

The Future of Hospital Care: How Will We Pay The Bill?

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Federation President Chip Kahn addresses *The Future of Hospital Care: How Will We Pay the Bill?* On the left is Patricia T. Lindler, Senior Vice President of Government Programs with HCA; on the right is Kathleen A. Buto, Vice President for Health Policy, Government Affairs, Johnson & Johnson.

WASHINGTON—Leading health policy makers from government, academe and industry came together in the nation’s capital to consider the fragile financial health of the U.S. hospital industry and future challenges. There was wide agreement on the diagnosis: hospitals are rapidly losing their ability to pass along to private payers the costs of caring for the uninsured and providing other essential community services. With the government chronically paying less than the full cost of care for the elderly and Medicaid patients, that leaves hospitals with little room to maneuver.

The result, some experts warned, could be a shakeout in the hospital industry akin to what has happened in the past decade to the U.S. airlines, where upstarts could maximize profit by picking and choosing only profitable routes to service, driving full-service stalwarts such as Pan Am, TWA and Eastern Airlines out of business.

Health care consumers could find themselves with an abundance of new specialty facilities offering only profitable procedures, such as heart bypasses and hip replacements, while they may be hard-pressed to find hospitals with burn units, neonatal intensive care and the capacity to care for seriously ill patients. Once hospitals lose their capacity to attend to the sick and the poor, one expert warned, they will be “wrecked for everybody.”

This sobering forecast was heard at a July 15 symposium on *Future Hospital Care: How Will We Pay The Bill?* convened by the Council on Health Care Economics and Policy and Federation of American Hospitals and cosponsored by AdvaMed, *Health Affairs* magazine, America’s Health Insurance Plans (AHIP), Johnson & Johnson, GE Healthcare, Johnson Controls and Medline.

Health researchers presented papers dissecting the pressures that hospitals face from both private and public payers. Many panelists and many in the audience of 125 have played a leading role in shaping and running the Medicare and Medicaid programs and advising Congress and the White House over the years about health policy.

The Revenue Conundrum

Charles N. “Chip” Kahn III, president of the Federation of American Hospitals, said that with Congress poised yet again to consider changes in the Medicare reimbursement formula, the issue is “how are we to make sure that the resources are available for the hospital care Americans expect?”

Allen Dobson, Ph.D., senior vice president at The Lewin Group and former director of the Office of Research at the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services), said that hospitals have been shifting costs “all over the place” for years. “It’s like smoke and mirrors; nobody knows quite what or whom they are paying for,” he said.

But now, with premiums soaring, private payers are balking at their end of that deal, and “the public payers have really gone south on the hospitals over a very short period,” said Dobson.

“If you wreck a hospital, it isn’t wrecked just for the Medicaid patients. It’s wrecked for everybody,” said Dobson. “If the cost shift dies, who pays for the uninsured and underfunded public programs?” He questioned whether that would “represent the point at which our health system becomes unsustainable.”

Princeton University political economist Uwe E. Reinhardt said, “Most hospitals would go broke if they had to charge one single price.” Charging different classes of customers different prices for the same service allows them

to treat more patients “at successively lower prices who would not be able to be served at high prices,” he said. Reinhardt sharply criticized what he called “the Soviet-style pricing of Medicare and Medicaid,” and ridiculed the notion that pushing consumers into health plans with high deductibles will help tame the health cost spiral. That is like sending shoppers into Macy’s blindfolded and telling them to shop wisely, he said. “If you inject patients with \$10,000, \$15,000 deductibles into the current hospital market with its chaotic, opaque, unreasonable pricing system, it makes a mockery of the very idea of consumer directed health care,” he said.

Instead, he proposed that Medicare’s Diagnostic Related Group pricing system – under which the government pays set prices set in advance based on the patient’s ailment – be expanded to cover all patients and services, with hospitals’ deciding for themselves and making clear to the public how much more (or less) they charged than average. “Tell patients,” said Reinhardt, “that if you want to go to this (expensive) hospital, pay for it out of your pocket.” Stuart H. Altman, the Brandeis University health economist who chairs the Council on Health Care Economics and Policy, argued that sick patients would suffer if hospitals went the way of airlines and streamlined operations to maximize efficiency and competitiveness. Some may believe that hospitals could deliver the same care at less cost, but it’s more likely they would reduce both the quality and quantity of services, Altman said.

The hyper-efficient hospital of the future might have full-pay patients attended by nurses on the top floors, with the middle floors for patients who paid adequately, and the basement or sub-basement “for those who pay next to nothing or nothing,” he said. There “you might see a nurse occasionally.”

“Let’s be careful. If we push too hard for an efficient health care system, there could be big losers,” said Altman, a former chairman of the congressional advisory panel that designed Medicare’s payment system. He estimated that the \$600 billion hospital industry now spends \$50 billion a year on the uninsured and underinsured. “That is an easy mark to get rid of if this (efficiency) thing really plays out.”

Reinhardt said that if overall reimbursement is reduced, hospitals would make do by cutting out expensive services.

Future of Medicare Hospital Payments

In a session on Medicare payments, William Scanlon, a senior policy advisor with Health Policy R&D and a former top health analyst for the U.S. General Accounting Office, said hospitals’ margin on Medicare services was a negative 1.9 percent in 2003 and was projected to be a negative 1.5 percent this year. He said a 2002 GAO study found hospitals ill-equipped to deal with an infectious disease outbreak such as SARS or with mass casualties in an incident of bioterrorism.

The government now stockpiles ventilators that can be sent to hospitals in an emergency, but it’s not as easy to deal with a shortage of isolation beds, said Scanlon. The GAO study also examined growing concerns about overcrowding in emergency departments.

“The reality was not that emergency rooms had shrunk or that the demand for emergency rooms had increased so much. It was the fact that the capacity in the rest of the hospital was more limited than in the past,” said Scanlon. Hospitals, smarting from criticism by payers about excess bed capacity, had “right-sized” and eliminated those beds.

While payers push hospitals to hold down costs, hospitals also face unprecedented scrutiny from business groups and public and private watchdogs to improve quality of care. The Federation of American Hospitals’ Chip Kahn and Thomas A. Ault, a principal at Health Policy Alternatives and former chief policy analyst for HCFA, presented their findings on the first two quarters of data reported by more than 4,200 hospitals participating in the Hospital Quality Alliance (HQA) initiative.

“Policy makers, regulators, employers, insurers and health plans have all become engaged to push the hospital buttons” on the need to improve quality and reduce medical errors, Kahn said. Kahn and Ault also looked at data from 274 hospitals from the Premier Inc. Hospital Quality Incentive Demonstration project on pay for performance for CMS. Those hospitals qualified for 1 to 2 percent bonuses for meeting quality targets.

Seventy-four percent of the hospitals hit the mark for dealing with heart failure, but there was a large gap between the best and worst performers. Those hospitals in the bottom fifth scored 64 percent while those in the top fifth got a grade of 87 percent, Ault said. Kahn said the jury was still out on whether incentive pay or public accountability (i.e., reporting hospital performance data) would have a bigger impact on changing medical practice.

David Nexon, senior executive vice president of the Advanced Medical Technology Association (AdvaMed), said that in considering changes to hospital reimbursement systems, the emphasis should be not just on cost but value, so that any new systems “enhance the rapid adoption of valuable new technology, not retard it.”

Patricia T. Lindler, senior vice president of government programs for HCA, after listening to the discussion about refining DRGs and the need to accommodate new technology, said hospitals also are bracing for a switch from ICD-9, the ninth revision of the International Classification of Diseases, which assigns codes to all hospital diagnoses and procedures, to ICD-10. On top of that, hospitals are required by law to adjust their systems to accommodate electronic health records and the new national provider identifiers. “I wonder how the health care system is going to handle” all these changes, Lindler said. Kahn concurred, saying, “I think we just have to admit the physical limitations within hospitals of meeting all these mandates.”

Future Of Private Insurance Payments

At a panel focusing on private insurance payments, Christopher P. Tompkins, associate professor of human services at the Heller Graduate School at Brandeis University, presented data illustrating “the precarious position” hospitals are in. “Hospitals may be reaching the limit of their ability to provide equal treatment—or close to equal treatment—for essentially unequal payment,” Tompkins said.

Len Nichols, director of the Health Policy Program at the New American Foundation, said, “Medicare is the only

buyer big enough by itself to compel reporting and to compel measurement. But the private sector is probably going to be much better able and more nimble at experimenting around the margins” with creative payment incentives, he said.

But he warned that “employers are desperate” over the escalation of health insurance premiums, and “we don’t have much time to make this work.” For employers, “Plan B is, ‘I get out of this business. I simply curtail my liability by retreating behind high deductible plans and let the increasing costs be borne increasingly by workers.’” Gail Wilensky, senior fellow with Project Hope and former HCFA administrator and former MedPAC chair, traced the growing enrollment in employer-provided Healthcare Reimbursement Accounts (HRA) and individual health savings accounts (HSAs), which now provide coverage to an estimated 3 million people. Early indications are that premiums are rising at lower rates for this type of high-deductible coverage, and some plans report that these customers are using more preventive and chronic care services, not fewer.

Wilensky, who also served as the White House health policy adviser to former President George H.W. Bush, said, “We may be a little too dismissive about how this could affect health care spending.”

Reed Tuckson, M.D., senior vice president of consumer health and medical care advancement at UnitedHealth Group, which serves more than 55 million individuals, said consumer-directed health plans are “the fastest growing new product that has ever been introduced.” UnitedHealth wants “predictability and fixed rates” for hospital reimbursement, Tuckson said. “We absolutely are moving towards and embrace the idea of DRGs.”

“The real key,” he said, for improving quality and effectiveness of care “is to move forward with patient-centered care support systems. People deserve to know in terms that are meaningful to them the relative costs for achieving a desired health outcome.”

J. Knox Singleton, president and CEO of Inova Health System in northern Virginia, one of the largest integrated health delivery systems in the nation and a leading hospital operator in metropolitan Washington, D.C., said that after initial skepticism, he has become convinced pay for performance and consumer-driven health plans were “a train that is moving.” He expressed amazement at “the number of insurers who are hitching their wagon to that phenomenon and showing up at the hospitals’ doorstep.”

“It’s a little bit like the Oklahoma land rush,” said Singleton. He predicted that employers would give consumers incentives to move quickly into these plans, and “it’s going to have a tremendous effect on hospitals. It isn’t the money. ... It’s the visibility of your relative performance compared to your peers.” Hospital trustees, in particular, will welcome that information and demand results.

Meeting Social Goals

Finally, the symposium considered how hospitals can continue to meet social goals and address geographic disparities in use of care while dealing with major changes in how they are reimbursed.

Bruce C. Vladeck, a principal with Ernst & Young's Health Sciences Advisory Services and a former HCFA administrator, said that from the viewpoint of hospital administrators, "revenue is fungible," and all that matters is that the incoming revenues equal or exceed the outgo.

But any pay for performance scheme will make it more difficult for hospitals to rely on the cross-subsidies that they have used until now to pay for community services that actually save lives. The stand-by capacity to treat the seriously ill, burn victims, premature infants and other difficult cases is inherently expensive and unprofitable, Vladeck said.

In some places the social compact that has allowed hospitals to pay these bills has already splintered. New York State's mechanism for taxing private plans to pay for the cost of the uninsured has entered a "death spiral cycle," said Vladeck.

Vladeck said experts often say the rise in U.S. health costs was unsustainable, and yet the system has survived.

"What's sustainable is not an absolute economic question. It is a political question," said the former Clinton administration official. If hospitals are to keep providing these community services, "sooner or later someone is going to have to make a politically explicit decision to do that and make some politically explicit choices about how to pay for it."

Reinhardt commented, "If you want to be your brothers' keeper, pay for it ... Sustainability is a code word for an unwillingness of the upper half of the income distribution to step up to the cashier's window to subsidize health care for the lower half who couldn't ... afford modern American health care."

Fix the System – Before It Collapses

Altman, bringing the conference to a close, said it was "nonsense" to think that simply adjusting DRGs to better reflect case mix could solve hospital's brewing financial problems. The ongoing battle over whether the government will allow physician-owned specialty hospitals to siphon off the most lucrative procedures "is really going to be the Achilles heel of whether we can keep patched together this sick tax that we have sort of under the table imposed on our system" to deal with the 45 million uninsured.

"The only way some of us sleep at night and think we're not as bad a country as we might appear by having 45 million uninsured is the fact that we have created this sick tax. If all of a sudden it stopped, then I'm going to have a harder time sleeping," said Altman. He exhorted the next generation of health care leaders—including those now in key positions across the government—to "fix the system before it totally collapses."

Papers presented at the symposium will appear in a forthcoming issue of *Health Affairs*, the journal of health policy and research published by Project Hope.