

 **EMERGENCY**

 **EMERGENCY**



CHAPTER 6



Kaestner

Lo Sasso

Public Policies to Increase Hospital Competition, Improve Quality of Inpatient Care and Lower Health Care Costs

By Robert Kaestner and Anthony Lo Sasso

This chapter provides an assessment of three state policies that are targeted at the hospital industry in Illinois. The authors take a close look at tax exemptions for not-for-profit hospitals, the Medicaid hospital assessment program, and the Certificate of Need laws. The authors discuss strategies to alter these policies in a way that could lower costs and create a more competitive, higher quality hospital industry.

NEED TO KNOW

- Not-for-profit (NFP) hospitals receive public subsidies from the state, most notably through tax exemptions and subsidies in the bond market.
- The Affordable Care Act will reduce the number of persons without health insurance, reducing the problem of uncompensated charity care that the tax exemptions are supposed to address.
- The hospital assessment program, a per diem payment matched by the federal government to reduce the cost of operating Medicaid, is not as effective as intended and has been targeted by national deficit reduction strategies for elimination.
- Certificate of Need (CON) regulations require an oversight authority to limit the growth of medical facilities to hold down health care costs. However, CON rules are anti-competitive and are prone to corruption. The authors suggest they should be eliminated.

The hospital industry in Illinois is important in terms of both its economic impact and its role in maintaining population health. According to the Illinois Hospital Association, hospitals in Illinois contributed directly \$32.8 billion, and indirectly \$78.7 billion to the Illinois economy in 2010-2011.¹ In terms of health care, the Kaiser State Health Facts database reported that hospitals in Illinois provided 1.6 million days of inpatient care (0.6 per person in Illinois) and 6.8 million outpatient visits (2.5 per person in Illinois) in 2010.² As the magnitude of these numbers indicates, hospitals are vitally important to both the economy and population health of Illinois.

Most hospitals in Illinois are not-for-profit (NFP). Of the 191 community hospitals in Illinois that provide

general medical and surgical care (e.g., not psychiatric care), 150 are NFP institutions, 25 are operated by state (i.e., University of Illinois Hospital) or local (e.g., Stroger Hospital in Cook County) governments, and 16 are for-profit organizations. Illinois has relatively fewer for-profit and government-operated hospitals than other states. A distinguishing feature of NFP hospitals is that they receive subsidies from the federal and state government; state subsidies include exemptions from property and

¹ (<http://www.ihatoday.org/uploadDocs/1/2012economicreport.pdf>)

² (<http://www.statehealthfacts.org/profilecat.jsp?rgn=15&cat=8>)

sales taxes and subsidies related to issuance of debt in the bond market.³ In this chapter, we assess the need for and consequences of these state subsidies.

The hospital industry in Illinois is regulated by the state along several dimensions, but one of the most important dimensions is the oversight of entry and exit of hospitals into new geographic areas or into new services. The Illinois Facilities Planning Board has oversight authority on hospital construction and its objective is to hold down the cost of health care by limiting the creation of new facilities so as to prevent unnecessary capacity. This chapter also considers the efficacy of this state policy.

15%

Portion of total inpatient revenue paid for by the Illinois Medicaid program in 2010 (approximately \$5 billion).

The last feature of the hospital industry that we highlight here is the significant share of hospital revenue that comes from the state through the Medicaid program. Kaiser State Health Facts reported that the Illinois Medicaid program spent approximately \$5 billion on inpatient hospital services in 2010, which represents approximately 15 percent of hospital inpatient revenue in Illinois. Of course, for some hospitals, for example those located in lower income areas, Medicaid payments represent a much greater share of revenue. Such an important stream of revenue can obviously affect hospital performance because of both the level of payment, (is it adequate to cover costs?) and the structure of payment, (is it per diem or per episode of care?). In addition, for the past several years, Illinois has

imposed a provider tax on hospitals, which helped attract federal dollars that reduced the state fiscal burden for Medicaid. In 2012, the provider tax raised \$900 million in revenue and brought an additional \$770 million in federal dollars to Illinois, and the assessment will increase in 2013-2014. A large share of the hospital assessment is repaid to hospitals under a complicated, legislated formula. In sum, the size and nature of the state contribution to hospital revenue will affect patient care. In this chapter, we discuss the consequences of this aspect of the hospital industry in Illinois.

Tax Exemption for Not-for-Profit Hospitals

Hospitals are unique in the health care sector in that they are dominated by NFP operators. Almost all other health care providers are for-profit. What explains this circumstance? One often cited explanation is that consumers may prefer NFP hospitals because the quality of care is difficult to observe for the consumer and NFP hospitals may be less likely to exploit this information asymmetry for organizational gain (i.e., profit). In short, NFP hospitals may provide higher quality care and, as a result, be preferred by consumers. This preference would provide non-profits with a competitive advantage and result in dominance in the market. Evidence on this issue suggests that there is relatively little difference between the quality of care provided by NFP and for-profit hospitals, but it is difficult to make an accurate assessment.⁴ There is limited, high-quality evidence from the nursing home sector that NFP facilities provide higher quality care, but whether this evidence applies to the medical/surgical sector is unknown.⁵ Overall, however, it seems unlikely that the explanation for NFP dominance is because of differences

³ Colombo, John D., "Federal and State Tax Exemption Policies and Healthcare for the Poor," 51 *St. Louis University Law Journal* 433 (2007) (Health Law Symposium issue).

⁴ Sloan, Frank A., Gabriel A. Picone, Donald H. Taylor, Jr. and Shin-Yi Chou, "Hospital Ownership and Cost and Quality of Care: Is There a Dime's Worth of Difference?" *Journal of Health Economics*, 20(1), 1-21, 2001; Roseneau, Pauline Vaillancourt and Stephen H. Linder, "Two Decades of Research Comparing For-Profit and Nonprofit Health Provider Performance in the United States," *Social Science Quarterly*, 84 (2) (June 2003): 219-224; Eggleston K, Shen Y.C., Lau J, Schmid CH, Chan J. "Hospital ownership and quality of care: what explains the different results in the literature?" *Health Economics* 2008 Dec;17(12):1345-62.

⁵ Chou, Shin-Yi. "Asymmetric Information, Ownership and Quality of Care: An Empirical Analysis of Nursing Homes," *Journal of Health Economics*, 21 (2), 293-311, 2002.

in the quality of care provided by them vis-à-vis for-profit hospitals.

Another explanation for the dominance of NFP hospitals is that they provide public goods (i.e., non-excludable goods such as use of emergency room by uninsured persons) that for-profit firms will not produce because they are unprofitable. However, this explanation is not particularly compelling because the majority of goods produced by hospitals are not public goods.

In our view, the best, although least validated, explanation of the dominance of NFP hospitals is that these institutions have different organizational objectives, for example providing charity care to the poor and uninsured, and that these objectives are best served by NFP status and are historically rooted.⁶ Perpetuation of the NFP institutional form is maintained by public policy (for example, tax-exempt status of NFP hospitals) which provides a cost advantage, and by the possibility that NFP hospitals have been “captured” by stakeholders such as managers, physicians, and other hospital personnel. While NFP hospitals are legally bound to return any surplus (i.e., profit) to the organization, that does not eliminate the surplus, which may be particularly large given the cost advantage associated with NFP status, and when there are no shareholders keenly interested in obtaining the profit, those who operate the hospital may be able to control the surplus.⁷ Moreover, conversion to for-profit status would be resisted by these entrenched interests, which may have limited the ability of for-profit hospitals to expand.

“Not-for-profit hospitals receive public subsidies from the state, most notably through tax exemptions and subsidies in the bond market.”

Regardless of the explanation, the fact is that NFP hospitals receive public subsidies from the state, most notably through tax exemptions and subsidies in the bond market. Here, we consider the rationale for and consequences of this policy. The most prominent explanation for the subsidies provided to NFP hospitals is that they provide community benefits (quid pro quo theory). Indeed, recently enacted legislation in Illinois (SB2194) explicitly links tax-exempt status to the value of community benefits, which is defined in the legislation to include, among other things, charity and uncompensated care and the shortfall between Medicaid payments to hospitals for services and the hospital’s costs for those services. Illinois now requires that hospitals provide community benefits that exceed the value of the property tax exemption they receive.

While the tax exemption seems reasonable and the newly passed legislation in Illinois is arguably a good start on requiring the quid pro quo criterion be fulfilled, further analysis suggests that there are good reasons to eliminate the tax exemption. First, the tax exemption makes the hospital the decision maker on what is the community benefit—for example free use of some hospital services. The community may prefer other benefits much more highly than the benefit the hospital provides.⁸ Consider the case of a hospital in a very high property tax district that is required to provide community benefits equal to the value of its tax exemption. Such a hospital may encourage the use of relatively idle resources (CAT scanner during off hours) or spend money on activities with questionable community value (e.g., sponsor a cancer walk-a-thon) to meet its community benefit quota, whereas those in

⁶ Horowitz, Jill R., “Hospitals Making Profits And Providing Care: Comparing Nonprofit, For-Profit, And Government,” *Health Affairs*, 24, no.3 (2005):790-801.

⁷ Brickley, James A., and R. Lawrence Van Horn. “Managerial Incentives in Nonprofit Organizations: Evidence from Hospitals,” *Journal of Law and Economics*, Vol. 45, No. 1 (April 2002), pp. 227-249.

⁸ David, Guy and Lorens Helmchen. “An Uncertain Prescription,” *Regulation* 2006.

the community may prefer to receive other medical services or even non-medical services. Why should a hospital decide how a community spends the state subsidy? Why not let the community itself, or the elected representatives of the community, decide? Second, and a related point, is that the tax exemption

is not well targeted to low-income persons who may be a priority for state subsidies. The exemption is largest where property taxes are highest, but communities in high property tax areas arguably require less state assistance and are a low priority for state subsidies. Nevertheless, hospitals in these areas will try to meet the community benefit requirement by providing services that are low value and/or low cost. Moreover, no matter how the legislation is written, hospitals will almost surely find a way to meet the community benefit criteria because costs are difficult to measure. This is why a hospital's reported "charges" for services

are routinely ignored by all hospital payers, and community benefits are difficult to define, so "better-written" legislation is unlikely to be the answer.

The third reason to eliminate the tax exemption is that there will be a marked decrease in the community benefit that is the most salient to the tax exemption—the provision of uncompensated and charity care. The Patient Protection and Affordable Care Act (ACA) will have a significant impact on health care

"The reduction in the number of uninsured persons in Illinois as a result of the ACA greatly reduces the problem of uncompensated and charity care that the tax exemption for hospitals is supposed to address."

1.9
MILLION

Number of uninsured Illinois citizens

in Illinois and the United States, and its greatest effect will be to reduce the number of persons without health insurance. In Illinois, there are approximately 1.9 million uninsured persons.⁹ The ACA will reduce this figure to roughly 650,000 through expansions in Medicaid and federally-subsidized private insurance.¹⁰ Notably, most of the people who will remain uninsured after the ACA will be undocumented immigrants who are ineligible for these two options. The reduction in the number of uninsured persons in Illinois as a result of the ACA greatly reduces the problem of uncompensated and charity care that the tax exemption for hospitals is supposed to address. The ACA will also result in the uninsured being concentrated in geographical areas in which undocumented immigrants reside. Therefore, a statewide tax exemption will almost surely misallocate resources because it does not target hospitals and areas in which the uninsured will reside. Again, better-written legislation cannot address this problem because it is simply too easy to manipulate the definition of community benefit and to spend money to meet the requirements of any legislation.

The tax exemption for NFP hospitals also provides a competitive advantage to NFP hospitals because of the lower costs resulting from state subsidies. This cost advantage can lead to larger hospitals (lower cost of capital) and therefore fewer hospitals in a market.¹¹ Indeed, NFP hospitals are on average much larger than for-profit hospitals.¹² Again,

⁹ statehealthfacts.org.

¹⁰ There are approximately 525,000 undocumented, foreign-born persons in Illinois (Pew Hispanic Center, <http://www.pewhispanic.org/2011/02/01/iv-state-settlement-patterns/>) who are not eligible for Medicaid or federal subsidies. We assume that all of them will be uninsured. In addition, approximately 10 percent of the remaining 1.4 million uninsured will be uninsured after ACA according to CBO estimates. This leaves a total of approximately 650,000 persons uninsured.

¹¹ Lakdawalla, Darius & Philipson, Tomas. "The nonprofit sector and industry performance," *Journal of Public Economics*, Elsevier, vol. 90(8-9), pages 1681-1698, September 2006.

¹² Guy David (2009), "The Convergence between Nonprofit and For-Profit Hospitals in the United States," *International Journal of Health Care Finance and Economics*, Vol. 9(4), pp 403-428, December 2009.

consider the NFP hospital located in a high property tax area. The cost advantage of the NFP in that area is relatively large, and it will be difficult for a for-profit hospital to enter and compete in this market because inpatient care is still a largely locally-provided service. In short, the tax exemption is anti-competitive and is likely to raise the cost of inpatient care.

Overall, there are strong arguments to eliminate the tax exemption for NFP hospitals. Most importantly, and ignoring the correct argument that there are more efficient ways to provide care for uninsured people (e.g., provide insurance for them) than through a tax exemption for NFP hospitals, there will be a significant decline in the need for hospitals to provide charity care because of the ACA. The need to provide charity care will also be concentrated in areas with large populations of undocumented immigrants. A statewide tax exemption is misplaced under these circumstances. Second, the tax exemption for NFP hospitals is anti-competitive and, as a result, likely raises prices for consumers. Third, the tax exemption is an abdication of the legislative responsibility to provide benefits that are most valued by the community. Residents or their representatives, not hospitals, should decide what benefits are most valued by the community. Finally, for all of the reasons just listed, eliminating the tax exemption will improve state and local fiscal circumstances and improve the efficacy of government in terms of providing valued benefits to citizens at the least cost.

Hospital Provider Assessment and Medicaid Reimbursement of Hospitals

Like almost all other states, Illinois has an assessment (tax) on hospitals that provides additional federal funds to use to reduce the cost of operating the state Medicaid program. The key to the hospital assessment is the fact that the federal government matches state expenditures on Medicaid and the assessment dollars are used to pay hospitals, which make these dollars eligible for federal matching dollars. The mechanics of the hospital assessment are as follows. The state assesses hospitals based on the number of (non-Medicare) occupied bed days the hospital provides. In 2012, the assessment rate

was approximately \$218 per occupied bed day and it raised \$900 million. This rate and total amount will increase in 2013 and 2014. The state kept \$130 million of \$900 million to use for other purposes and returned the remaining \$770 million to hospitals as payments through a complicated, legislated payment system that is largely a per diem payment to hospitals for inpatient care. The federal government then matches the \$770 million that the state spent. The net result is that the state attracted \$770 million in federal funds that it otherwise would not have received, and the hospitals benefited by receiving \$640 million of that \$770 million (after getting paid back \$900 million for the assessment).

So what is wrong with this policy? All states do it and it brings in a lot of federal money. The hospital assessment seems like a great idea. It is. And that is part of its problem—it is too good and the federal government knows it. A quote from the *Wall Street Journal* editorial page sums up the inside-the-beltway view of these hospital assessment policies:

“A deal also ought to end the long-running ‘bed tax’ scam in which states charge hospitals a fee to increase health-care spending and thus their federal matching rate. Then they launder some of the money back to the hospitals to offset the fee. This is real waste, fraud and abuse, not the talking-point version.”¹³

While the *Wall Street Journal* is known to favor Republican positions, the bull’s eye on hospital assessment taxes has been nonpartisan. Both the National Commission on Fiscal Responsibility and Reform (Bowles-Simpson) and President Obama’s Framework for Shared Prosperity and Shared Fiscal Responsibility proposed limiting the use of hospital tax assessments.

Regardless of the political support and long-term viability of the assessment, which is somewhat recognized by current Illinois law that limits the

¹³“An Entitlement Reform Guide.” Editorial. *Wall Street Journal* east. ed. 3 Dec. 2012: A16. Print.

assessment to the end of the 2014 fiscal year, another major problem with the assessment is that hospitals end up being paid for services on largely a per diem basis. Indeed, the distribution of the hospital assessment funds is embedded in legislation and is quite complicated (see Public Act 097-0688, SB2194). The per diem nature of the payments provides little incentive for hospitals to manage costs efficiently. In contrast, the federal government through its Medicare program pays hospitals a lump sum per admission and the amount of money the federal government pays depends on the severity of the illness (diagnosis related group, or DRG) and expected use of resources. The DRG payment mechanism is widely recognized as an effective way to provide an incentive for hospitals to be efficient and cost effective, particularly with respect to length of hospital stay. Illinois also pays hospitals on the basis of DRGs for part of their reimbursement, but at rates that are frozen at 1993 levels.

A disadvantage of the per diem hospital payments stemming from the hospital assessment is that this system significantly reduces the incentives provided by the DRG reimbursement mechanism. Therefore, it is likely that hospital length of stay of Medicaid patients in Illinois is more than it would be otherwise because the hospital has less incentive to move patients out—the hospital is reimbursed for every day. There are also several other “adjustments” such as the Medicaid volume adjustment and outpatient service adjustment that dictate how much of the hospital assessment money flows back to hospitals. In the end, the amount of Medicaid payment to a hospital for inpatient care may be relatively far removed from the amount of actual (as opposed to “charges”) resources used to treat Medicaid inpatients. The weakening of the relationship between actual resources used and payments received for that admission may have perverse incentives, for example, by providing an incentive for the hospital to avoid patients with high costs. Under the DRG system, this problem is diminished because DRG payments account partly for expected costs of an admission.

The per diem payments with substantial “adjustments” break the link between resource use and payments. It provides an incentive for a hospital to take on relatively healthy patients who use fewer resources.

The second disadvantage of the per diem payments is that it is very difficult to assess whether the total Medicaid payments for inpatient care are adequate. For example, it is very difficult, if not impossible, to compare on an equivalent basis what a hospital in Illinois receives in payment for a heart attack admission for a Medicaid patient to a similar (e.g., urban, academic medical center) hospital in New York, Detroit or Atlanta.

"Paying hospitals on a per diem basis weakens the incentive to be efficient in determining the optimal length of stay for a Medicaid patient."

In sum, while the Illinois hospital assessment program brings in substantial federal revenue that helps patch a structural deficit related to Medicaid financing, it has a couple of features that diminish its overall effectiveness. Most importantly, the hospital reimbursement system that surrounds the hospital assessment program may seriously distort hospital incentives with respect to how they treat patients and how they structure the hospital. As noted, paying hospitals on a per diem basis weakens the incentive to be

efficient in determining the optimal length of stay for a Medicaid patient, which may significantly increase length of stay and hospital costs. The current reimbursement system also weakens the link between actual resource use and payments and creates an incentive for hospitals to select healthier patients. Third, the complicated and non-transparent way of paying hospitals makes it nearly impossible to compare payments to hospitals in Illinois' Medicaid system to payments in other states, and it makes it difficult to assess the adequacy of payments. While recent legislation has called for moving to a 100 percent DRG system, the legislation does not require it. Finally, the hospital assessment is likely to be ended by federal budgetary problems and the well-recognized frisking of federal coffers by state Medicaid agencies.

Certificate of Need Regulation

Certificate of Need (CON) regulations were originally instituted as part of the federal “Health Planning Resources Development Act” of 1974. The intent of CON laws is to restrain health care facility capacity in the belief that, if hospitals and other health care institutions are prevented from being built, then medical costs will fall (or not rise as fast). The 1974 federal law required all 50 states to have in place some structure requiring a formal approval from a state health planning agency before beginning any major capital projects, such as building expansions or ordering new high-tech devices. Federal funds provided incentives for states to implement CON regulations. The law (and federal CON subsidies) was repealed in 1987, leading 14 states to discontinue their CON programs. Illinois is one of the 36 states that still maintain some type of CON regulation.

The basic premise of the CON regulation is that there is a need for an oversight authority because once a medical facility is built the organization running it will be able to create demand for its services regardless of actual need. This “induced-demand” will raise costs. Accordingly, there is a need to limit the growth of medical facilities to hold down health care costs. Unfortunately, this hypothesis has never been demonstrated in the scientific litera-

“In the end, the amount of Medicaid payment to a hospital for inpatient care may be relatively far removed from the amount of actual...resources used to treat Medicaid inpatients.”

ture. In fact, the evidence is clear that allowing competitors to enter a market serves to exert downward pressure on prices.¹⁴ The Federal Trade Commission and Department of Justice issued a report suggesting that CON regulations if anything served to increase prices by limiting competition.¹⁵ A study in 1998 found “no evidence of a surge in acquisition of facilities or in costs following removal of CON regulations”.¹⁶

Moreover, given that existing hospitals have a strong incentive to lobby against new competition, the opportunity for corruption is intense. Illinois’ recent experience with CON regulations is instructive. In Illinois in 2004, the CON Board (then known as the Illinois Health Facilities Planning Board) came under scrutiny when it became apparent that a member of the board attempted to engineer payments for him and his friends in exchange for votes. The evidence was obtained when a hospital CEO with a project that needed approval by the board wore a wiretap for the FBI for several months. The resulting investigation led to a number of convictions.

The anti-competitive nature of CON laws and the potential for corruption should be sufficient to end this state policy. It is difficult to justify why nine gubernatorial appointees would be privy to more information about the need for expanded health care options and choices than the private investors who are willing to put forth their own money to undertake such an investment. The evidence specific to CON laws and on the benefits of competition in the hospital industry simply do not provide any support for the existence of CON laws.

36 States, including Illinois, that maintain some type of Certificate of Need regulation.

¹⁴ Gaynor, Martin & Vogt, William B. “Competition among Hospitals,” *RAND Journal of Economics*, The RAND Corporation, vol. 34(4), pages 764-85, Winter 2003; Vogt, W. and R. Town. 2006. “How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?” RWJ Research Synthesis #9; Abraham, Jean Marie, Martin Gaynor and William B. Vogt. “Entry and Competition in Local Hospital Markets,” *Journal of Industrial Economics*, Wiley Blackwell, vol. 55(2), pages 265-288, 2006.

¹⁵ Federal Trade Commission, Department of Justice, *Improving Health Care: A Dose of Competition* (Washington D.C.: FTC, DOJ, 2004) 361 pages. http://www.justice.gov/atr/public/health_care/204694.pdf accessed on December 3, 2012.

¹⁶ Conover C.J. and F.A. Sloan. “Does removing certificate-of-need regulations lead to a surge in health care spending?” *J Health Polit Policy Law*. 1998 Jun; 23(3):455-81.

Conclusion

In this chapter, we have provided an assessment of three state policies targeted at the hospital industry in Illinois: tax exemptions for not-for-profit hospitals, the Medicaid hospital assessment program, and the Certificate of Need (CON) law. While state policymakers have recently altered each of these policies, the steps taken can be improved upon, and by so doing Illinois can have a more competitive, lower cost and higher quality hospital industry.

The most obvious change based on the evidence is to eliminate the CON law. Many studies have shown that greater competition in the hospital industry leads to lower prices for consumers. There is little theoretical or empirical justification for limiting such competition in Illinois.

Another way to increase the competitiveness of the hospital industry in Illinois, and thus lower prices and increase quality, is to eliminate the tax exemption that provides a substantial cost advantage to not-for-profit hospitals and limits the ability of for-profit firms to compete. The tax exemption can be

eliminated on other grounds, too. It is poorly targeted to those most in need; it allows hospitals instead of legislators or community residents to decide what the community benefit should be; and the most salient community benefit it is intended to provide is disappearing because of the large decrease in the number of uninsured persons that will result from full implementation of the Affordable Care Act.

“While state policymakers have recently altered each of these policies, the steps taken can be improved upon, and by so doing Illinois can have a...higher quality hospital industry.”

Finally, the Medicaid hospital assessment needs significant modification. While it clearly brings in federal revenue for the state, it distorts incentives for hospitals in terms of how many patients to treat, and how they should be treated. The hospital assessment system, and the hospital reimbursement structure that has arisen from it, is also non-transparent and prevents easy assessment of the adequacy of payments.

More importantly, the hospital assessment and reimbursement system helps preserve the status quo and dampens competition by providing existing hospitals with fixed payments that would not readily adjust to changes in hospital size, patient base or other organizational characteristics. ■