to your health. It should be public policy that public money be spent to pay physicians to organize and maintain a statewide system of quality assurance. To implement control on hospital costs, without at the same time implementing a quality assurance system, in my opinion, would be absurd.

I am also compelled to comment on the high disparity between the amount of public money that is spent to monitor nursing homes and that which is spent to monitor hospitals. There is perhaps in this state a ten- or twenty-fold difference. Yet the capacity to do harm in a hospital is much, much greater than in a nursing home. The complexity of the services delivered alone, versus the services delivered in nursing homes--let alone the differences in the numbers served, as well as the costs involved--would lead you to believe that we have the shoe on the wrong foot. I am not, however, advocating that more money be spent on regulation of hospitals, but rather that less be spent regulating nursing homes. Excess regulation gets in the way of quality care.

I am also compelled to comment on the success or failure of the VBRO. If the VBRO has failed in any way, it has been a failure of false expectations. The Voluntary Budget Review Organization has set up a sophisticated, voluntary budget review organization that has helped hospitals prepare budgets, has reviewed those budgets against predetermined targets, and has made changes in them,

and can document those changes and has done so. If there is any failure in the system, it is the failure of this committee and the legislature to outline clearly what its expectations were. I will never forget the public hearing prior to the passage of the Health Facilities Cost Review Board Act, when the president of the VBRO was asked if he thought a VBRO could contain hospital costs. He very correctly answered, Yes. Yet there was no discussion at all as to the expectations of the committee as to what that containment would be. I believe the only way to bring about significant improvements in the quality and economy of hospital care is from within, through carefully thought-out and publicly-discussed and stated expectations. That is Public Policy Number Three.

I am compelled to also make a comment about consumers, since consumers are in this boat that we're all now in. A consumer representative who is not accountable to a consumer body is accountable then to the system he is in. While the idea of consumer representation in everything we do in health matters sounds good, unless the consumer represents someone, he soon learns that "to get along, you go along." Besides, who is he going to have to answer to? Public Policy Number Four ought to be that the legislature is the public's representative. And they ought not to delegate that responsibility to someone who then never reports to them.

Next, it ought to be publicly acknowledged that people respond to incentives. As the twig is bent, so is the tree inclined. If the major third-party payor in this state has a reimbursement system that financially rewards hospitals whose charges are at least 16 percent higher than their costs, it should come as no surprise to anyone that hospitals raise their charges. If this committee wants to do something about controlling hospital costs, it will have to do something about the shape of the reimbursement system of Maine's largest payor. That's Public Policy Number Five.

The final public policy issue I would raise is the issue of declining census. Some hospitals and some nursing homes are

facing a decline in census and/or revenues, which make their continued existence questionable. At a recent meeting of the Maine Hospital Association, the term was used about "doomed hospitals." When questioned by a participant about his role in the issue of doomed hospitals, the speaker (who was the president of a large hospital association) said essentially, he has no role; if they are doomed, let them go. I think that's baloney. I think he, and everyone in his state, has a role to play in assisting those responsible for that facility to deal with its demise. That is a significant public policy issue that we all need to deal with.

GILL: Are there any questions? We'll be talking with you again. At this point, we'll go on to the Maine Committee on Aging. Alice Bourque will speak next.

BOURQUE: I am Alice Bourque, chair of the Maine Committee on Aging's ad hoc committee on health care costs. On behalf of the Committee on Aging, Stuart Ferguson and I will present some brief comments this morning in support of the Health Facilities Cost Review Board's recommendations on hospital cost containment.

The ad hoc health care costs committee of the Maine Committee on Aging was formed in September, 1981, to study the high cost of health care for Maine's elderly. While our examination included study of physicians' costs, insurance costs, and other health care costs that the elderly assume, it of course included many discussions of the Health Facilities Cost Review Board's study on hospital cost containment. In 1980, 28.2 percent of total discharges from Maine hospitals were aged 65 and over. Over 41 percent of total patient days in 1980 were for those aged 65 and over, indicating lengthy hospital stays. Clearly, the cost of hospital care has a dramatic effect on the elderly, and the elderly have a dramatic effect on hospital costs.

Because Medicare and Medicaid pay for approximately 88 percent of the elderly's hospital bill nationwide, the cost of

hospital services affects our state's and nation's economy as well. The ad hoc committee, therefore, examined the hospital cost containment proposals carefully. We met with representatives from various interested and affected parties, many of whom you have already heard, including the Maine Hospital Assocation, the Maine Medical Association, Blue Cross/Blue Shield, Union Mutual, the Voluntary Budget Review Organization, the Health Facilities Cost Review Board, and the Department of Human Services. We also held three public hearings across the state, where we discussed health care costs with consumers.

Based on these discussions with interested parties, and our meetings and discussions with consumers throughout Maine, and on our study of the problem, we decided to endorse the recommendations of the Health Facilities Cost Review Board for (1) a prospective reimbursement system for hospital services, based on a statewide maximum revenue cap, (2) equity among payors for hospital services, (3) coordination of budget review and certificate of need, and (4) coordination of budget review and utilization review.

At this time, the Committee on Aging has also taken positions endorsing these four recommendations which are contained in the study report. Clearly, we are anxious to see the Governor's proposed legislation, which we will discuss further when it is available.

We considered the following issues in making our final determinations. Hospital costs have increased significantly faster than the general price level of the economy and are consuming a substantial portion of the Gross National Product. The current retrospective cost reimbursement system does not reward efficiency and, in fact, rewards increased expenditures that may or may not be the most efficient use of scarce dollars. Cost-shifting is occurring due to inequity among payors for hospital services. All payors are not paying the same amounts for the same services.

To date, the voluntary budget review program does not appear to have contained hospital costs in Maine. Implementation of prospective reimbursement systems by some other states has been effective in containing hospital expenditure increases without negatively affecting the quality of hospital services or access to hospital services. Coordination of budget review and certificate of need must take place to assure that the two functions do not work at cross-purposes, while enhancing planning, quality, and efficiency. Utilization review is an important factor in determining adequacy of service availability.

In conclusion, the Maine Committee on Aging concluded that the Board's recommendations would be an important first step to containing hospital costs in Maine. For the elderly constituency which we represent, we see a prospective payment system encouraging the most efficient use of scarce resources. Equity among payors, including Medicare, would create a fairer payment system. Efficiency could be rewarded. In addition, the Maine Committee on Aging wants to see more involvement by the consumer, because we feel they can assist in cost containment efforts if they are better educated about cost factors.

We urge the first step to be taken by the state through the creation of a mandatory prospective reimbursement system which rewards efficiency and moderates the rate of hospital expenditure increases.

NELSON: How would you suggest educating your constituency, which, as you said, are the people who make the most use of hospitals, as far as hospital charges? Right now, I understand you don't get an itemized bill from the hospital. Do you think that would help in educating the public as to how much things really do cost in hospitals?

BOURQUE: We are in the process of putting together all our findings. And we have a copy of the results of our three hearings across the

state. If you are interested, you will find that is one of the main complaints that we heard: that people were not getting itemized bills. The consumer wants to know what the costs are. The consumer is willing to be more knowledgeable about it. At this point, hospitals seem to be happy with the way things are. Doctors seem to be happy with the way things are. Medical industries are happy with the way things are. But the consumer is not happy. And it probably remains with the consumer to start making waves.

GILL: Is this report available, or will it be available at some point, so that the committee might read what the consumers do have to say about medical care and what the deficiencies might be from their point of view? ... We'll read this document and at some point in future I'm sure we'll have more questions. Thank you very much. Stuart Ferguson will now speak for the Committee on Aging.

FERGUSON: I'm Stuart Ferguson of North Whitefield. I'm a member of the ad hoc subcommittee of which Alice Bourque is chairman. I'm not a member of the Committee on Aging, however. Ms. Bourque has just given you the unanimous view of the committee that she chairs. My function is to add a few comments in light of her remarks and the things that have been said here this morning.

I agree with everything that has been said here this morning, but I differ on one conclusion: the matter of the cap. I think we had a superb discussion of the hospital expense picture by Mr. McDowell. No question but that's the picture. There are inequities in the way depreciation is handled because of historical things having to do with the federal government. We seem to be stuck with this picture. I don't believe hospitals are terribly inefficient. I think some are more efficient than others. I was a communications computer consultant on the

original Mass General computer project in the 1960s. I was a consultant to New York University Medical Center for years. Also to Downstate in New York. And to the Board of Trustees of Duke University, whom I represented against the medical school.

I don't think there is massive inefficiency. From my experience, hospital trustees, administors, finance officers are doing their best to maintain efficiency and contain costs. There are questions in my mind as to whether they're really in a position to do so, when you consider the pressures placed upon them by the physicians, by the community, by the patients, and everybody else--except those who wish to contain costs from the outside. I think the result is that, in the absence of pressures from the outside, it's something like a girdle with a three-way stretch: you push here, and it bulges out there. Without a cap, prospective reimbursement--which everybody wants--then becomes sort of retrospective reimbursement ahead of time, you might say. And prospective reimbursement becomes meaningless. You just have that uncontrolled bulge.

For reasons that I will explain in a moment, I don't think the cap is necessarily that harsh or that brutal. I think I am most impressed that everybody this morning has been talking about cuts in services and looking at the past. The Health Facilities Cost Review Board report and the proposed legislation, as I understand it, doesn't talk about cutting anything; it talks about placing a cap in the future. Now, a cap in the future with an inflation allowance on top would mean that the hospitals could continue precisely as they are. If they wanted to add services, they might have to go through a certificate-of-need process. They might have to ask for more funds on some other basis. Or they might be able to consolidate some functions.

Let's take the laboratory test situation that Mr. Kessler discussed. I think he was talking about something like $2 million in his hospital for tests. And he pointed out, quite accurately,

that if you reduce the number of these tests substantially, the savings would be small. You probably wouldn't be able to cut the staff. But the question is, if you add service over the next ten years, if you then started reducing the number of tests that were made in each particular case, would you be able to make that 500,000 tests or 200,000, or however many it may be--would you be able to make them cover more services with a more efficient use of testing in the future?

So I'm not sure that we're spending too much on health care. Great Britain, with a totally socialized system, spends a little under five percent of GNP; Israel, between 12 and 13 percent; we're at about 9.5 percent. I don't know that that's too much. But I don't think it's too early, particularly in view of the public temper, to consider what can be done to contain health care costs in the future. So I think everybody this morning was concerned with fears based on the past. And those fears, I think, would be fully justified if a Draconian system of the New York State variety (which really forced the Rochester experiment), or the California system, or the Massachusetts system (where an 80-year-old friend of mine has to wait three months for a CAT scan)--certainly if you're talking about a Draconian budgetary situation of those types, then the fears that they have expressed are perfectly understandable. I hope that in Maine that would not be the case, that the cap would be reasonable and reasonably administered, and that the legislature would see to it that that was the case.

So I think if one looks at it from a future perspective, considering that we're not cutting budgets as they now exist; we're talking about restraining the growth in budgets, or the growth of inflation, or the rate of inflation in the future. And I do believe that consolidations could be helpful. I'm a Togus outpatient. I get an x-ray every six months for my chest. My doctor thinks it's wise and I'm sure he's right. I get a pulmonary function test and blood gas test every three years. He seems to feel that's adequate. I'm sure he's right. But I

notice that when I get my blood gas test, the technician who gives it to me is also a cardiovascular technician. There is a consolidation where the testing program is less expensive because you have a double-duty man. So I'm sure there are efficiencies that can be made in the future without cutting services, by consolidation, by increasing efficiency in the administrative end of hospitals. ¶ I feel that the real source of pressure in this has to come from the consumer. Alice Bourque is absolutely right. I'm convinced that patients are concerned with costs, if those costs are brought to their attention with itemized bills. I really believe that the added constraint of the cap, which would not go beyond the hospital door--that is, the state would put a cap on presumably--what happens behind the hospital door is still up to the trustees, up to the doctors, up to the administrators within the hospital. I don't think any independence is being taken from them. They are simply being told: try and live within this budget. That's something they're not able to do with the VBRO system as it now stands, because they've been consistently running over the VBRO budgets. We on the ad hoc subcommittee sincerely feel that the quality of care will not be hurt. I don't think any of us want to see the quality hurt. We all use the hospitals. I believe that Mr. Kessler is right that the best medical service must be available. After you've decided what the best medical service is, then you look at the cost; you don't look at the cost beforehand, but afterward. And then you see, if by consolidation and measures to increase efficiency, if you can do it. If push comes to shove in the future, if it turns out that vitally needed services can't be had without increasing the cap, then I would say at that time the legislature and the other authorities should consider increasing the cap.

MANNING: Both you and Ms. Bourque indicated that you think the consumer has to get involved. It seems to me that I've

talked to enough people who, for instance, aren't in the health field at all. When you're dealing with union contracts, they say, I've got my Blue Cross, that's all I need. They don't address what the bill is, so long as either Uncle Sam pays it or Blue Cross pays it or Union Mutual, or whatever. Do you feel that the employer ought to start making the employee look at what he is getting for his Blue Cross benefits?

FERGUSON: Yes, Representative Manning, I do. I think the notion that the public has led into, that somebody else is paying their hospital bill, is a false notion. They're paying it. They've paid the Medicare premiums all their working lives. They're paying for the Blue Cross. If the employer is paying the Blue Cross, they're still paying it, because the employer is paying money to Blue Cross that he might otherwise pay to them. So they're still paying. The consumer is still paying the bill. And the consumer must be made to realize that. And the fact that his bill is only one out of millions doesn't make his bill insignificant. It may make it small, relative to the total, but it's not insignificant.

MANNING: Do you think it's up to the employer to start emphasizing that?

FERGUSON: I certainly think the employer should start emphasizing it, yes, very much so. And the unions, too.

GILL: Thank you. We will recess now for lunch.

GILL: We'll continue with the Maine Medical Association this afternoon. We have Frank Stred, who is executive counsel; Dr. Valentine Moore, a physician from Waterville; and Louis Bachrach, a physician from Brunswick.

STRED: The Medical Association is happy to have this opportunity to meet with the committee and has asked several of its members to share their personal observations on some facets of the Health Facilities Cost Review Board proposal.

To add to Mr. Kessler's mention of alcohol abuse as one of the great inflators of medical expenditures, we would add, before beginning our testimony, the use of tobacco as one of the great causes of health care costs, and call attention also to the massive amounts of care which may be required in coming years for the treatment of maturing drug abusers--those persons who are currently seeking treatment for the immediate effects, but where the long-term effects are not yet known.

With me today is Dr. Louis Bachrach. He is a graduate of Harvard College and Long Island College of Medicine. He has been an internist, with an office-based practice in Brunswick since 1948. Also with me is Dr. Valentine Moore, a graduate of Fordham College and Long Island College of Medicine. He has been an anesthesiologist, practicing at Mid-Maine Medical Center and its predecessors since 1949.

The Medical Association has monitored each of the meetings of the Health Facilities Cost Review Board and is understandably concerned about how any new proposals might affect patient care and the practice options of its members. One of the obvious differences that we have observed in the discussions of the Board is that our member physicians are reimbursed in somewhat different fashion from the ways that hospitals are traditionally reimbursed. Physicians might operate on a fee-for-service basis, on a salary basis, on a percentage-of-gross-receipts of the depart-

ment with which the physician is associated, or a percentage of the net receipts of his department, on a base salary plus fee-for-service, on a base salary plus a percentage, or on a flat amount per procedure or service unit. Regardless of the payment mechanism a physician uses, his current obligation ethically is to be patient-oriented. Whereas the majority of hospital income is received through third-party payors, a greater proportion of the physician's income comes directly from the patient, although commercial carriers, Medicare/Medicaid, Title XXIV carriers, and CHAMPUS all play sizable roles. Many people feel that the market-place is working better in providing cost containment incentives for the public to shop among physicians than it is for the public to shop among hospitals. While there are an increasing number of physicians available in the state, and a greater proportion of the physician's fee comes directly from the patient, there are fewer and fewer hospitals, and a greater proportion of the care is covered by third-party payors.

In an effort to contain costs among its own members, the Medical Association approximately a year ago changed its health insurance policy to eliminate first-dollar coverage. It now has a policy which includes deductible and co-payment features. Because the first full year of coverage under this policy isn't complete, the track record for this attempt is not yet clear.

Similarly, the Medical Association had an interest in utilization review. And for the past six months, it has been discussing a statewide utilization review program with the Maine Osteopathic Association and Blue Cross/Blue Shield of Maine. All three organizations have adopted the basic principles of the review procedure. In the months ahead, we will be working with the institutions and their representatives in which care is delivered to discover problem areas and refine the mechanism.

Some of the questions which physicians have asked upon hearing of the proposal which was sent to the Governor's desk last December were: Would physicians' services billed through the hospital be

included in the maxi-cap? If an institution is near the end of an accounting period, will there be pressure on a physician to be other than patient-oriented? Would the hospital-employed physicians' salaries be in or out of the cap? And would hospital-employed physicians need to join a bargaining unit in order to negotiate their salaries, as other medical care providers do? How would or could a twelve-member board, with a single physician member, carry out utilization review? And finally, and perhaps most important, how would appropriateness review affect the physician-patient relationship?

Physicians aren't newcomers to cost containment efforts. While over the years hospital charges have been figured retrospectively, most physician charges have not been figured in this fashion. A doctor knows that he's going to get eight dollars or so for a routine office visit under Medicaid. Since that payment does not, in many cases, cover even the cost of office overhead (nurse, secretary, rent, heat, light, insurance), the physician is placed in the position of charging his private paying patients more to make up the difference, or limiting the number of Medicaid patients he can see.

Physicians generally work on a fee-for-service basis. They cannot inordinately add to their fees without driving the patient to another provider or away from medical care. The hospital patient, when he knows he's going to be hospitalized, not only has little shopping alternatives but also is not particularly concerned at that point with price, because more than 75 percent of the time a third-party payor is getting the bill.

Another facet of the cost containment equation for society at large is the reimbursement mechanism which pays a doctor more in the hospital setting than it does in his office. If a physician is not reimbursed for putting on a cast in his office, but is reimbursed for the cast if it's done in a hospital Emergency Room, and, further, the third party payor reimburses

for the material involved in the cast when it's done in the hospital setting, then it is clear where, in the long run, most casts will be applied.

Finally, we listened with interest to Dr. Block's presentation several weeks ago, and we share the concern that has been previously expressed here today about whether a metropolitan, upstate New York city's voluntary experience should be the basis for imposing this type of regulation by law on rural Maine hospitals, given the costs of carrying out regulations over such a widespread area. Geographic and demographic differences are tremendous, as the committee well knows. We feel that it would be helpful also to know whether or not there are differences in the levels of care delivered in Rochester and in Maine, and whether there are substantial differences in employment patterns, and whether the presence of a number of large employers in Rochester further skews the comparison.

Now, for his personal observations on utilization review, I turn to Dr. Louis Bachrach.

BACHRACH: Utilization review is a means of cost saving for the hospital and for the patient. But before I start on this, I want to tell you about the experience of the physicians in Brunswick and Bath in our attempts at saving costs. The Regional Memorial Hospital, where I have done most of my practice, shares a purchasing agent with the Bath Memorial Hospital. The implications of this are obvious. Also, there are three hospitals in this area where we share facilities. Nuclear medicine is practiced at Bath, the echocardiogram and angiography are done at the Parkview Memorial in Brunswick, the electroencephelograms are done at the Bath hospital. If we want a CAT scan, we go to Portland or Lewiston. These are obviously advantages because we don't have to buy all of these types of equipment.

All of the doctors that I am familiar with are very cost-conscious. I think the problem with cost does lie, however,

with the doctor and the patient. You can't separate one from the other obviously. Let me tell, first of all, what we do at the Regional Hospital as far as utilization review.

When a patient comes into the hospital, the admitting officer notifies the patient care coordinator about this admission. In our case, it's an RN who looks over the record and determines whether or not this patient's illness is severe enough to warrant hospitalization. She reviews the chart at least every three days. If, in her opinion, the patient doesn't belong in the hospital, she will speak to the physician coordinator, who in turn will review the chart with her and speak to the doctor about hospitalization. If he agrees that the physician is correct, the patient will stay for another two or three days, until the nurse coordinator again reviews the chart. So the patient's chart is reviewed every three days, and sometimes every two days. If, in the opinion of the nurse coordinator and the physician, the patient doesn't warrant hospitalization, then the patient receives a letter of denial and payment for his hospital stay is discontinued.

This has worked very well for us. The Regional Hospital has one of the lowest length-of-stay records in the state. Again, the savings are obvious.

I would like to point out one more way in which we have tried to cut down costs by naming several of the committees, all of which look into hospital costs. The Medical Record Committee looks over all the records. Tissue Review and Transfusion Committees: Is this surgery necessary, is this transfusion necessary? Medical Care Evaluation. Utilization, which I have just gone over. Intensive Care Committee. Pharmacy Committee: Do we need half a dozen different types of penicillin? Why can't we buy it all from one company? An Infection Control Committee. A Collaborative Practice Committee, formed by the doctors and nurses to see how we can cut down hospital costs and improve service to the patient.

This is all I want to say on utilization review. If there are

any questions that I can answer, I'd be very glad to do it, particularly on the patient-physician relationship as far as hospital costs are concerned.

GILL: Dr. Bachrach, do you have patients that are in need of nursing home care?

BACHRACH: Absolutely. Many of my patients are in need of nursing home care.

GILL: And they have to wait in the hospital until a placement is found?

BACHRACH: Many of them do. We have three or four nursing homes in the area. There is a little discrepancy there. If a patient is on Medicare or Medicaid, and there is no room in the nursing home, then the hospital will have to keep them, but the rate is obviously reduced. On the other hand, if the patient is a Blue Cross/Blue Shield or self-pay, and there is no room in the nursing home, he pays for it himself.

GILL: I've found that there are people who are waiting, and the cost is higher in a hospital keeping them while they're waiting for a nursing home bed. We have had a moratorium on nursing home beds. I hear from constituents that they have a problem in that they can't get their loved one in a place. I just wondered whether you saw the back-up in the hospital.

BACHRACH: Yes, there is a back-up. Recently, the Department of Human Services has decreed that the patient must go wherever there is a bed. And this imposes a hardship on many of the people, because we've had patients go as far as Pittsfield.

MANNING: You've indicated that your hospital has a good utilization record. But it seems that everybody who has testified today,

for both the hospitals and the medical profession, has the best or does a good job. There are 45 different hospitals out there. Somebody must be doing something bad. Granted that your hospital might be great, but that isn't saying that the other 44 have done a great job. Can I say that?

BACHRACH: I made that statement on the basis of statistics that are passed to us, in which they list the different hospitals on the lengths of stay of patients. And we are among the lowest. I don't know about the others. Maybe their cases are more difficult. It's obvious, for example, if a man goes into the Maine Medical Center with a third-degree burn that he's going to be in the hospital for a long time, and this is going to raise the average length of stay. On the other hand, if your hospital practice consists mostly of obstetrics, your hospital stay will be cut down by two or three days, or whatever they allow for obstetrics nowadays.

MANNING: Getting down to Brunswick, it seems to me that Brunswick and Bath are in such close proximity and yet you have three hospitals in that area. Portland, which is the largest city in the state, has three hospitals. I wonder if you've looked at the possibility of combining all three hospitals into one?

BACHRACH: Yes, as a matter of fact that question has come up repeatedly. And it has been voted down. The Parkview Hospital, which is an excellent hospital, has a religious affiliation and would prefer to go its own way. Consequently, they're not part of our cost-saving device. I mentioned that Regional Memorial and Bath share a purchasing agent and Parkview is not part of that. I have no explanation other than that. But the answer to your question is that many attempts have been made. As a matter of fact, we no longer do obstetrics. We used to do

obstetrics at Regional, but Parkview does it all now, so there is one way of consolidation.

MANNING: If we, as government officials, look at the rising cost of hospital care, and we know that 50-60 percent is paid by Medicare and Medicaid, and the next big chunk is Blue Cross, a good part of which is paid by taxpayers through Maine State Employees and other organizations, do you feel that we as legislators have the right to mandate that hospitals start consolidating? If we're going to be paying 75 percent of the bill, and private industry is paying 25 percent of the bill...

BACHRACH: I can't answer that question. There are constitutional involvements. I think you'd find it very difficult to do so. For example, in Portland you have Mercy Hospital, Maine Medical Center. In Lewiston, there is St. Mary's and CMMC. And never the twain shall meet. In Waterville, they did succeed in combining the two hospitals. Bigger isn't necessarily better.

MANNING: I grant you that, but we heard talk this morning about fixed costs. You have to heat three plants in the Brunswick area. Brunswick certainly doesn't have that large a population in that general area, because you don't have to go too far before you're into Lewiston or the Gardiner-Augusta area.

BACHRACH: Everything you say is what many of us have wished would happen, namely, one good hospital centrally located. But when I came to Brunswick in 1948, the hospital was an old home that a doctor had converted. There was no elevator. You went up and downstairs by being carried on a stretcher. Parkview Hospital was built in 1959. Right after that, the Regional. An effort was made in 1959 and 1960 to get all three hospitals and have one central hospital, which would have been great.

If you have patients in two hospitals, it's almost impossible to make your rounds. If you have them all in one place, that's great. The Parkview Hospital would have none of it. And the Bath Hospital wanted to be autonomous. You're right, it would have been much better, in the opinion of most of us, if there was one hospital.

NELSON: Dr. Bachrach, as a physician, what do you think are the professional incentives for you to keep the cost of hospital stay down? Do you see that there are professional incentives?

BACHRACH: Absolutely. People don't want to pay all that money.

NELSON: But if you tell me that I have to go into a hospital, I am assuming that what you tell me is true and that I have to go. Then why does it really matter to you, since you're not a part of the hospital process? Why would you want to keep the hospital costs down?

BACHRACH: I myself find it more convenient to treat patients in my office. I don't have to take out the time to go to the hospital. And this is what most of the doctors say. If they didn't have a hospital practice, they would be much happier. Not surgeons; I'm talking about medical men. You don't have to serve on all the committees. You don't have to write the voluminous records that take hours to write, even though we dictate them. It's much more convenient for me to go to the office. Most doctors do their best to keep patients out of the hospital. That's the birth of ambulatory care, as a matter of fact: in in the morning, out in the evening. You don't have to make rounds twice a day.

NELSON: But financially, are there incentives to keep your patients out of the hospital?

BACHRACH: I was surprised to find that someone said a doctor makes five times as much putting his patients in the hospital. I never

looked at it that way. To me, it's inconvenient to have them there. It certainly was inconvenient for them, too.

KETOVER: It has bothered me, and I'm sure it bothers a lot of people, the high cost of doctors' fees. I would like to know your feelings about competition among doctors. Also, how do you feel about a fixed fee for physicians?

BACHRACH: Let me speak about fees. There is something magnetic about charging a higher fee. I am considered a "cheap" doctor. But that's because I've been there a long time. I've noticed many times that someone comes into town, charges a higher fee, calls himself a specialist, and immediately builds a big practice. People think, if he charges more, he must be worth more, and he must be better. So there is nothing to keep a doctor from raising his fees. Are you asking me, should doctors have a standard fee? No, I think I'm better than a lot of other doctors. And I don't feel that he should get as much as I do. One of the things that used to burn me up, and burn up a lot of doctors, is that when Medicare or insurance companies set a fee, some guy coming out of medical school and having a couple of years of practice can go in and charge the same fee that you charge, and you've been there thirty years. The answer is no.

KETOVER: Then, with this kind of attitude, the fees will never come down, because the competition will not be there. It has been done in other states and it has worked, especially with specialists. Specialists today are charging far more than the general practitioner or the family practitioner. To me, that's coming back to the public where they're going to be using more family practice doctors. Hopefully, they will go into clinics and they will have a system where they will have set fees.

BACHRACH: I don't know how I feel about fixed fees. I think some of the fees are outrageous. I don't know what I can do about it. But you're right.

KETOVER: Hopefully someone will come up with a solution

BACHRACH: There is one thing I would like to bring up. The Maine Medical Association is adopting, or has in the process, a utilization program similar to what we have. The other thing I would like to mention is this. In a way, I blame Blue Cross and Blue Shield for increasing hospital costs. The reason I say this is because, as far as I know, they absolutely refuse to have a deductible clause in their contract. It's well known that if a person has to pay some of his own medical fee, he's going to think twice. If you come into my office and you have Blue Cross and Blue Shield, and I can order anything, and you won't say a word, you'll probably welcome it. But if you know that either the first $100 or $200 or $300 is going to come out of your pocket, you're going to say, is this trip really necessary? Do I need a GI series, do I need a gall bladder series, is the arthroscopy necessary? Maybe I can get by with just a couple of aspirin. You'll question this. The way it is now, you have very little input to what a doctor orders. Many times, a doctor is on an ego trip and wants to get a reputation for being thorough. He'll order what one of my roentgenologist friends calls a "blue-plate special"; namely, you come in and get a T-3, T-4, TRH thyroid test, blood tests, urine test, IVP, chest plate, etc. Routine tests are abhorrent. And one of the ways you can cut hospital costs is to cut down on routine tests. On the other hand, the hospitals love routine tests because that's how they make their money.

NELSON: We were told that the reason they have all these tests is to protect the doctors from malpractice problems.

BACHRACH: Absolutely. That's another aspect. Defensive medicine is well known.

GILL: I think it is a Catch-22 situation. If I go to a doctor and I have a particular problem that I'm going to see you for, I want that taken care of. But I want to come out of there with you telling me: You've got a clean bill of health in every area. I think that's what doctors have tried to do, to allay the fears of some of the patients. A patient isn't educated enough to know what actually is needed in the way of testing and what is extra.

BACHRACH: At one hospital where they were trying to cut costs, they discontinued urinalysis as part of the admitting routine. Well, it's ridiculous to go into a hospital and not have a routine urinalysis. Maybe you have blood in the urine, or pus. Maybe you have sugar or albumen. Not to do it, or a blood count... Another thing is this. If you have an item such as reimbursable costs, that's like giving the hospitals a blank check. Every year, all the hospital has to do is tell Blue Cross, we're so far behind. And the first thing you know, you have a form of revenue sharing, and the Blue Cross forks over a certain amount of money to the hospital--money that really belongs in the patient's pocket, not the hospital's pocket. They have this figured out. I don't know how it goes. But it is tantamount to a blank check that is given to the hospital by Blue Cross, which really belongs in the patient's pocket.

GILL: You're saying that Blue Cross is partially responsible, but, as we look at health care in general, we can point fingers at physicians, at hospitals, at the insurance companies, at the patients. And isn't that all the more reason why everybody should work together?

BACHRACH: Yes, but point it at the physician. He is the director. And you should have an active part in this. But you will never have an active part as long as you know that someone else is going to pay all the bills.

GILL: Is the physician ready to change his behavior? Is he willing to look at the system and willing to say, I have contributed to the cost of health care escalating? Would he be willing to adjust his practice?

BACHRACH: All the physicians I know are cost-conscious. But look at this. Thomas Almay, who is professor of medicine at Dartmouth, wrote an article in the New England Journal of Medicine about six months ago. He wrote about the different apparatuses that hospitals have. Now, if a hospital buys a gastroscopy setup, you can rest assured that the frequency of gastroscopy is going to double and triple and quadruple--because there is a gastroscopy set there. The same is true for arthroscopy. If the patient says, Is this gastroscopy necessary, or is this arthroscopy necessary, because it's going to cost me $2-300, then I think that is one way of holding down hospital costs.

GILL: I don't want to get into a debate, but I do hear from the other point of view that a hospital gets this equipment because the physician requires it.

BACHRACH: Absolutely right. Every year we are asked, Is there any piece of capital equipment you would like? You write it down and they may get it for you or they may not. The chances are that they will. It's one way of attracting specialists to your hospital. Certainly, if you're going to have an orthopedic surgeon, you want to have an arthroscopy setup. If you have an ENT man, you want to have an operating microscope. So you have to provide the equipment for these people to work with.

PINES: Do you feel that generally hospitals are doing what they can to restrain costs?

BACHRACH: Yes, I do. I think the Regional Hospital does. I'm a little upset by the fact that they've had to increase their room rate to build an addition. But, on the other hand, as someone said this morning about depreciation, everything wears out and has to be replaced. That's one way of doing it. But I believe that most hospitals that I'm familiar with do try and cut costs.

MANNING: Going back to the deductible, a couple of months ago I had the privilege of listening to one of the neurologists at the Maine Medical Center. And he started talking about $1000 deductibles. Probably the people who were sitting there could afford a $1000 deductible. But I'm looking at a few people on this panel up here who can't afford that. If somebody can afford a $1000 deductible, let him go ahead and take it.

BACHRACH: If he can afford a $1000 deductible, that means the premium is very much lower.

MANNING: But if he can afford a $1000 deductible, they've got the salary to pay that. What I'm saying is, would you go along....

BACHRACH: If he has a $1000 deductible, you can rest assured he thinks he's in pretty good shape physically as well as financially.

MANNING: But would you go along with a sliding-scale deductible?

BACHRACH: I think people have to figure out their own deductibles. We had to do it when we switched from Blue Cross/Blue Shield to John Hancock. You know what you can afford and what you can't.

BUSTIN: I appreciate your forthrightness and honesty, Dr. Bachrach. Usually when I heard this kind of conversation, it's in a dark corner that a doctor is willing to say those kinds of things. The other thing that constantly comes up as I listen to the testimony that comes before this committee... it seems to me that the only thing that I should have to consider as a committee member is the minimum amount of health care that a constituent in the State of Maine should get. How that is distributed out there in the field is up to somebody else and really isn't up to me. To follow that up, what I would hope and what I would like to have confidence in, is that those providers--whether they be the doctors or the hospitals or the administrators, or whoever is giving the health care--have enough honesty and forthrightness, as you have displayed, to make some kind of determinations about whether you have a urinalysis before you go into a hospital or not. There ought to be somebody besides me, who is not a medical person, making that kind of decision.

BACHRACH: Let me just say that my colleagues are familiar with my positions, so they wouldn't be outraged by what I'm saying. There is no minimum health care among the doctors I know. They all go out one hundred percent. I've never seen the hospital turn down one request for anything that I have asked. It's all maximum quality care, the best a doctor can give.

BUSTIN: That's exactly my point. We're talking about cost containment here. And we're talking about third party payors paying that bill. My question is: How can I, as a Health & Institutional Committee member, depend upon the provider community to tell me what that minimum level of care is?

BACHRACH: You have to trust your doctor. If you have an abdominal aneurysm, for example, and it needs to be surgically repaired, and Blue Cross is going to give the doctor $600, and his charge is $1500, he certainly isn't going to do half a job; he's going to do

a $1500 job, whatever Blue Cross pays. There's no quibbling there.

BUSTIN: I understand that. But I, as a patient, or as a committee member, do not know what kind of tests I need, or whether my doctor is ordering the correct number of tests. How do I know the doctor is calling it right?

BACHRACH: You have to trust your doctor

GILL: We're ready to go on to Dr. Moore

MOORE: I would agree with one of the statements my colleague made. I think that most concerned physicians in Maine are truly aware of the high cost of medical care. You can't pick up a newspaper or periodical or medical journal without being faced with the increased cost of medical care. I think we're all aware of it.

Recently, there was an endorsement made at the House of Delegates meeting, with a resolution endorsing a cost containment program. So the Maine Medical Association is aware that there is a problem and would like to do something about it.

Having practiced for 32 years in the field of anesthesiology, I see a lot of changes--a lot of budgetary changes and personnel and everything else. I happened to sit for a while on a hospital cost containment committee in our local hospital. This was a physician-staffed committee. And we tried to look at some of the problems as we saw them in an attempt to curtail some of these costs, among them being some of the laboratory tests we've been talking about and x-rays and one thing and another. We found it very difficult to come to any conclusions. You've already heard the problem. Yes, we'd like to cut some out. On the other hand, if you cut some out, you're liable to wind up on the short end of the stick and face litigation. So, as Senator Gill said, we're in a Catch-22 position. You're almost forced to order more than perhaps you think is necessary, just purely in defense of

your practice. And the suits, as you know, are multi-million dollar suits. This committee managed to do a few things that I thought were fairly constructive. We cut down on the amounts of food served, substituting sandwiches, etc. A very small attempt, but at least a start.

Another avenue was the institution of a blue-room set-up. These were two rooms set aside in the hospital which a physician could use without charge to see a patient in consultation. And there was no charge made to the patient. It was a gratis move performed by the hospital to accommodate the physician, which I think might have helped a little bit.

Every year for many years, I was asked to make out a projected five-year budget. It's pretty hard to sit down and figure out what equipment you're going to need in the field of anesthesia even next year or the year after, in this age of monitors, refined equipment--all of which you really should have and be using. Going back to what I just said, if you don't have it and don't use it, you have a problem. We're at the point now that we're buying monitors to monitor the monitor; to make sure that's working. It just snowballs. So, even at the departmental level, we were involved with the budgetary attempt. And having made out the budget, you would be asked to prioritize your budgetary items, to write letters stating why you needed this particular item, following which a member of another department would interview you and try to ream out even more things that you had put down. So I think there is an attempt even on the physician level to try to keep costs down.

Another thing that I think has been very important... One of the speakers this morning referred to outpatient or ambulatory surgery. In the last couple of years, we found in Waterville that our ambulatory surgical load has increased phenomenally. Many procedures--ear, nose and throat, gynecological procedures, orthopedic procedures--which heretofore had been done on an

inpatient basis, are now being done as outpatients. And so far we've seen no problem. I can't quote a figure, but there must be some saving along the line. These patients come in the morning, they have their procedure, and two or three hours later they're pretty well recovered and they're on their way home.

The thing that concerns me in this legislative document, as I read it over, is the appropriateness review section. Perhaps I'm not clear as to what this implies to the public, to the physician, to the hospital. Does this mean that certain hospitals, physicians, or patients--based on age perhaps--will be disallowed procedures that may be medically indicated? Let's use an example. The older you get, the more care you seem to need. If some of these people need a total hip replacement, if they need renal dialysis, if they need coronary bypass surgery (which we don't do in Waterville)--will this be permitted? If so, who will be in charge of the permission? Will it still be the physician-patient-family relationship? Or will it be mandated by society or some other agency? I'm afraid, if the latter is true, that it may perhaps not destroy but it might alter the patient-physician relationship to a certain extent. This is something I question.

Generally, I think I'm in agreement that medical costs are, like everything else, spiraling and almost out of control. I for one would like to see some kind of handle put on it some place along the line in the way of a program. However, I think we have to keep in mind ... we've all talked about the quality of medical care. How you define quality care is a very difficult thing to do. It's a nebulous term and there is no yardstick by which to measure it. I think quality care is something that Dr. Bachrach alluded to as coming from within an individual, whether it be a physician or whatever job he or she holds, to do the very best job they're capable of doing under the circumstances. And yet having the guarantee that the expensive equipment is available to do this capable job. I think that the legislation we're talking

about, if it doesn't alter or affect quality care, which people say it won't--and I'd like to make sure it won't--then I think the concept, as far as I'm concerned, would be acceptable to most physicians.

GILL: Are there questions for Dr. Moore?

NELSON: Dr. Moore, I take it that you are basically an employee of a hospital. As an anesthesiologist, you generally don't have a private practice?

MOORE: No, on the contrary. We're hospital-based but we're fee-for-service. The American Society of Anesthesiologists historically has recommended that members of the Society engage in more or less free enterprise.

NELSON: But I wouldn't come in off the street to speak to an anesthesiologist. You would come to me after my surgeon had determined that he would use your services?

MOORE: That's right

NELSON: And you would come to my hospital room and explain the procedures for the next day?

MOORE: Right

NELSON: In the course of your explaining the procedures, have you ever said to a patient: There are three procedures that I could use to put you to sleep. And, of the three, this one is less expensive. I do know they always speak in terms of risk. But in my experience, money was never even discussed. I just wondered if that might be one way that physicians might begin to think in terms of costs, by simply reminding people

that they have choices. And one of those choices has to do with cost.

MOORE: We use so many agents. It's not a one-agent world any more. Back when I started originally, we were in the ether era. And it wasn't worth more than $2. But now we use probably five to ten different drugs throughout the procedure: muscle relaxants, different gases... There is a myriad of different agents and techniques that are used. There isn't anything in anesthesia that's simple and straightforward. In answer to your question, I don't think I could say that one particular method is cheaper than another. It's what is best for that particular patient. You may have a problem which perhaps might preclude the use of such-and-such an agent or technique. In that case, we would say, on the basis of your history and what we find, we would suggest that you entertain the following type of anesthesia--going through the informed-consent routine.

Another problem arises also insofar as now we have about fourteen nurse-anesthetists. We think they're excellent. They do a good job. But the salary structure has multiplied. I'm not saying it shouldn't have. But it has gone from the area of $10-12,000 a year up to about $25,000 per individual. It is pretty hard to keep prices down when you're faced with increasing expenditures for personnel which you require.

BUSTIN: There are other services in the hospital--for instance, radiology. Are they also fee-for-service?

MOORE: I think they have a split type of mechanism. There is a hospital charge for the technical work of taking the x-ray, the part that the technician plays. Then, for the interpretation of the x-ray, the radiologist usually submits a separate and distinct fee. The same would happen with an electrocardiogram, at least at Mid-Maine Medical Center. The technician would do the

procedure and the hospital would bill for the procedure. But the cardiologist who interprets the tracing and renders his opinion would send his own bill.

BUSTIN: So, in other words, I'm getting billed double?

MOORE: In a sense, you are. You're probably being billed minimally by the hospital for the technician's work. I hope you are. And the cardiologist sets his own fee. However, I think they charge a moderate fee because they read an awful lot of them every day. Again, I would hope that the fee isn't exorbitant. But, other than that, I can't answer your question because it's really out of my area.

STRED: May I just add to that. It's not really a double billing, Senator Bustin. There is one component for the technical work which is done and the other for the scientific or the interpretive component. It could be, in another hospital, that that might all be billed through a single billing. It would depend upon the individual institution.

BUSTIN: Mr. Stred, which is it? Fee-for-service or percentage-of-gross? What is it?

STRED: The scientific component, as I understand what Dr. Moore said, is fee-for-service. The technical component was flat rate in that particular hospital.

BUSTIN: Might this be one of the areas where we might look at some cost containment?

STRED: I think you might look at a number of hospitals and see whether it's cheaper to do it one way versus another.

GILL: Dr. Bachrach, I'm interested to know what do you consider to be a patient's record. There has been a lot written and a lot said about it. From your point of view, I'd like to know whether you consider it your workup, or whether you consider this as something which belongs with the patient, so he knows his own medical record and maybe could carry it on if he moves, or just to have it in hand.

BACHRACH: Legally, the record belongs to me, the physician. And if you want the record, I'll be glad to send it to any other physician of your choice. Many times, if I have a patient who is moving, I just give them the record. I have nothing to hide. But, legally, I can keep the record and just transfer it.

GILL: I happen to have been at a conference recently where we saw a computerized record. And the printout was given to the patient so that they could have it in hand. This seems to be something that may be coming down the road that's very different from what we've known in the past.

STRED: Senator Gill, were I representing a malpractice insurer, I would probably amend Dr. Bachrach's statement to say that if he's insured with us, he probably should retain the record for his own protection, at least through the period of the statute of limitations--and not give the original away, but retain the original for his own files or for that of the benefit of his estate, even if he's retired from practice.

GILL: Any other questions?

BUSTIN: Would it make any sense, Mr. Stred, to have these different services, like radiology and cardiology, etc., be hospital staff and paid as staff, negotiating the salaries? Wouldn't that be cheaper for health care costs?

STRED: It might be. It might have the direct opposite effect of locking in the costs. When it's fee-for-service, the patient pays only when the service is performed. If you lock in the cost to the hospital, then you're paying for it, whether it's utilized or not. For instance, some anesthesiologists in this state also maintain a family practice. The immediate past president of our association was an anesthesiologist but is also now one of the teachers at the family practice institute in Bangor. So, were he on a salary at his previous hospital, the entire cost would have been picked up by that hospital and would tend to inflate the cost.

GILL: Aren't some radiologists on salary in this state?

BACHRACH: There's another aspect of cardiology. You have to remember that reading electrocardiograms is a lot of gravy in the doctors' pocket. And if there are a half-dozen cardiologists on the staff, and only one cardiologist reads them, there's a lot of problems that arise. Most hospitals will divide reading of electrocardiograms among the different cardiologists so that they each get a cut.

GILL: Thank you very much. Next we'll hear from Blue Cross/Blue Shield. We have Frank Faherty, David Crowley, and Dr. Henry Miller. Dr. Miller is from the Center for Health Policy Studies in Columbia, Maryland, who is doing some consulting.

FAHERTY: My name is Francis X. Faherty. I am senior vice president of Blue Cross and Blue Shield of Maine. My purpose here this afternoon is to give you some idea as to what Blue Cross is seeing in terms of the impact of health care costs on our subscribers, and to introduce the two associates that Senator Gill has just mentioned, who will speak to the specific elements of the Health Facilities Cost Review Board's report--as that Board, this committee, and the administration attempts to deal with what seems to all of us a problem; that is, the rate of increase in the cost of health care.

The symptoms of the problem that our subscribers are seeing are, in part, these. While our subscribers are using fewer hospital services--567 days per 1000 members in the first quarter of this year, compared to 615 days in the first quarter of last year (and this is a drop of 7.8 percent); and we are seeing 7.4 percent fewer admissions in the first quarter of this year as opposed to the first quarter of last year--the cost for an average Blue Cross hospital day has increased 18.6 percent, from approximately $340 per day to about $403 per day. For this period, there has been a modest increase--roughly about one percent--in the number of outpatient visits. But the cost of the average visit has increased by 24.6 percent, from an average of $59 in 1981 to $73 in 1982.

You'd expect, with other things being equal--and we know they're not--that a stable or declining utilization pattern should result in a cost line somewhat reflecting those trends, even after an adjustment for inflation. This is not what we are seeing, however. While the volume of claims for all lines has remained relatively stable from the first quarter of last year to the first quarter of this year (they have increased roughly 0.5 percent in volume), the expense for those claims has increased 14.8 percent.

The end result is that, while Blue Cross and Blue Shield members are using about the same number, or fewer, services,

they're paying more for these services. And they are seeing annual rate increases of 20+ percent. Certainly greater than any measure of the current inflation rate.

Our subscribers tell us that they are having great difficulty and in some cases cannot afford these increases. Therein lies the basic question, a public policy question, I believe, that faces government, the health care industry, the public: How much can the public afford to pay for its health care?

I would echo the comments that were made by several of the speakers this morning, that the consumer is heavily involved and interested. We hear it daily. We hear it from the decision-makers that buy our coverage. We hear it from the individual subscribers, complaining to us about the cost of health care to them individually.

We are pledged to cooperate and to assist in the search for an acceptable solution to this problem. The tangible model of a reimbursement mechanism that is before us at this point is the report of the Health Facilities Cost Review Board. At this time, I'd like to ask Mr. David Crowley, who is a payment specialist on our staff, to address the specifics of that report.

CROWLEY: As the committee is aware, Blue Cross is supportive of many of the recommendations in the Cost Review Board's report. You have heard from us before about the potential advantages of prospective reimbursement, such as its ability to provide incentives to control costs, and the predictability it lends for both hospitals and payors. Although prospective reimbursement is not the total answer, it is a very important part of the solution that we are all seeking: a reduced rate of escalation in health care costs.

We also agree with the Board on the question of capital expenditure review. To strengthen a system-wide prospective reimbursement system, we, too, feel it is essential to have a

strong certificate-of-need program, and it is essential to firmly link that program to a prospective budgeting and reimbursement system.

We agree with the Board that Medicare and Medicaid must participate in the system. We do not believe that the new payment system can be equitable or effective unless it includes both governmental and private payors.

We believe that hospitals should be expected to operate within approved economic limits. The maximum revenue authorization, or cap, envisioned by the Cost Review Board would set those limits and provide the necessary controls that a prospective system needs to be effective. A cap is an approach worth trying, though it must, of course, be developed with proper safeguards, so as not to put hospitals at risk for cost increases beyond their control, like general economic inflation; so as not to reward inefficient providers while penalizing efficient ones; to somehow accommodate the older facilities as well as the newer ones; and to take into consideration the difference in needs between small and large hospitals.

We are pleased that the design of the overall limitation is going to be determined by the legislature. We believe the legislature is the proper setting for such a major public policy decision. Once the nature of the limit is established (the actual setting of the limit), year-to-year can and should be left to some broadly representative authority, with a make-up similar to that of the Cost Review Board.

Historically, Blue Cross, on behalf of its subscribers, has determined, through negotiations with hospitals, the financial terms of its contract with hospitals. The Board proposes to give a state authority extensive control over the financial terms of our hospital contracts. This concerns us. We have reimbursed hospitals on the basis of their costs, and we have elected to identify certain financial needs in addition to

those costs. We maintain that a prospective payment system that focuses on the recovery of costs and other agreed-upon financial needs, done through a prospectively determined reimbursement scheme, is the way to proceed. We must not allow a loose interpretation of the definition of "financial needs" that results in the Blue Cross subscriber assuming an unfair share of financing hospital services in Maine. We pay the hospitals fairly through our present arrangement. I think you are all familiar with our present system of payment, as we discussed it with you a couple of months ago in some detail.

The Board report implies that, because of our payment methodology--a cost-based approach--we are not contributing fairly to hospital needs. We disagree with this notion. We believe a cost-based payment system can be fair and equitable. Our present method uses the Medicare principles to define allowable costs that are related to patient care services. We do not apply to our reimbursements the limits that Medicare applies to its reimbursements, such as Mr. McDowell mentioned this morning--malpractice insurance, etc. The Medicare base for defining costs, which we believe is sound, is used in the programs that were discussed by the panel at the hearing on June 10th--the programs in New York, Massachusetts, Rhode Island, Washington, New Jersey, Maryland, and in Rochester. All of these use this base to determine the elements of cost.

The report also states that a hospital's success in realizing its financial needs depends on having a base of charge payors, and some emphasis has been placed by the Board on a payment system based on the hospital price. We feel there are certainly other methods for payment that can be as effective in controlling costs, particularly when a system will include major contract payors, such as Medicare, Medicaid, and Blue Cross.

A problem that we see in the charge-based approach is that a hospital charge can be set such that the hospital can

include any expense they wish to recover. The charge may also reflect costs that are not directly associated with providing care to Blue Cross subscribers. We believe the system should be constructed to assure recovery of essential financial needs. Of course, the sharing of these determined financial needs must be done in a fair and equitable way. I don't want to leave you with the impression that we do not support the general direction of the Cost Review Board's report. We think the direction is the right one. However, I want to emphasize that the system must be fair to the Blue Cross subscriber. We will not compromise on that issue at our subscribers' expense. We do not expect others to subsidize Blue Cross subscribers, nor do we expect our subscribers to subsidize others.

Blue Cross can support an appropriately capped or otherwise controlled prospective reimbursement system which meets the agreed-upon financial needs of the hospital, including their approved capital needs, which has appropriate safeguards on the utilization of hospital services and which provides for the equitable distribution of these agreed-upon financial needs among classes of payors, all payors.

Dr. Henry Miller has had considerable experience in dealing with the issue of equity among payors in other states. He has some thoughts to share with you now.

GILL: Before we hear from Dr. Miller, the Board's report came out in December, 1981, and Blue Cross couldn't approve of it. You said you could not consider endorsing the report in February of this year. Why have you changed your position? Was it because you were afraid legislation was coming while we were still in session? Or have you looked at the report again and rethought your position on it?

CROWLEY: I don't think that we've had categorical support of the report, nor did we have a categorical disagreement with the report back in February. We came out in favor of a number of aspects, and we are still supportive of a number of aspects of the program.

GILL: I have a statement in front of me that says, "We cannot consider endorsing the report."

CROWLEY: Again, the report itself--to give a stamp of approval on all of the recommendations of the report, I don't think we were prepared to do that at that time.

NELSON: Perhaps the gentleman who wrote the letter is no longer with Blue Cross/Blue Shield?

GILL: Are there any other questions for Mr. Crowley?

NELSON: We do know, because you came before our committee to explain how you negotiate costs, how you negotiate to pay for your 25 percent of hospital costs. How do you know that the hospitals haven't increased their rate so that you pay more than your share, because the hospital rate has gone up? They may set a higher rate in order to make up for the four percent of bad debts and so forth. How do you know that in your negotiations? Is that on good faith?

FAHERTY: I think that after Dr. Miller's discussion we can probably more comfortably deal with that question, and we will.

GILL: Let's go on to Dr. Miller, because I have additional questions, too.

MILLER: My name is Henry Miller and I'm the president of the Center for Health Policy Studies, which is a research and

consulting organization that is headquartered in Columbia, Maryland. We investigate problems in health care costs, reimbursement, and regulation. In addition to Blue Cross and Blue Shield of Maine, our clients include the federal government, state governments, health insurers, and also health care providers.

I'm going to speak today about payor equity and its importance in hospital payment programs. Payor equity is one of the difficult issues, as you know, that you will have to address as you consider legislation aimed at containing hospital costs. Despite what you've heard, payor equity is really a very straightforward concept. It's based on the recognition that there are differences among payors for hospital care, and that those differences affect the cost of care, both to hospitals and to their communities. The same concept also implies that the payment for services should be related to the costs for services, with different levels of payment necessary to avoid having low-cost payors subsidize high-cost payors.

This is an issue that I've been personally involved in for several years. I've directed studies aimed at determining equitable payment rates in Connecticut, Illinois, Maryland, New Jersey, North Carolina, and Virginia. In New Jersey, my study was used to establish the payment rates for Medicare, Medicaid, and Blue Cross that are currently in place. The study I directed in Illinois was also used to establish payment rates, or differentials, for Medicare and Medicaid. Blue Cross's differential, which was the prime focus of the Illinois study, will be determined after additional hearings are held.

My participation in these studies, as well as my testimony on payor equity in forums like this one in other states, have allowed me to make substantial contributions to the definition of equitable payment and to the identification of differences among payors. I want to cover three points in my presentation. First, I want to discuss how the payor equity concept grew and became important. Then I want to discuss the differences among

payors that must be recognized to achieve equity. And I want to emphasize at that point the attributes of Blue Cross that make it unique among private-sector payors. Finally, I want to summarize some issues that I think this committee will need to consider in regard to payor equity.

The concept of equity in hospital payment is found in federal and state law. In 1974, Congress included it in the National Health Planning and Resources Development Act. In a section of that Act, Congress said that a system of rate-setting should be established nationally, and added that the system shall provide that revenues derived from patients in one category shall not be used to support the provision of services to patients in any other category. Similarly, statutes establishing rate-setting commissions in different states also explicitly recognize the need for payor equity. As these states sought to implement their legislative mandates, they went further to define payor equity, in order to provide some guidance for values and measurement.

Among the commissions, as in other cases, the Maryland commission was most specific. The Maryland commission's guidelines read: "Equity among individual purchasers is achieved by having each pay rates based on the cost of care provided to them. Equity for classes of purchasers can, in part, be achieved by granting discounts or including add-ons relating to actual savings or expenses caused hospitals." An example of the former is the working capital provided by Blue Cross and Medicaid. Examples of the latter might be the more-than-proportionate need for nursing services by Medicare subscribers and a more-than-proportionate need for the services of house staff by Medicaid beneficiaries, many of whom may not have private physicians. The Maryland commission went on to say, "The activities of certain third parties may reduce the need for charity care and shouldn't be discouraged. To account for the savings to hospitals resulting from the reduced charity care burden, the commission staff will recommend a differential in rates for third-party payors whose

policies provide substantial coverage."

As rate-setting commissions went on and implemented their various prospective reimbursement methodologies, the need for equity became even clearer. Regardless of the methodology that is used--for example, whether inflation adjustments are used as in Maryland, or DRGs [diagnostic-related groups] as in New Jersey, or budget review as in several other states--the procedures for granting differentials to payors were established and they were similar. And the number of payors that have received differentials has been small. Medicare and Medicaid receive differentials in each state where there is a rate-setting commission. Among private-sector payors, only Blue Cross and a small number of HMOs [Health Maintenance Organizations] have been granted differentials. In fact, every state hospital rate-setting commission that has considered payor equity has granted a differential rate to Blue Cross because of its unique attributes that reduce hospital costs--attributes such as prompt payment to reduce hospital working capital costs, substantial and available coverage especially provided to high-risk individuals and groups to reduce hospital bad-debt and charity-care costs, administrative practices that reduce hospital patient accounting costs, and cost containment programs to reduce health care costs to communities.

The unique attributes of Blue Cross plans that have given rise to differentials in other states can also be found in the practices of Blue Cross and Blue Shield of Maine. In fact, in some ways, Blue Cross and Blue Shield of Maine engage in some practices that are likely to have a greater effect on hospital costs than Blue Cross plans in many other states.

The savings to hospitals that are generated by prompt payment are probably the easiest to understand. If a payor remits payment to a hospital promptly, the hospital receives cash that can be used to reduce borrowings, or increase interest income from short-term investment. Differences in promptness of payment have become especially significant as interest rates have

risen. Blue Cross and Blue Shield of Maine pay hospitals in no more than ten days in nearly all cases. Other payors in the private sector take much longer. In the studies that have been completed in other states, the average commercial insurance carrier has been found to require between thirty and sixty days to submit payment. On the average, commercial carriers pay six weeks after receiving the hospital bill. A four-week difference in working capital costs is substantial when you have a prime interest rate as high as sixteen or eighteen percent.

While these kinds of cost differences are important, the differences in coverage among payors are even more important. Every rate-setting commission has recognized that Blue Cross plans not only provide comprehensive coverage but they also provide comprehensive coverage at an affordable cost even to high-risk individuals and groups who might not be able to secure coverage from any other source. While the differences that occur in coverage are complex, there is no doubt that the availability of coverage reduces hospital bad debt costs as well as the uncompensated care burden that must be borne by communities and state Medicaid programs. These differences in coverage occur in several ways. There are very few differences between Blue Cross plans and commercial insurers in their provision of coverage to large groups. But as groups grow smaller, and for individuals who are not group members, the differences increase and become substantial. It is easiest to understand these differences when you examine individual or non-group coverage.

Blue Cross and Blue Shield use a practice called community rating to establish subscription or premium rates for individuals and groups up to a hundred members. Community rating is the simplest premium rate-setting concept. It simply says that you take the expected utilization of all the individuals that are enrolled, add some administrative factors, and then the resulting total cost that you expect is divided by the number of individuals

you expect to cover. Every individual who purchases coverage, therefore, pays the same rate, regardless of age, sex, or location within the state. This approach tends to make coverage somewhat more costly for a low-risk person, but it uniquely provides opportunities to purchase coverage at an affordable rate to high-risk people.

Commercial insurance carriers use different techniques to establish premium rates. They use age, sex, location factors in their rate calculations. All carriers increase rates annually, as beneficiaries grow a year older. Because women through age fifty utilize more health services than men of similar ages, their rates are higher. Because health care costs differ among locations within a state, rates are adjusted to reflect insurer expectations for local cost increases. The result of the commercial carrier approach to premium rate-setting is to provide coverage at moderate cost to low-risk individuals while making coverage prohibitively costly to older, high-risk individuals. It is not surprising, therefore, to find that the vast majority of high-risk individuals select Blue Cross's community-rated coverage.

There are other important differences in coverage for individuals, too. Perhaps most important, Blue Cross accepts nearly everyone who applies for coverage, regardless of their prior history of illness. Furthermore, Blue Cross provides coverage to these individuals at the same standard rate that is charged to other healthier people.

There was a recent survey of the commercial insurance industry, conducted by the commercial insurance industry, which found that, on the average, eleven percent of the applications for individual health insurance coverage that were submitted to commercial insurers were turned down. And some companies turned down as many as thirty percent.

In addition, the commercial insurers that accepted the high-risk people did so only by charging them higher-than-standard rates.

In a study that was recently completed by the Illinois Insurance Department of the commercial insurance industry, it was found that commercial insurers either don't provide coverage for many health conditions, or cover them only at increased rates. For example, the conditions they studied included diabetes, Parkinson's Disease, epilepsy, cirrhosis, and several others. In every instance, commercial insurers restricted coverage to individuals suffering from these conditions. And in every instance, Blue Cross provided coverage at standard rates.

My investigation of the underwriting practices of Blue Cross and Blue Shield of Maine have revealed that they, too, provide standard coverage at standard rates for many individuals who suffer from these illnesses.

While these differences in coverage that I described make Blue Cross less competitive in the health insurance marketplace, they have a considerable effect on hospitals and their costs. The high-risk subscribers that Blue Cross covers are frequent users of hospital services. Without Blue Cross coverage, they would increase hospital bad debts and many would add to Maine's Medicaid burden. In other states, the reduction of hospital bad debts due to Blue Cross's provision of coverage to high-risk individuals and groups at standard rates has been recognized in the form of a substantial hospital payor differential. I should point out also that Blue Cross engages in practices that reduce hospital patient accounting costs, such as placing terminals in hospitals that allow the hospitals to verify coverage on an on-line basis. In addition, just the sheer economies of scale generated by the number of Blue Cross subscribers help hospitals to reduce their costs. Those factors have also been included in the payor differentials Blue Cross has received in other states.

And, of course, Blue Cross engages in cost containment activities. It actively supports and participates in health planning. It engages in health promotion and health education

activities. While these activities are important--and perhaps even more important than some of the others--they have not necessarily been recognized in differentials in other states, because their value is so difficult to assess.

The issues that this committee faces as it seeks to make improvements in Maine's hospital environment, as I am sure you can see, are going to be difficult. But several precedents have been established in other states. And these precedents can be used to guide your judgments. Among the precedents has been the consistent recognition that Blue Cross, because of its unique practices, merits a payor differential; and that, furthermore, payor differentials are needed in order to assure an equitable system of hospital payment.

As a concluding note, I want to make a brief comment about cost-shifting. I hope that you understand, while there is some shifting of costs from Medicare and Medicaid to the private sector, costs are not shifted by Blue Cross under its current reimbursement system. Blue Cross and Blue Shield of Maine currently pay at least their fair share. In fact, in 1981, Blue Cross paid nearly 113 percent of hospital operating costs. If I were to put up a chart, as Mr. McDowell did, my chart would look somewhat different. His hydraulic approach to explaining reimbursement has inaccuracies in it. Blue Cross pays considerably more than he implied, and commercial insurers and others pay considerably less.

Finally, I want to point out that Blue Cross and Blue Shield of Maine has engaged in the coverage and business practices that I described earlier for many years. The desire to provide these services undoubtedly stems from the plan's role as a nonprofit provider of health care coverage. But the funding for the services has flowed from the plan's ability to negotiate a payor differential with Maine's hospitals. Many of the reimbursement approaches that you have heard about, that have been presented

to you, could eliminate Blue Cross's opportunity to negotiate a payment formula with hospitals. In these instances, it will be essential for you to consider the importance of Blue Cross practices to the state and the need for continuing them through an equitable system of hospital payment.

GILL: Mr. Faherty, do you want to make your rebuttal to Dr. Bachrach, and then we'll get into questions.

FAHERTY: Dr. Bachrach's observations in a couple of areas, I think, warrant some comment from us. He makes the observation that payment for certain procedures in the physician's office is, by and large, less expensive than having that same service provided in the hospital. And, by and large, that statement is true. However, it does not consider a couple of elements that you need to be aware of. First of all, by providing those services in the physician's office, you do not relieve the hospital of the responsibility for maintaining the facility to deliver the same service. You do not cut that cost out. That cost remains. Secondly, one has to be very careful when one opens the door to paying for office procedures to the potential for increased utilization. I believe that observation was made by one or another of the professionals. There is a tendency, when the service is there and you're capable of delivering it, for increased utilization. So that you do have the potential for offsets, and the saving is not as pure as you might be led to believe.

Blue Cross has been active in the area of utilization review, as mentioned by Mr. Stred, and has worked with the professional associations. It is soon to begin working with the hospitals on implementation of this utilization review program. And that deals specifically with the quality of care. And that's very important. We cannot jeopardize the quality of care. Let me give you an instance or two where we believe that that is the

right direction, and that it has a potential for success, and in a couple of areas has been successful.

I don't believe that anyone is deliberately attempting to torque this system to their own financial advantage on any large scale. I don't believe that that is the motivation. But in the area of professional consensus about certain diagnoses, and how you treat those conditions, there is divergence of views. We were able to show some markedly large numbers of in-hospital diagnostic D&Cs, just a short time ago, and a large number of removal of wisdom teeth in the hospital. And through the professional associations, working with physicians--we took those data to them--they in turn took those data to the appropriate professional grouping within their association. They developed guidelines for the admission of patients for these two procedures. And we have seen a marked decrease in the number of hospitalizations for those two particular conditions. That is utilization review. That is quality of care. That is gaining consensus about the treatment of a particular entity, so that you do see consistency, and you do see it done in a less costly environment. Utilization review is important. We have supported it. It has been part of our participating agreement for years. We assist in the payment for that. We intend to continue to do so.

In the area of routine testing, the Blue Cross Association and our plan has been instrumental in developing lists, with the assistance of the physicians in the American Medical Association, of tests and procedures that are probably no longer useful or are obsolete in terms of newer technologies. So we do encourage and ask for documentation when we find these specific tests or procedures being charged or claimed for. We ask for documentation to support the need for those procedures.

The notion that we have a large basket of money that we somehow shovel out on demand is a bit overdone. We make a rigorous determination as to what the actual costs to the hospital for

delivering patient care are to the Blue Cross subscriber. Several checks and audits are made for each institution. And many times these stretch out to eighteen months before final settlement is made. So the flow of funds is rigorously controlled.

With respect to patients waiting in hospitals to find beds elsewhere, Blue Cross does provide payment for home health care and does provide payment in Skilled Nursing Facilities, in an attempt to move patients out of the higher-cost acute-care institutions. We have expanded our coverage of out-patient services. Many of these things have contributed to what we see as a decrease in in-patient days used by Blue Cross patients. So there are a number of items and programs that appear to be useful and effective in decreasing utilization, while at the same time protecting quality.

We need to work together to get a handle on the costs of those services.

Representative Nelson, we haven't answered your question as yet. Let me turn it over to Dr. Miller.

MILLER: I've lost track. Could you repeat it?

NELSON: In Mr. McDowell's diagram, we were told that approximately 25 percent of the hospital's cost was paid for by Blue Cross. And that, we know, is negotiated. The price that you pay the hospital is a negotiated price. We know that because people from Blue Cross came to tell us how they did that. Now, the hospital sets the rate per day and you negotiate with them. How do you know that hospital, in setting that cost per day, does not set it arbitrarily that much higher, knowing that Blue Cross will pay a certain proportion of that, and therefore, by increasing the cost per day, knowing that Blue Cross will pay a percentage of it, that they don't increase it to be sure that part of that four percent which is bad debts gets decreased. How do you know you're not being used?

MILLER: I have no doubt that the description that you just provided has passed through the minds of both the hospital personnel and the Blue Cross personnel involved in the negotiating process. The point that needs to be made, though, is that, regardless of whether or not the hospital seeks to do that, Blue Cross in its negotiating process has a great many tools at hand. For one thing, Blue Cross is one of the agencies that audits the hospital. So Blue Cross has a pretty good feel as to what costs are. Blue Cross is also in a good position in that they also have the data on all of the hospitals, which individual hospitals do not. And so Blue Cross is in a position to be able to make comparisons among hospitals, and ask the question, why one particular indicator--perhaps the number of FTE personnel per bed is so high in one place and not another. In addition to that, of course, there is the VBRO, which has been reviewing hospital budgets and also provides information. I can't speak specifically to what Blue Cross does in each instance, but there is a lot of information in hand with which to make the decisions necessary as part of the negotiating process. And one of the first indicators that is examined is the rate of increase from last year to this year, and an attempt to determine why it is what it is.

NELSON: In relation to the legislation which may or may not be presented, that was one of the things that it was felt we should have something to stop that--not to allow that to expand; that is, the power of the hospital to set that rate arbitrarily, and then negotiate with Blue Cross or whomever to make up the difference.

FAHERTY: That certainly is a possibility within the realm of the possible. However, as it currently operates, we do not pay on the basis of the hospital's charges. We pay on the basis of the hospital's actual cost to deliver those services which our people receive. So that you're looking at a caution that

you need to keep in mind as you think about charge-based reimbursement. We reimburse on the basis of the actual, auditable cost to deliver the service to that patient. And to that cost we add deliberately, through negotiations, additional factors to reimburse the hospital for bad debt, for capital expansion, and several other motivators in an attempt to change some management behavior, looking for more efficiencies. So, again, that rate does not, in and of itself, affect the payment.

CROWLEY: Our basis of payment is cost. There is a part of the contract that stipulates that a minimum payment will be made to the hospital for in-patient services. And that minimum payment currently is set at 84 percent of the benefit, which is the covered charge. And that minimum payment has always been part of the Blue Cross-hospital contract. And hospitals have been paid on the in-patient basis as a result of that part of the contract. So, primarily, the contract is cost-based. Most hospitals are on the basis of cost-plus; however, some hospitals are being reimbursed on an in-patient basis on a guaranteed minimum level of the covered charge, which is really the Blue Cross benefit.

NELSON: Dr. Miller, if indeed a person of low risk and a person of high risk pay the same premium, what is it to my advantage to be a low-risk person? Why should I work hard not to smoke, to run in the morning, and do all those things to keep me healthy, when I go and I pay the very same rate as the person next to me who smokes and does all the things we've been told are bad for you, and he and I pay the same insurance premium?

MILLER: I agree with you that it's a difficult situation. The problem is a serious one. The point that I was trying to make is that, by doing what it does, Blue Cross enables that person who is--regardless of the reason why, whether because of smoking or some unfortunate accident--a higher-risk individual...

if Blue Cross did not pool those individuals with its healthier group, then the rate that would be charged to those individuals for their premium would be prohibitively high. And they couldn't pay for their coverage. The point that I wanted to make was that Blue Cross does that at the risk of losing the low-risk individual like yourself, who might find (not always) it more economically advantageous to obtain commercial health insurance coverage, because there the low risk will be recognized, because the commercial insurer will establish the rate that is prohibitively high for the high-risk individual, primarily because, as profit-seeking companies, they don't want the high-risk individual. And Blue Cross is not doing that, making it less competitive in the marketplace, but making that coverage available. I was only trying to make that point.

NELSON: That sort of leads into my next statement. There are a lot of people who don't go out and shop for insurance. And a statement was made at our last meeting, to which I'd like you to respond: "Blue Cross payments essentially look like withholding taxes. I have no choice, as a professor at Johns Hopkins, but to pay my employer (because he takes it out) my Blue Cross premium to a quasi-public corporation. It sure looks like public money to me. From my perspective, it looks like a tax." Do you want to respond to that?

MILLER: It clearly sounds like something that my friend Carl Schramm said. I clearly disagree with him. What he is referring to is almost like saying that, when you get a cut and you put an adhesive bandage on your hand, it's a Band-aid; or when you use a computer, it must be an IBM computer. He's saying that if you have a deduction for health insurance on your payroll slip, that it must be for Blue Cross. But in fact, of course, if the deduction was for monies paid to Metropolitan Life, or to Connecticut General, it would look the same on his

payroll stub. What he's saying is that the payment he makes for health insurance, perhaps--not necessarily Blue Cross--looks like a tax. I think he knows better. And I think he knows also about the difference between quasi-public organizations and private organizations. But I think the point is made that individuals who are employees of large groups don't necessarily appreciate or understand the significance of the payroll deduction that is made. And even for other reasons than he mentioned. For one thing, his employer might pay eighty percent of his health insurance premium, and the amount he sees there is only twenty percent, and it may not look like very much money. In that sense, he's right. It diminishes the importance of the cost of health insurance. And it's part of the really important problem that you're talking about and that you're going to have to deal with. I just don't think that Blue Cross should necessarily be distinguished in this regard from other insurers.

FAHERTY: There is one other point that Dr. Bachrach made that I had intended to ask Dr. Miller to speak to and I've neglected to do so. May I do that now? And that is to speak to the idea about deductibles and just how effective they are in the health care market.

MILLER: I appreciated Dr. Bachrach's candor, but I was upset by his logic in that statement that he made. It seemed to me that he was saying that it's Blue Cross's and Blue Shield's fault for covering the total bill, even if a physician irresponsibly orders a lot more tests than he needs to. It's therefore Blue Cross's fault that those tests are ordered, because it will pay the bill. Somehow, the logic escapes me. It remains the physician's responsibility. And Dr. Bachrach made it sound as though Blue Cross and Blue Shield force everybody who purchases their coverage to have to take mandatory complete comprehensive

benefits. Blue Cross and Blue Shield (unlike perhaps hospitals and sometimes physicians) does exist in a very competitive marketplace. There are lots of options available to that comprehensive coverage. People want comprehensive coverage. And if people want comprehensive coverage, and Blue Cross is expected to provide a service that people want, then it has to sell them comprehensive coverage. And then it has the responsibility, through the utilization review procedures of the type that Mr. Faherty mentioned and other activities, to make sure that that privilege is not abused.

Just to take it one step further, I think it's important that you know that there is no evidence--especially in regard to hospital care--that co-payment of the type that is normally talked about (20 percent co-payment for individuals with maximum total out-of-pocket payments)--there is no indication in the research that has been done that that will reduce hospital utilization. In fact, there is one major study that was done by the Rand Corporation, published recently in the New England Journal of Medicine in summary form, that indicated that in the populations that they studied--and they set up experimental groups--they found no substantial difference in the utilization of services for hospital patients with comprehensive coverage, full coverage, and hospital patients with coverage requiring 20 percent co-payment. There was no difference in the utilization of services. If you follow through logically, it's easy enough to understand. The patient, once arriving in the hospital, does not _à la carte_ pick the tests that he wants or doesn't want to receive. The physician does that and the patient has to go along, whether they're paying 20 percent of the bill or not. Very few patients want to question that judgment. What the Rand study did find, though, was that patients with a significant co-payment requirement may be admitted to the hospital less often. There may be a deterrent to going into the hospital at all. And while that sounds like a good idea, the Rand Corporation

was also quick to point out that they don't know whether that means that when the patient is hospitalized at a later time, the cost will be even greater.

So there is no question at this point that, on that issue, the jury is still out. There is no conclusion. And I would maintain--though, unfortunately, I don't think there is much we can do about it--that it is the physician's responsibility to act responsibly in the ordering of tests and services for a patient in the hospital, and not be concerned about who is going to pay the bill. Hopefully, the physician would not act differently. In fact, we heard that they do not act differently because the patient has to pay a small portion.

GILL: I have heard recently that eighty percent of maladies would go away without physician or hospital intervention--just the natural course of events. So if some of these people didn't require hospitalization, they'd get better on their own anyway probably.

Mr. Faherty, when you talked about problem areas, you mentioned wisdom teeth, for instance, and that you worked together with the professional group and tried to resolve that. Can I now go into a dentist's office and have three bad wisdom teeth removed and have Blue Cross pay for it?

FAHERTY: My recollection is that that is correct

GILL: I had the opportunity not too long ago to have a child have four wisdom teeth... and he happened to be lucky enough to have four bad ones and we could have it taken care of in the physician's office. But that doesn't happen very often. Has that been resolved?

FAHERTY: I don't know that the specific problem that you point out has been resolved. However, we do cover three or four wisdom teeth, if they need removal. And we're continuing to look at it.

To have that procedure done in the hospital would clearly be more expensive. You can see where the advantage is, both to the patient and to the payor, be it Blue Cross or anybody else. It is clearly less expensive in the dentist's office.

GILL: I am wondering, if some of those procedures are done in physicians' offices, it might curtail admissions into hospitals and maybe we would get where we're supposed to be, as far as hospital beds throughout the state in the proper amount. I wonder whether it isn't a contributory factor as far as how many times people are admitted to hospitals and for what conditions they are admitted.

FAHERTY: There is certainly something to that. I was hoping to make the point that we are dealing with that problem, citing those two specific instances, where we have been working through the professionals (the physicians and dentists) and have been able to establish standards which have been accepted by their specialty societies to enable us to keep people out of the hospital. And for us to help by paying for those procedures in a more appropriate setting, after it has been clearly and clinically determined that that procedure was necessary.

GILL: Dr. Miller, in Maryland, does Blue Cross have a deductible?

MILLER: There are different programs. In most of the large and medium size group programs, there are no deductibles, although there is a lot of discussion now at Maryland Blue Cross and Blue Shield about establishing them, as there are in a lot of Blue Cross and Blue Shield plans. In the individual, non-group, and small groups, there are deductible options that are available, so that the individual can select either.

GILL: Did you say you were involved in New York State?

MILLER: New York State is one of the states where I was not involved.

PINES: Does Blue Cross/Blue Shield place riders on policies for people with chronic diseases such as diabetes, in order to justify the flat fee charged for the policy?

CROWLEY: On the group business, I believe we have no riders or pre-existing coverage limitations. On the non-group, we do have some restrictive endorsements, medical riders. I'm not sure whether diabetes is one of them. I know that on the non-group side there are some. However, very few.

MILLER: That's an issue that I've studied. It's necessary for a Blue Cross and Blue Shield plan, as it is for any insurer, to protect its resources. It's foolish for a Blue Cross plan to accept an individual for coverage, knowing that that individual is very likely to be entering a hospital the next day and incurring a hundred thousand dollars worth of bills. That would not be a prudent business practice. Nevertheless, Blue Cross is in a sort of conflict about that, because, at the same time, it has the general policy of providing coverage to all who seek it. As a result, Blue Cross and Blue Shield plans generally--with very few exceptions--will put riders on individual coverage only, not on group coverage, for certain kinds of illnesses--but only by examining the individual circumstances in some depth. And the number turns out to be very small.

BUSTIN: Dr. Miller, I'd like to get back to the issue of accountability, because it always comes up. It seems to me that we're always talking about extra tests and things that shouldn't have been done, admissions that shouldn't have taken place. If you had legislation that would allow an insurance carrier, for instance, to say to a doctor: make some determination that a test was unnecessary, and that doctor has a history of doing that,

yet Blue Cross doesn't want to pay it. If you decide not to pay it--and I don't know whether you can or can't, under your policy--it then gets passed on to the person who has received that testing. Legislation could make that impossible. It would have to be the doctor that would have to take the bath on the test that wasn't paid for by the insurance carrier. Can you comment on that?

MILLER: That is a policy that is in effect in several places, particularly in regard to hospital services and not physician services. For example, it's very difficult obviously for Blue Cross, or any insurer, to deny a claim for payment before the claim occurs. It has to take place after the claim occurs. An individual might easily have run up a five thousand dollar bill in a hospital for no good reason. And Blue Cross or another insurer might determine that. The action at that point becomes very important. In a number of Blue Cross plans, the action would be to retroactively deny the claim, which would then remove the payment from the provider's rolls of payment in one form or another. There are many Blue Cross plans that have established, either voluntarily through their contracts with providers, or through legislation in their state, a hold-harmless clause which indicates that the provider cannot then go back and seek those funds from the individual. I'm really not sure how that works in Maine.

BUSTIN: Could somebody answer that question? How does it work in Maine?

FAHERTY: It works as Dr. Miller described it. And, as we mentioned earlier, we're now developing the protocol for utilization review. Of course, if that patient insists on staying in the hospital against the advice of the physician and against the advice of the institution, that individual then becomes responsible for the bill. But the attempt is to provide quality care, the appropriate amount of quality care, and hold the appropriate

individual responsible. That's an active part of utilization review.

BUSTIN: Historically, how often have we used it here in Maine?

FAHERTY: I don't have the numbers

BUSTIN: At all? A little bit? A lot?

FAHERTY: A little bit. That may be suggestive of the fact that we don't find that kind of abuse. But we will get you a more precise answer.

MANNING: You had indicated earlier, when you first spoke, that you can only go so far into the doctor's office when you start taking away from the fixed costs of a hospital. But on the other hand, you're saying that we maybe should be going to the dentist's office for removal of wisdom teeth rather than going into the hospital. When do we cut that off? When do we go to the doctor because it doesn't hurt the hospital? And when do we go to the hospital when it starts huring the hospital rather than the doctor?

FAHERTY: We're actively involved in expanding those out-patient coverages to bring people out of the more expensive environment. And we will continue to do so. We are currently looking at additional instances where we can pay for services outside of the acute care institution. The point I was making was that, by doing that, we do not guarantee that the comparable equipment, comparable technologists, comparable reagents, comparable space, is going to be turned to some other use in the hospital, and that you then gain the value of a cost saving there. That is not a hundred percent gain. The hospital still must maintain the clinical laboratory, with technologists, with reagents,

with equipment, to meet the lower demand for its services.

MANNING: Recently I asked a question of a doctor at the medical center about second opinions. I asked him what happens if I'm going in for surgery, and one doctor says one thing, and the other doctor says another thing? Who do you listen to?

FAHERTY: We will pay for a third opinion in that situation. We will pay not only for the second opinion but for a third opinion as well.

MANNING: The answer that I got was that he doesn't like second opinions. That way, you're not confused.

FAHERTY: We encourage the use of second and, if necessary, third opinions, so that an informed consumer can make a decision. I think Senator Bustin hit the nail on the head, though, that many consumers of health care services can't ask, aren't educated to ask the question as to whether a gastroscopy is appropriate for me, today, in this condition. They take it in good faith when it's ordered by the physician. To do that kind of shopping, you had best have an education at least equal to that of physicians. You might ask what a gastroscopy is, and how it's done. But the ultimate determination is going to be made by that physician.

MANNING: How much of a response have you had to second opinions?

FAHERTY: It has not been overwhelming. You must remember that there has been a process of second opinions rendered, long before Blue Cross began to pay for them, within the physician community. If a patient said, I'd like to hear from somebody else, they readily forwarded records to other physicians to get a second opinion. I have worked in hospitals for a number of years, and

there are many instances when a second opinion is rendered by another surgeon, or by another clinician, in the hallway or in an office, looking at medical records--that never becomes a part of the record. So there has been a long history of second opinions. We want to encourage the continuance of that. We feel that it is good practice for the consumer and we are willing to pay for it. It does not get wide use. The use that we see made of second opinions runs roughly parallel to the amount of exposure we give to the availability of the program.

GILL: Are there any other questions? Thank you very much. When we get into our workshops, I'm sure we'll have some more questions, but we'll give you plenty of notice.

Next we'll hear from Jeff Goodwin, who represents the Health Insurance Association of America.

GOODWIN: My name is Jeffrey Goodwin. I am speaking today on behalf of the Health Insurance Association of America. The Association represents about 340 insurance companies, which write about 80 percent of the privately sold health insurance in the United States.

In the early to mid-1960s, I was fortunate enough to live in Maine. At that time, I was a student at Colby College in Waterville. During that period of time, health care costs were not the major topic of discussion and concern that they are today. I left Maine in December, 1964. According to the statistics provided in the Health Facilities Cost Review Board's report, hospital costs in Maine in 1965 were relatively modest. What is striking is the degree of increase in hospital costs since then, when compared to the rate of increase in costs generally in the economy.

Before I point out some of the specific figures that I feel deserve emphasis, I'd like to first make a general comment on data and how to look at it. In one of my initial projects in

graduate school, I was assigned responsibility for collecting a fair amount of information on utilization of an inner-city hospital. At that time, my professor warned me not to be seduced by the figures I was collecting. In essence, he said that if you have enough data, you can create a bible. By this he meant that when you view enough data in small isolated discrete segments, you can almost prove anything you want to prove. What is more important than looking at individual statistics, and where they might go--and this is something I think the committee needs to keep in mind as they are hearing testimony today and in your own deliberations--it's not what the specific figures show, as you attempt to set public policy, but rather the overall trends represented by these figures.

A review of hospital cost figures contained in the study completed by the Health Facilities Cost Review Board, I think, leaves little room for doubt. The general trend of almost every index, whether you accept the Board's figures or the figures of the VBRO, trend in only one direction. And that direction is up. The difference, if any, is not the direction but the degree of magnitude. During the last 25-30 years, health care costs have consumed an increasingly greater percentage of the country's GNP. Nationally, health care costs have gone from consuming approximately 4.5 percent of GNP in the mid-1950s to almost 10 percent of the GNP projected for 1982. Regardless of who says what about health care costs, the inescapable conclusion is that health care costs are increasing at a rate that is almost twice as fast as all other costs in the U.S. economy.

I recognize, and so should the committee, that health care costs are made up of more than hospital costs. We are concerned today with the hospital component of those costs. And they have also been increasing at a significant rate.

The overall figures for Maine are following the national trend. Health care costs in this state are rising at a faster rate than all other costs. When I left Maine in 1964, the

average cost per capita in Maine, in current dollars, for health care was about $35.85. In just fourteen years, per capita health care costs increased nearly fourfold in this state. More specifically, hospital costs, as measured by average per patient day cost, in constant 1967 dollars, increased 170 percent between 1965 and 1979. During this same period of time, consumer price index (also measured in 1967 dollars) increased only 125 percent. Thus, it appears that hospital costs in Maine rose at a rate nearly 40 percent faster than other costs.

The hospital industry would probably argue that this increase is perfectly understandable and justifiable. Although some of this increase might be warranted, it is hard to see how it all could be needed, in the absence of a conscious decision on the part of public policy-makers--a decision which, to my knowledge, hasn't been made, to see the health care economy continue to increase and consume ever-greater amounts of the national product. Rather, the health care system has increased its costs and its share of GNP in the absence of any clear-cut policy to the contrary. We should not fault the industry for that. Where a vacuum exists, people with ideas and programs will move in. However, the country as a whole and, more specifically, you representing the people in Maine, are now questioning both the absolute amount of health care dollars being expended and, even more importantly, the rate of increase in the expenditure of those dollars. The greater that increase, the fewer dollars that are available for other goods and services purchased by the state in particular and society as a whole.

The report prepared by the Board is an excellent starting place for review of the current health care system in Maine. Some of the data may well be amplified and possibly even amended or corrected by others. However, I think the important conclusions to be drawn from the report are still valid and would not change. I would like to take this opportunity to commend the Health Facilities Cost Review Board and its staff for the thoroughness of

the report, the care shown in putting it together, the educational and consultative sessions they helped arranged, and finally, their willingness to hear and respond to all sides of a very complex issue.

Acknowledging the foregoing, where do we turn now? I think that the country is groping for some type of solution to the health care financing problem. No one solution probably exists that could be applied everywhere in the country. Several general or generic terms can probably be interpreted a number of different ways. After all, if beauty is in the eye of the beholder, the perfect system for controlling health care costs is probably in the eye of the regulator who is designing it. But solutions must be tried, and soon. Failure to take action by you will probably add fifteen percent or more to hospital costs this year. At that rate, costs will double in only five to six years--something I find intolerable, and I believe you do also.

What would the Health Insurance Association of America recommend? We offer no panacea or simple solution. The suggestions I am going to make need to be fleshed out in legislative language. I could point you to several sources, but you already have an excellent proposal prepared by the Health Facilities Cost Review Board. Its draft legislation is a fine jumping-off place, which the Association could support. The HIAA feels that there are certain fundamental elements which need to be incorporated into any reimbursement program in order to make it effective. Most of them are already in the Board's proposal. We support the development of an incentive-based manadatory uniform prospective reimbursement system.

I would like now to outline the elements we feel are necessary in such a system. First, a uniform definition of the hospital's full financial requirements must be developed. It should be developed in consultation with the hospital industry, third-party payors, state government agencies, and other major interested organizations that will be asked to pay the hospital

bill based on this definition.

Second, all third-party payors and sources of revenue must participate in the program.

Third, there needs to be an application of the definition of financial requirements to all sources of revenue, leading to an equitable reimbursement system for all third-party payors. Please note that I am saying an "equitable reimbursement system," not a uniform reimbursement system. The HIAA recognizes that discount, or differentials, do have a place; but only when it can be proven by independent study that the differentials granted are a result of actions that can be quantifiably shown to have reduced the hospital's costs. Further, the actions should not lead to any cost or charge increases for any other payor.

Fourth, a total hospital revenue cap needs to be prospectively developed and implemented. When base-year costs are determined and verified, future hospital revenues should be limited by the application of some formulas that allow for increases due to inflation, volume, certain costs beyond the hospital's control, and other factors that should be established by the rate-setting commission in advance. These hospitals should then be held to that total revenue cap.

Fifth, there must be mandatory compliance with the revenue cap, including penalties for hospitals that exceed the cap.

Sixth, there must be positive incentives for hospitals to reduce their costs below the approved limits established by the cap. These incentives could take the form of reimbursing hospitals up to, if necessary, the total amount they were promised prospectively at the beginning of the year. These additional revenues would then be available for expenditure at the discretion of hospital management and their boards.

Seventh, an all-patient utilization review program must be established, implemented, and tied to the budget approval process.

Eighth, an all-patient health care data base must be established,

including discharge, billing, and utilization information. This can be used to help monitor the health care system and assess compliance with the regulatory process.

Ninth, the other health care regulatory apparatus in the state, including the certificate-of-need program, must also be closely coordinated with the rate-setting process.

Tenth, finally, but by no means least, the state must apply for a Medicare waiver. For any review program to be successful, it is critical that all sources of revenue be included. If one or more sources of revenue is left out, either costs not recognized by those in the system will be shifted to the payor or payors not in the system, or the hospitals will find that they are still dealing with an unwieldy, uncoordinated reimbursement system. Incentives to make the system work by the hospitals are therefore reduced.

I recognize that what I am suggesting is a major structural change in the way hospital financing currently works in Maine. But it is a change that must be made, and made sooner rather than later. By the time you complete your hearings, you will realize the soundness of our proposal and the need to take some fairly strong actions to protect the financial welfare of both the State of Maine and its Medicaid program as well as the citizens at large, neither of which can continue to afford the sizable increases in health care costs that are currently existing.

The final proposal drafted by this committee and enacted by the legislature should be done with great care. You should ensure that there is sufficient time for the regulatory authority to develop the regulations and reporting forms necessary to implement its program. An advisory body should be established to insure input into the regulatory authority's regulation development process by the hospital industry, third-party payors, the state, and most importantly, the public at large.

The results of such a program won't be dramatic and won't be seen immediately. However, by compounding savings of as little as 0.5 or 1.0 percent per year over time, the savings can be significant. If you think of the figures that Mr. Heggie mentioned this morning--I believe about $420 million a year as the hospital industry's impact in this state--if you could reduce the rate of increase in those costs one per cent a year, you're talking about saving the citizens of the state $4.25 million. Compound that over time, and your banker will tell you that it can become significant.

Let's look at a specific state, Maryland. In the first three years of their waiver, the Medicare and Medicaid programs in Maryland saved a total of $86.3 million. Attached to my testimony is a detailed chart showing the savings for the state and the Medicare and Medicaid programs over the first three years of their full payor participation program.

In summary, I wish to urge you to send a strong prospective review proposal to the full Maine legislature, with your unanimous recommendation that it be speedily enacted. The time for study and delay in taking action is past. You have an excellent, thoughtful study done by the Maine Health Facilities Cost Review Board, documenting the problem in Maine and making recommendations to address the problem. You have the successful experience of other state budget review agencies on which to build. You have our recommendations, which are consistent with those of the Board. You have to act.

GILL: Mr. Goodwin, where are you based?

GOODWIN: I'm in New York

NELSON: Regarding the Medicare waiver, we heard this morning that Maryland got such a waiver, and that generally speaking they would not be given out any more. Could you respond to that?

GOODWIN: That's not our understanding. As a matter of fact, with the Budget Reconciliation Act of last summer... up until last summer, there was a limit to six prospective reimbursement experiments that the Department of Health and Human Services could participate in. That limit of six experiments was done away with. And now the Department may, at its discretion, participate in an unlimited number of experiments. They haven't issued any new waivers in the past year. However, New York State currently has a waiver application pending. I believe that by July 1st the New York State legislature will enact the changes to the New York State law that will be necessary for them to finalize the waiver application. Massachusetts has a waiver application pending. And there are efforts being made also this week to make changes in the state law there with regard to the regulatory process, so that their waiver application can be considered.

NELSON: So you are giving testimony contrary to what we heard this morning?

GOODWIN: Yes

GILL: Gary Gaumer, who was here at our last meeting, indicated that commercial carriers were being driven out of New York State because of cost subsidization. Can you respond to that?

GOODWIN: Statewide, the average discount in New York is approximately 25 percent. In some areas of the state, particularly the metropolitan New York area, the discount in particular hospitals may range as high as 40 percent. There is no way anybody can stay in business, selling the same product as your competitor, when you have to charge 40 percent more for it. The reasons for that in New York are very complex, but the state has had a rather draconian set of Medicaid rate controls in place for

almost a decade. In New York State, the Blue Cross reimbursement system to the hospitals is tied very closely to Medicaid. And the system has essentially driven the commercial insurance carriers out of business where there are high Medicare and Medicaid populations, in the metropolitan area in particular. As you heard this morning, Medicare and Medicaid tend not to pay substantial portion of costs that hospitals do incur and have to pass on to someone else: free care, bad debt, certain medical education costs. It begins to appear that the nursing differential cost that Medicare has paid is going to be completely eliminated in the federal FY 83 budget.

GILL: In my reading, I came across the term "preferred provider organization." The explanation was that it gives a discount to an insurance company in return for a volume of patients and for quick reimbursement of bills. What would be a preferred provider group?

GOODWIN: I'm not sure I understand the term

KETOVER: I have a quote where preferred provider organization is where health providers competing for business from union funds and employers... or do you feel that costs must be controlled through the government, through comprehensive national insurance?

GOODWIN: My understanding of the concept is--and some of our member companies are experimenting with it--they, in effect, will go to a provider entity, be it a group of physicians or an institutional provider, and say: If you will provide care at pre-established prices, we'll pay your total costs and we will try to encourage our policy-holders to use your services, but policy-holders will still be free to use whomever they want. However, they will have the traditional 80 percent reimbursement,

with 20 percent co-payment, if they use somebody who is not on a preferred provider list.

GILL: It's a prepaid "sweetheart" arrangement, is that it?

KETOVER: It says that Medicare and Medicaid, through the tax incentive, favor comprehensive private medical insurance. He says this has brought the pot to boil, to quote Reagan.

GOODWIN: I'd prefer not to try and take on the President right now, but the concept of a preferred provider is one that is just beginning to develop now. I don't know if it's appropriate to call it a "sweetheart" arrangement, because that has a certain connotation.

GILL: That's my own terminology. The only other thing I can equate it to is a Health Maintenance Organization [HMO] that is prepaid. I guess I'm going to have to read up on it, because I really don't know that much about it, except that I know it's being tried in different places.

GOODWIN: To my knowledge, it doesn't necessarily have to entail prepayment or capitation payment to the preferred providers. It may well be a contractual arrangement which says the average cost for an appendectomy is $1,000 for the hospital, and the physician charges $500 in this area; if you, Mr. Doctor, will take $400, and you, Mr. Hospital, will take $800, as payment in full, we will encourage more of our patients to go to you. The idea is that volume will replace high unit cost.

GILL: Any more questions? ... Thank you very much. We will now hear from David Hughes, second vice president at Union Mutual.

HUGHES: My name is David Hughes. I live in Cape Elizabeth and I work for Union Mutual Life Insurance Company, which is a domestic Maine insurance company, located in Portland. Its national headquarters is there and it operates in all fifty states and Canada. Union Mutual has approximately two thousand employees here in the State of Maine. We are the largest private health insurance company in the State of Maine, except for Blue Cross, which is larger by far in its volume of health insurance.

We've all been flooded with complex data, confusing numbers, and a lot of arguments and cross-arguments. I'm going to do my level best to try to speak plainly to you today and to keep it brief.

The first thing I want to say is that Union Mutual wants to compliment the Health Facilities Cost Review Board for an outstanding study and an outstanding report. Union Mutual wholeheartedly and unequivocally endorses the recommendations of the Health Facilities Cost Review Board, and urges this committee to adopt those recommendations into legislation at the earliest possible opportunity.

The problem, briefly restated, which you've heard many times, so I won't dwell on it, is simply that hospital costs in Maine are rising much faster than the overall rate of inflation, and have been for a number of years. All trends indicate that they are going to continue to do so, unless some intervention is made.

The second point that I'd like to summarize is that the hospital finance system now is absurd, inequitable, and contains no meaningful incentives whatsoever to help contain costs. The presentation by Mr. McDowell this morning and his hydraulic chart leave little room for doubt that it is certainly a ridiculous system as it currently exists. You heard Dr. Schramm and others a few weeks ago point out that, if the system has incentives in it at all, it contains what he referred to as "perverse incentives"; that is, the more the

hospital spends, the more it gets reimbursed for. But it has no incentive whatsoever to reduce its costs, because it simply gets a reduced amount of money and has no benefit. Nor does it have any market type incentives or competitive type incentives built into the hospital system as it currently exists. When was the last time that any one of you, or any one of your loved ones, or anyone of your acquaintance, shopped for a hospital on the basis of the lowest costs? When did you ever ask, Are your rates lower than the hospital across the street? Everyone in this room knows that there is no incentive, in the market sense of that word, when you're involved in the hospital system.

The third point I'd like to make is that State resources are being drained away at an unacceptably high rate to pay for this cost escalation. More and more money is being spent in the State of Maine, by the State of Maine, just to maintain the same level of services that we now have--without increasing that level of services in any way.

Finally, I'd like to stress that there are no villains in this drama. You've heard from a lot of different parties today. A search for who's the bad guy, I believe to be a futile one. I have not located a villain yet. I think the problem is that we have dedicated, high-quality professionals here in the State of Maine who are trying to function under a bad system.

The big danger that I would caution you against is that you may become bogged down in debating numbers and arguing over data. The easiest thing in the world for someone who wants to derail any proposition of this complexity is simply to throw up a smoke-screen of numbers and get everybody confused with complex and confusing data. The challenge to you, and the clear need in the State of Maine, is to make sure that you resist the tendency to become paralyzed by all of this confusing data into inaction, and that you somehow become so intimidated by this mass of complex data that you refuse to take that action.

Today, I'd like to make a clear call to this committee to utilize your good old common sense when you're evaluating all of the information that you've heard. No problem that I have ever encountered--and certainly not this problem--is so complex that it can't be solved by an application of good old common sense.

The best single thing I have ever heard to help explain the entire scope of the problem with hospital costs is a story told by a Dr. McClure who testified here about three years ago at a conference on Health Maintenance Organizations. He was from Minnesota. He said, Suppose that we were the national leadership, the Congress of the United States. In this instance, let's just imagine that we were all-powerful. And we decided to call in before us all of the generals and admirals of our country and say to them, generals and admirals, We want you to go out and design for us the best conceivable system of national defense. Take as much time as you need, but design for us the best system that you can come up with. Money is no object. We don't want you to waste a penny. Please, waste no money. But money is no object. Is there any doubt in the mind of anybody in this room that those generals and admirals would come back in, in six months, with a system of national defense that would cost hundreds of billions of dollars more than we are now spending in this country for national defense? And they could justify every bit of it. There is no doubt in my mind of that.

Now let's suppose we decided to call in all of the nation's best educators. And we said to them, Educators, go out and design for us the best conceivable system of public education that you can. We want the best system. Money is no object. But don't waste a penny. Is there any doubt in any of your minds that those educators would come back in with a system of public education that would cost us hundreds of billions of dollars more than we're now spending? And they could justify every bit of it as an element that would improve public education.

Dr. McClure goes on to say, The only difference between those two hyoptheticals and our system of health care in this country is that we have said that to the hospitals. Now, I think that makes several very cogent points. The first thing that story does is illustrate why we have a problem. That is because we have said that in a systemic way to the hospitals. The second thing it illustrates is exactly the way the hospital finance system now really works. You heard one of the doctors testify that it is essentially a blank check. We've given them a blank check and said, Do what you feel is necessary and we'll pay whatever that is. The third point that that story illustrates, I believe, is that even the best people can produce unacceptable results if they're working within a bad system.

We've heard from some of the very best people in the state today. And yet, consistently, they keep coming up with bad results, with rates of inflation that vastly exceed the overall cost of living index. And that is because even the best people cannot produce good results operating within a bad system.

The fourth point of the story is that we will never solve this problem by reviewing each and every expenditure for reasonableness. The generals are always going to be able to justify each of those expenditures as something that contributes meaningfully to a better system of national defense. You heard Warren Kessler do that this morning in listing all the different inputs that have been added to his hospital. Of course they're all fine and we really can't quarrel with them. You heard David Bourne of the VBRO describe that this is the exact approach, however, that the VBRO has been using in this state; that is, reviewing each expenditure of the hospitals for reasonableness. It's not that anybody is trying to do anything wrong. It's that that system and that approach will never work. We now know that from experience. And if you try to transpose the system that we've got in health care into any other system that you can think of, you will immediately see that it's silly

and that it would never work in any other system. And it's not going to work in the health care system.

The fifth point that I think is important is that other, equally vital interests in our society operate within budgets and under spending limits. And they operate successfully under those limits. Only hospitals in our whole society operate under such a blank-check system.

The final point, and I think probably the most important, is the need to apply some good old common sense as a test for determining all of the claims that you've heard today and at your last meeting. You need to apply your common sense. For example, will the imposition of spending limits, which is what the HFCRB is recommending, in and of themselves destroy the quality of health care? Your common sense will tell you that everyone else lives within a budget. And there is really no basis in fact or logic to assume that the hospitals cannot live within pre-established budgets.

Another example of the type of question I think you should be asking yourselves from a common-sense standpoint. Will a system that is designed to guarantee that everyone pay their fair share of hospital costs somehow be unfair? Does payor equity, which is what the HFCRB recommended, somehow sound unfair to you? I think an application of common sense will help cut through a lot of the mumbo-jumbo and help you reach the right conclusion. And I urge you to apply that kind of common-sense standard.

We've taken a good look at this at Union Mutual. Let me just share with you some of the things that our common sense tells us. First, common sense tells us that hospital costs are simply going up too fast. Second, common sense tells us that, unless we can find some way to get hold of this problem, it's going to break the bank. Make no mistake about it. We're all paying for this problem, either through the Medicaid budget, or through state employee health premiums, or through taxes, or

through Medicare, or through private insurance premiums. Ask the Department of Human Services how many millions of state dollars are being used this year just to pay increased health care costs--dollars that could have been used for other, badly needed purposes.

Third, our common sense tells us at Union Mutual that we had better work very hard to help get these costs under control, because our clients blame us when we have to charge them higher insurance premiums. So we feel we have a very strong incentive to try to get hold of this problem ourselves.

Fourth, common sense tells us that we at Union Mutual are paying three times for this problem, this runaway hospital cost problem. We're paying for it in the cost of our direct benefits to beneficiaries. We're paying for it through our taxes. And we're paying for it through cost-shifting, which Mr. McDowell described so well this morning. Union Mutual and the other private insurance companies operating in the State of Maine are that last column on his hydraulic chart, that 21 percent who are paying $27.5 million [sic] additional over and above the cost of providing care to our beneficiaries, because of the things the Blue Cross and Medicare and Medicaid refuse to pay. So we're paying three times.

Common sense also tells us that the HFCRB's insistence on payor equity is essential. Common fair play also tells us that that's essential. There has been some talk about that from the people who spoke on behalf of Blue Cross and Blue Shield. I think it's very important that we focus on the fact that the purpose of this committee is not to get embroiled in the details of the debate as to which cost is justifiable and which cost is not. Just as nobody at this point and on this committee is trying to debate exactly what the revenue cap should be. We're not here to do that. We're here to try to establish standards for someone else to establish those revenue caps.

We would not care to debate specifics of exactly what elements of differential between Blue Cross and the private insurance companies is justifiable at this point. We would urge the committee to establish, by law, a common-sense standard for payor equity. Place that into law and delegate that to the board that you're going to be creating to make those factual determinations after full hearing and an opportunity to hear both sides. Our definition of payor equity is very simple: everyone--all payors--should pay the same thing for hospital services, should pay their fair share of hospital services. And any differential that is permitted should be permitted only on the basis of hard data--factual, empirical, accountable numbers that actually show dollar savings; not theories, not speculation, and not wild ideas. Any quantifiable material that shows there is in fact a cost saving to a hospital from a particular practice by any payor should be allowed to be considered. A second element of our standard is that all payors must be allowed equally to make such a showing. The way the system works now, because of Blue Cross's market share, Union Mutual cannot negotiate a discount with hospitals. We have tried. We have gone to hospitals expressly in the State of Maine and said, We'll pay you in ten days, give us the discount. No. Why should they? We can't blame the hospitals. The system is wrong.

So we would say that any quantifiable differential, available to all, should be permitted, provided that that can be demonstrated by an independent showing before the board.

Common sense tells us that creation of prospective budgeting systems, such as that recommended by the HFCRB, will not solve the entire health care cost problem. Of course not. This problem is far too complex and far too big to be solved by any single solution. But we are convinced that the system recommended by the Board will in fact represent a major first step in the right direction. We think that this committee should endorse that recommendation and proceed without delay. What we

need here in the State of Maine is a public body, with teeth, to set a statewide revenue ceiling, to assure that our hospitals' full financial requirements are met, to prospectively determine hospital budget levels, to require that all payors participate. If I can digress a minute, this is particularly important, because, once again, referring to the statement that the system is the villain, representatives of Blue Cross testified as to their tremendous efforts to help control health care costs. And they have made them. No one payor operating within this system, however, can really have any meaningful effect. It hasn't been described so far, but that's the reason that chart is called a "hydraulic" chart. The notion behind that is that that is a tank full of fluids, semi-compartmentalized. There is an overall level. And if you push down on any one of those levels--just like a piston--it's going to go up in some other level. Until you get hold of the whole thing, no one party on that chart can do anything to meaningfully hold down costs. All they can do is shift them around. And that's the reason that mandatory participation of all parties is absolutely essential.

We think also that the board should provide real incentives to control costs and provide real disincentives on exceeding authorized spending levels.

Finally, we think this board should assure equity among all payors.

Now, of course, it is paramount to all of us to maintain the very high standards of quality care which we all enjoy here in Maine, and to preserve broad access to the health care system. We live here, too. Our families as well as yours rely on Maine's system of health care to take care of us when we're sick. We all want to make sure we do that. And we at Union Mutual are totally convinced that the adoption of the type of system recommended by the HFCRB will have no detrimental impact whatsoever on quality or access.

The task of getting hold of skyrocketing hospital costs, while maintaining quality and access, is a challenging one. But it must be done. And you, right here, right now, have all the tools and all the information necessary to do it. You could devote the rest of your lives to studying the health care system. People do that. The problem is not a technical one at this point. The problem is not a fiscal problem. The problem is not a conceptual problem. The problem right now is a political problem. The problem is in your laps right now. What's needed now in the State of Maine is not more study, but action--and a health dose of common sense.

GILL: Thank you very much. That was an excellent presentation. Any questions? ... We'll have you back, I'm sure. Now we'll hear from Don Marden, who represents the Maine Association of Life Underwriters.

MARDEN: My name is Don Marden. I'm an attorney from Waterville. I represent the Maine Association of Life Underwriters, who are life and health agents. There are over five hundred in the State of Maine. They are in the business of writing business with the various companies that are represented by the HIAA, one of which, of course, is Union Mutual.

We are very concerned and have been concerned for some time with this particular issue. As a matter of fact, at the first regular session of the 110th Legislature, we had presented to the legislature L.D. 793, which was an Act to prohibit contractual allowance in health insurance, which was heard by the Business Legislation Committee. We spent a considerable amount of time discussing this issue before that committee. We did so because of the concern over cost-shifting. At that time, we also heard a great deal of the same testimony that you heard here today. And we came to the conclusion that

listening to Blue Cross define equity among payors is like the old phrase, "All men are created equal, but some are more equal than others." We think they are totally misguided in their use of the term equity. We are talking about equity of all payors, equity of all persons who use health care, and not just equity of those who use a particular system, whether it's Blue Cross or whether it's a particular private carrier.

I would simply reiterate the comments of Mr. Goodwin and Mr. Hughes, and will not take any more time. There are just two main points I would like to make.

First, we do not think there can be equity without a statute, without a change in the law. We think that other things have been tried and studied, as has been mentioned. We think that true equity among the various agencies has to mean that it is across-the-board. And the only way that it can reach all these constituencies, including that mythical individual who actually pays out of his own pocket, is with some statutory relief.

The second major point I would like to make is that it seems to me that it is obvious to all of us, from the testimony today and from all the information that has come to you, that you cannot have equity without control of some kind. Control in a very firm and a well-established and a well-defined sense. To leave it to an area which has been very well described in the study that has been made just has not worked. It is an area unique to our free enterprise system and to our society. And so it takes something more. For that reason, we support the study. We support your efforts. And we support the controls, particularly the elimination, once and for all, of the cost-shifting which has caused such a tremendous burden on the entire community.

At the time of your work sessions, we would be happy to provide you individual agents who have been heavily involved

in this issue. They also can indicate to you what some of the comments and reactions are from some of the consumers they have come across.

GILL: Any questions? ... Thank you. Is there anyone else who would like to testify that hasn't been given a chance? We have gone through our agenda. But I want to give everyone an opportunity... I thank you all for coming.

NELSON: I would simply like to say that I think it is a credit that we met our time limit today and how neat everything went.

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