Managing the Risks: Healthcare Reform's Challenge to Hospitals

Commentary

Jeff Goldsmith

Healthcare financial executives will need to manage payment and risks with fewer resources under health reform.

At a Glance

Three big risks for hospitals under healthcare reform are:

- **The inevitable deficit reduction initiatives beginning in FFY12**
- **The estimated one-third increase in Medicaid enrollment**
- **The dramatic increase in regulation of private health insurance**

The healthcare reform "circus" phase ended on March 23 with President Obama's signing into law the Patient Protection and Affordable Care Act of 2010 (PPACA). Hospitals watched nervously as Congress reorganized the health insurance marketplace. Financial executives are now attempting to model the economic effects and timing of the financial "contribution" they were asked to make to funding a trillion dollar extension of the health coverage entitlement to 30 million more Americans. The field is now bracing for what could end up being 20,000 pages of implementing federal regulations.

It is difficult to gauge the net effect of adding 30 million new paying customers for hospital services against the reductions in Medicare diagnosis-related group (DRG) and hospital outpatient prospective payment system (HOPPS) updates and downward adjustments in disproportionate share subsidies contained in the PPACA. However, I believe the most significant risks to hospitals lie elsewhere than the visible reductions in Medicare funding the field seems to be focused upon.

The big risks to hospitals cluster in three areas:

- The inevitable deficit reduction initiatives that will commence in federal FY12
- The estimated one-third increase in Medicaid enrollment envisioned in the PPACA
- The dramatic increase in regulation of private health insurance

Deficit Reduction R Us

Although healthcare reform proponents claim that PPACA did not increase the federal government's long-term deficit, without any help from healthcare reform, the deficit itself is unsustainable. In FY09, which ended last September, the federal government borrowed roughly *half* of what it spent. In the current year, FY10, we are projected to spend about $1.3 trillion more than we take in. Ten-year deficit forecasts suggest that the federal debt is expected to exceed $19 trillion. Long before we reach that number, foreign investors will flee our debt securities and currency, requiring the federal government to impose austerity measures similar to those now being implemented by the government of Greece, and for the same reasons.

Why should this concern hospitals? Simply because Medicare is the balancing item in the federal budget, and hospitals represent about 46 percent of Medicare spending. The hospital industry's advocates claimed

immunity from recommended reductions in hospital payments from the new Independent Payment Assessment Commission until 2019. Of course, that does not mean that *Congress* cannot reduce Medicare hospital payments, as it inevitably will have to do to help balance the budget. The most vulnerable reduction targets are not the obvious inflation updates, but rather hospital outpatient payments under HOPPS for surgery and imaging. From these services (private insurance plus Medicare) hospitals derive a scary fraction of their total operating profit. Another obvious risk will be indirect medical education subsidies long targeted by MedPAC.

Hospitals differ markedly in their Medicare "profitability." Recent MedPAC estimates suggest that approximately 10 percent of hospitals have 100 percent or better Medicare cost coverage ratios; that is, they do not rely on cost shifting to cover losses on their Medicare patients. Even those 10 percent will be pressed to reduce their costs because Medicare payments will absolutely not keep pace with the rising cost of caring for Medicare patients. Some hospitals run Medicare cost coverage ratios of 70 percent at today's Medicare rates. That's the equivalent of borrowing money from a bank whose loan officers are about to go on holiday (or off to jail).

In the future, hospitals will need every penny of their "cost shifting" power to cover their *Medicaid* losses (see "Medicaid: 60 Million Strong" below). Hospital CFOs should see their Medicare cost coverage ratio as the financial equivalent of the Hemoglobin A1c levels—the level of blood sugar—in a diabetic. Reducing their exposure to Medicare losses will, of course, help reduce the Medicaid losses as well. Importantly, this effort will require not merely the forbearance of physicians and hospital departmental managers, but also their active collaboration. Preparing for a period of fiscal stringency might seem an odd thing to do with 30 million new paying customers at the gates, but hospitals are going to have to learn to run on regular gas, and to ration both capital and operating dollars until health reform is fully implemented.

Furthermore, many of the "science projects" (e.g., demonstration and pilot projects) called for by the PPACA contemplate placing hospitals at risk for a wide variety of Medicare costs (such as postacute care, community-based ambulatory care through accountable care organizations, and readmissions) they do not currently worry about. Depending on which of the science projects prove out and form the basis for further Medicare changes, hospitals will experience heightened financial risk, which will require them to play a role in reducing Medicare spending not under their current management control.

It is far too soon to speculate on the result of the science projects, which will take years (and create massive opportunities for healthcare consultants everywhere). I've argued elsewhere that hospitals have a powerful incentive to participate in these demonstrations, to get up the learning curve on how new payment models might work, and prepare themselves if they are, in fact, implemented with the new fast-track authority enjoyed by the Department of Health and Human Services (HHS).

As the Centers for Medicare & Medicaid Services creates its innovation center, hospitals and health systems should create their own, to organize and manage their participation in the pilots and demonstrations.

Medicaid: 60 Million Strong

Hospitals fought hard during the health reform debate against proposals to enroll several million people over the age of 55 in Medicare. Yet at the same time, they collaborated in expanding Medicaid coverage by at least 15 million people. Even though Medicaid represents only about 15 percent of hospital revenues, like the poor themselves, hospital Medicaid exposure is not evenly distributed. For Medicaid-intensive institutions, this expansion is a far more serious financial risk than the relatively modest trimming of Medicare payment. Moreover, because states are forbidden to reduce eligibility for Medicaid or SCHIP between now and 2014, state efforts to cope with their currently ruinous budget deficits will focus entirely on reducing already inadequate provider payments, long before the Medicaid expansion has even begun. Medicaid is the balancing item in most states' budgets.

By 2019, Medicaid will be far larger than any private health insurer in the country, with more than 60 million covered lives. Medicaid has been expanded to cover anyone whose individual or household income is less than 133 percent of poverty (about $29,000 for a family of four). States have the option of creating Medicaid-like public plans to cover up to 200 percent of poverty (about $44,000 a year) if they can find the money. Those new plans will most likely pay at Medicaid rates, adding to the torque on hospitals' rate structures.

As part of the stimulus legislation, states got a temporary increase in Medicaid federal matching that postponed but did not eliminate the risk of hospital payment reductions. That matching increase expires at the end of this year, two years shy of the start of coverage expansion. Most states thus face a Medicaid funding "cliff" in their next fiscal year, for which reason they

are now proposing or enacting Medicaid payments.

Many believe that the temporary "federalization" of the huge PPACA Medicaid expansion (coming on the heels of the temporary increase in federal match from the American Recovery and Reinvestment Act of 2009) could herald a federal takeover of the program. If that happens, hospitals need to be prepared to ask their local Congresspeople to explain how two federal programs can possibly justify paying such widely divergent rates to the same hospitals for the same services.

The only reason Medicaid plays such a large role in the PPACA's coverage expansion is because it was so much *cheaper* than private insurance. The completely political reason: The poor and those who care for them simply do not have as much political clout as the "elderly" and the much larger swatch of hospitals that care for them. If both programs become, effectively, federal programs, paying far less for Medicaid merely because, historically, its beneficiaries were poor (and business could cross-subsidize the losses passed on to them through cost shifting) is completely indefensible public policy.

Although, unquestionably, some payment (e.g., Medicaid rates) is better than no payments (e.g., uninsured patients), the increased Medicaid exposure could nonetheless swamp a lot of urban academic health centers, as well as rural sole community providers, whose ability to shift costs to private insurers will be severely limited by the new restrictions being placed on private insurers (see below).

Because Medicaid patients are concentrated in a subset of DRGs, and tend to flow through the emergency department, clinical process redesign focusing on those DRGs, and on making sure that Medicaid patients have a place to go clinically when they leave the hospital (e.g., community health centers or the hospitals' own primary care practitioners or clinics) might help reduce the likelihood of repeat hospitalizations (and deepened losses). Rigorous efforts to reduce care defects, poor care coordination, and other causes of extended hospital stays will also help reduce, but not eliminate, the losses from treating Medicaid patients.

Private Insurance: The New Federalism

The most important changes in PPACA are those that dramatically increase regulatory oversight over private health insurance, the source of 120 percent or better of the hospital industry's net income. Private insurers' gross margins (e.g., their "medical loss ratios") are explicitly capped by federal statute. Insurers that spend less than 80 percent of premium on individual and small group (e.g., less than 100 employees)—currently the source of nearly all the profit from their commercial business—and 85 percent of their large group premiums will be required by federal law to rebate the difference to subscribers in the next coverage year. Insurers are also forbidden from rating subscribers or groups based on their past healthcare costs or illness and must guarantee both initial issue and renewal of coverage.

The HHS secretary has the right under PPACA to "review" health insurers' rate increases for "reasonableness" and can recommend to state exchanges that "unreasonable" health plans be excluded from registering with the exchanges, effectively shutting off access to at least 15 million new customers. At the end of this section of the law, Congress authorized the secretary to create a uniform reporting system and requiring hospitals to report to HHS their standard charges for all their services (!). Uniform charge reporting has been the traditional first step in instituting *hospital* rate controls, an unmistakable signal of regulatory intent.

As of this writing, Congress and the administration want more authority than that granted to them in the PPACA: explicit mandates that states actually review and approve health insurer rate increases if they do not currently do so, or to provide the federal government the backup authority to do so if the states decline. These proposals, although unlikely to be implemented by this Congress, suggest that price controls on health insurance premium increases could be the "remedy of choice" if double-digit health premium increases persist in the next few years.

Furthermore, PPACA authorizes demonstration projects for state all-payer provider rate setting, and allocates $250 million for states to increase "consumer protection" activities by state insurance commissioners. This latter funding is a not-so-subtle hint that the dozens of state insurance commissioners who currently do not approve health insurer rate increases ought to consider doing so with all the new staff they will be able to hire.

In other words, if hospitals respond to the Medicaid payment reductions discussed above by shifting costs to private insurers, or attempt to leverage private insurers to improve their cash positions in the face of the above discussed uncertainties, they could help create the conditions that result in price controls on insurance premiums. Concerns about provider consolidation, and their consequent ability to leverage larger than normal rate concessions from private health insurers, have led not only to calls for more

stringent hospital antitrust scrutiny, but also to a steady drumbeat from the health policy commentariat for all-payer rate regulation by hospitals, such as that in the state of Maryland. Prominent health policy analysts—including Stuart Altman, Uwe Reinhardt, Paul Ginsburg, and Bob Berenson—have spoken up recently advocating state all-payer rate controls on hospitals.

How health insurers respond to caps on their gross margins and political jawboning about rate increases from the Obama administration is anyone's guess. The first target for cost reduction (and appropriately so) will be insurance brokerage commissions, which can amount to as much as one-third of the spread between premium and medical expense. Health insurers can also be expected to reduce their administrative costs. Provisions in PPACA to encourage completely automating claims management and payment might finally evoke action by insurers to web-based 24/7 claims systems.

But after that, it is reasonable to expect insurers to push back hard on provider payments (even though they are in the medical expense part of their costs) to keep them out of double-digit premium increase territory. Good news or not, medical expenses themselves appear to be modestly declining as of this writing. Even if provider payments do not threaten the medical loss ratios caps, they will create cost pressure that insurers might not care to pass through the health exchanges, or explain to the secretary of HHS or their state insurance commissioner.

All this regulatory huffing and puffing will create an additional incentive for hospitals to "run on regular" besides avoiding losses from treating publicly funded patients. It also creates a powerful reason for providers to befriend anew their state legislators and governors, on whom could fall the ultimate pressure to create all-payer rate-setting programs, a 1970s solution to a 21st century cost problem.

PPACA will trigger an onslaught of state and federal regulation, of both insurers and providers, unseen in the lifetimes of the current generation of healthcare financial professionals. Space does not here permit a recounting of the billions being flung at the IRS and Office of Inspector General to hire new auditors and FBI agents to focus on the health sector. Hospitals are going to spend the next decade under detailed public scrutiny of their costs and business practices. Get used to it.

The most powerful levers for managing hospitals' destiny in this new post-healthcare-reform world will be those that enable management of the cost/value equation, reducing the defects in care that generate cost, and creating accountability for physicians' patient care decisions in and around the hospital. Survival under PPACA will also require ending the "pass-through" management culture embodied in the obsolete term *reimbursement* (which continues to baffle me whenever I hear it). It is, increasingly, publicly managed *payment*, and the political and financial risks Congress and the president have attached to it, that hospital executives and their clinical partners must seek to manage in a resource-constrained world.

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