

Cost Containment: Hospitals

Rate setting

In areas with multiple facilities, hospitals compete for managed care contracts, leading to lower their prices. In areas without competition, facilities have greater leverage to charge higher prices. Hospital rate setting might contain costs in non-competitive regions by regulating the price of a local monopoly service. Voluntary systems have proved minimally effective in the past.¹ Rate setting programs vary. Some focus on per diem rates, per service rates or per case rates, global revenue caps, or a combination of these tactics.² In theory, this could encourage hospitals in areas without competition to efficiently produce services while staying within the confines of a constrained budget.³ However, rate setting has historically encountered the problems with hospitals increasing rates of admission to offset lost revenues.

Certificate of Need Programs (CON)

This program requires hospitals and certain other health providers to obtain approval, in the form of a Certificate of Need (CON), from a designated authority prior to making major capital expenditures (i.e. spending on costly facilities and purchasing expensive medical equipment). This regulation of supply achieves cost savings by preventing duplication of health facilities and services and thereby minimizing excess capacity (i.e. unoccupied hospital beds). The costs of excess capacity are typically passed on to consumers in the form of higher costs for services rendered.⁴ The caveat to CON programs is that it may protect certain hospitals by making it difficult for others to “compete “for certain services which they believe ... strengthen their financial position” and delivery systems.⁵ Additionally, patients often value the most advanced technology, believing it represents the highest quality services. CON may create barriers to meeting this type of consumer demand. CON has historically been difficult to administer in an equitable, neutral and efficient manner.

Consolidation of Care in Centers of Excellence

Providers that specialize in certain types of programs or services tend to produce better outcomes. In contrast, medical complications typically occur more frequently in facilities that are not well equipped and practiced to conduct the specific procedure in question. Studies show that facilities that provide a procedure with high frequency tend to generate greater success rates.⁶ If an insurer directs a patient with a serious illness to a center of excellence that has a history of treating large volumes of individuals with that specific condition, the insurer may derive cost savings from reductions in complications that would be addressed by more follow-up care. An indirect consequence of consolidating care in centers of excellence may be freezing out new competitors and a reduction in the incentives that produced excellence in the first place.⁷

Evidence based adoption of new technology

Advances in new medical technology are a major source of increasing health expenditures. While some new technologies vastly improve patient health, others only provide marginal improvements or fail to demonstrate clear benefits. An evidence based adoption strategy would ensure that the reduced risks and increased benefits of new technology justify the costs. Policymakers could use this information to give preference to technologies that demonstrate the greatest cost-effectiveness. While some managed care organizations have instituted such measures, there has been difficulty in ensuring compliance by hospitals and other providers. Providers and the public commonly believe that “managed care policies are colored by perverse financial incentives.”⁸ The public also expects their providers to factor in their preferences and medical history in addition to evidence based guidelines in the decision-making process.⁹

¹ Ellen Jane Schneider, Trish Riley, and Jill Rosenthal, Rising Health Care Costs: State Health Cost Containment Approaches, National Academy for State Health Policy, June 2002, <http://www.nashp.org/Files/GNL46.pdf> (accessed March 22, 2007).

² Ibid.

³ Ibid.

⁴ Ibid.

⁵ Trends in New Jersey Hospital Financing Status Since 1995, State of New Jersey, <http://www.state.nj.us/health/hcsc/acoh/trends.htm> (accessed March 23, 2007).

⁶ Edward L. Hannan, The Relation Between Volume and Outcomes in Health Care, *The New England Journal of Medicine*. 1999; 340: 1677-79 [Letter]

Nance J.O. Birkmeyer, Phillip P. Goodney, Therese A. Stukel, Bruce E. Hillner, John D. Birkmeyer, , Do Cancer Centers Designated by the National Cancer Institute Have Better Surgical Outcomes? *Cancer*. 2005; 103-435-441.

Ethan A. Halm, Clara Lee, Mark R. Chassin, Is Volume Related to Outcome in Health Care? A Systematic Review and Methodologic Critique of the Literature. *Annals of Internal Medicine*. 2002; 137:511-520.

⁷ Lucien Wulsin Jr., ITUP Discussion of Reform Opportunities, February 2007, http://www.itup.org/Reports/UniversalCoverage/ReformOptionsPaper_final.pdf (accessed March 22, 2007).

⁸ Dan Mendelson and Taniusha V. Carino, Evidence-Based Medicine In The United States – De Rigueur Or Dream Deferred, *Health Affairs*, January/February 2005, Vol. 24, No. 1, <http://content.healthaffairs.org/cgi/reprint/24/1/133> and Paul Keckley, Evidence-based Medicine in Managed Care: A Survey of Current and Emerging Strategies, *Medscape General Medicine*, 2004, Vol. 6, No. 2, <http://www.medscape.com/viewarticle/470303> (accessed March 23, 2007).

⁹ <http://content.healthaffairs.org/cgi/reprint/24/1/133> and P. Keckley, "Evidence-based Medicine in Managed Care: A Survey of Current and Emerging Strategies," *Medscape General Medicine* 6, no. 2 (2004): 56.