Eye on Washington by William H. Harrison

Medicare cuts threaten more hospitals

Bush's plan to cut $4.4 billion from Medicare will accelerate the collapse of our health care system.

The Bush administration's latest budget proposal to cut another $4.4 billion from projected Medicare outlays in Fiscal Year 1991 will accelerate the rate of collapse of the nation's health care infrastructure, which worsened in 1984, when the change in the Medicare payment system was first implemented. Current policy is dooming 44% of the nation's currently existing hospitals to potential bankruptcy.

Chiseling cost adjustments for inflation for Medicare is essentially how the $4.4 billion "savings" is going to be squeezed from the FY91 budget, according to the Bush plan.

For doctors, hospitals, and groups attempting to keep their heads above water by consolidating their operations through mergers, the Federal Trade Commission and Department of Justice are poised to pounce with heavy-handed anti-trust legal actions.

The real victims are those Americans who are in the greatest need for care and least capable of paying for it themselves. The American Hospital Association (AHA) is not willing to try to put a figure on the needlessly lost lives, or lives cut short as a result of these policies, but the staggering drop in the length of the average hospital stay is an indicator that the general level of care has nosedived during the past decade.

Hospital closings jumped from 23 in 1982, to 88 for 1988. Between 1984 and 1986, fifty hospital mergers occurred. Estimates are that by the year 2000, approximately 20% of the current acute care bed capacity in the U.S. will be closed.

Inpatient admissions dropped only 0.5% in 1983, but fell by 4% in 1984 when the new Medicare policy was first put into effect, and fell a staggering 4.6% further in 1985. The drop in admissions was 2.1% in 1986, and has continued each year since. Length of stay has also declined. In total, over 4 million fewer people were admitted to hospitals in 1988 than 1982.

The trend has also led to a steady decline in hospital revenue margins. Since 1984, total net revenue margins have declined 24%, and net patient revenue margins have declined 95%. In 1987, the average hospital earned just $1 of surplus on each $1,000 of patient revenue. In 1988, aggregate patient revenue margins fell to zero. The change in the Medicare reimbursement policy that began in 1984 is responsible for these harrowing trends, as Medicare accounts for approximately 35-40% of the average hospital's patient revenue.

In 1984, the Medicare system ceased reimbursing hospitals according to what they spent on patient care, within certain limits, and instituted the "prospective payment" system, which pays hospitals a predetermined sum for operating costs for each Medicare patient based on what the diagnosis is supposed to cost.

Under this system, if it costs more to treat the patient than the predetermined sum allows, the hospital, or doctor, must make up the difference. This has led to the introduction of "cost-benefit" considerations into the quality of care provided, and driven hospitals toward early release of patients and outpatient instead of inpatient care.

In recent years, even more stringent "utilization standards" have been added by Medicare, such that it now refuses to reimburse hospitals for certain services if they are done on an inpatient instead of an outpatient basis. Since 1984, growth in the Medicare budget has chronically lagged behind the national inflation rate, and the federal government has stated that it does not intend to make up the gap.

Medicare officials openly acknowledge that the effect of this policy will be to reduce hospital profit margins to zero. "We could do fine with fewer hospitals. The question is whether the right hospitals will go out of business," one official said.

According to the *New York Times*, a survey of 1,419 hospital officials found that 48% believe that their institutions are vulnerable to financial failure within five years. For hospitals with fewer than 100 beds, 63% said they are at risk of closing.

Yet, when hospitals react to these conditions by trying to merge in order to consolidate operations, reduce redundancy, and lower operating costs, they are subject to a crusade by the FTC and DoJ using anti-trust guidelines which were drawn up to apply to commercial enterprises, not hospitals.

No fewer than 84% of the communities in the U.S. with more than one hospital have too few "competing" hospitals to avoid triggering a federal agency "market concentration presumption" that a merger is likely to violate anti-trust laws. By the criteria now used, a community must have at least six hospitals in order for a merger of any two, in order to remain below the threshold. According to estimates, 44% of all hospitals in the U.S. would be subject to federal anti-trust action if they sought to survive through merger.

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