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Hospital Executives Worry About the 'What-Ifs' of Reform

Some See Pluses While Others Fear Mandates

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AUSTIN -- Charles J. Barnett's fears about a federal health-care overhaul are outrunning his hopes.

From his perch as the chief executive of a nonprofit hospital network that draws patients from 11 counties in central Texas, Barnett sees plenty of problems in desperate need of fixing, especially in a state with a higher proportion of uninsured -- nearly one in four -- than any in the country. He has hopes for reform, particularly a larger pool of insured customers.

But then the what-ifs take over.

What if new policies reduce revenue and increase demand? What if existing doctor shortages grow worse? What if some of the most vulnerable and expensive patients continue to have no coverage, like the nine people who made 2,678 visits to local emergency rooms in one six-year stretch and soaked up \$3 million in expenses?

And those are just his concerns growing out of the Washington policy proposals that he knows about. Given the scale of the overhaul the Obama administration seeks, Barnett predicts "there will be new vulnerabilities inside whatever changes get made," adding: "I don't think it's anyone's intention. It's just inevitable."

Anxiety is running high among hospital executives as they ponder the ever-changing proposals on Capitol Hill. Wary of changes to payment formulas and fiercely protective of their franchise, industry groups are spending millions to lobby Congress. They also pledged \$155 billion in Medicare and Medicaid savings in a deal with the White House in hopes of avoiding a deeper restructuring that could cost them more.

"Any savings beyond this agreed-to amount would harm hospitals' ability to provide the care their communities need," the American Hospital Association said in talking points to members, including nearly 5,000 hospitals and health networks. The document noted "serious concerns" about House legislation that includes a government-run plan competing with private insurance.

Worries vary, and some institutions expect to gain more than they lose. "Safety-net" hospitals, which treat high percentages of patients with little or no insurance, anticipate more revenue if coverage is extended to 95 percent or more of the U.S. population.

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The ability to provide care for the uninsured "improves dramatically with them having an insurance mechanism," said Alan Channing, chief executive of Chicago's Mount Sinai Hospital, which serves a largely impoverished population. After all, he said, the hospital is seeing most of those patients anyway and collecting little.

Even for the roughly one in six U.S. hospitals considered safety-net facilities, uncertainties remain, particularly in funding formulas. For hospital systems, such as the 11,000-employee Seton Family of Hospitals run by Barnett, the complexities multiply. Barnett said Seton executives are particularly troubled by a potential public insurance option that might pay rates comparable to Medicare.

Such a plan "would compromise the sustainability of Seton and most hospitals in the United States" by limiting their revenue, he contends. Further, if lawmakers say that hospitals and doctors may opt out of the public option, he says, the system would fracture: Access to "boutique hospitals and physicians" would improve and lines would lengthen at places that accept public insurance.

The mere act of providing coverage to more people would produce a new order of challenges in Travis County and its surrounding jurisdictions, where experts say doctors are in increasingly short supply. One in 10 Medicare patients already reports trouble finding a doctor, and Seton projects a shortage of 2,900 physicians in the 11-county region by 2020, even without adding people with new coverage.

"Coverage is only a vehicle to access, and if you don't improve access, we're not going to solve the problem," said Barnett, who moved to Seton from Fairfax Hospital 16 years ago. "If we don't address the supply problem, we'll get into the position where you just queue up."

The Obama administration says that there is significant waste in hospital care and that costs must be curbed. Reformers hope that competition will lower fees and that new incentives will prod and inspire hospitals and doctors to work better together. "That can lead to greater efficiencies and potentially could benefit both of them," said Paul B. Ginsberg, president of the nonpartisan Center for Studying Health Care Change.

To manage rising costs, many hospitals have been adapting already, introducing reforms consistent with the proposed legislation. At Seton, this includes call centers staffed by nurses to cut down on emergency room visits and protocols that reduce birth complications, saving money and beds.

Seton, a group of 10 hospitals and a network of community clinics, delivers a mix of care to a broad array of patients in an area with 1.7 million residents and 400,000 uninsured. It handles organ transplants and cancer treatment, while also running the former county public hospital. Two-thirds of the charity care in Central Texas is provided by Seton, the company reports.

"We know there are more people who are uninsured here than we have the capacity to serve," said Patricia A. Young Brown, Travis County Healthcare District executive. "The question is, how much does reform reduce that need?"

Current reform proposals would cover as many as 95 percent of Americans, a significant improvement. That suggests more money available to health-care providers and, if the theory holds, a healthier population that needs less care over time.

Yet when health-care specialists such as Barnett look at the remaining uninsured, they see the part of the population least likely to take preventive measures and most likely to abuse their bodies or suffer a calamity and end up on a hospital doorstep, unable to pay the full tab.

Nowadays, one way governments help such hospitals meet their costs is through tax breaks. Another is a program that provides "disproportionate share" payments -- Seton has collected \$48 million in the past four years to defray the costs of hospitals with a larger-than-average proportion of indigent patients.

Barnett and others say they fear those payments will be eliminated as part of the Washington changes. He said Seton has already allocated \$29 million of its payments to expand community health centers and increase treatment options -- the sort of innovation the Obama administration considers essential.

Seton researchers studied 7,410 patients whose treatment cost an average of \$2,645 more than the hospitals collected, or about \$20 million in a year. The researchers said members came from identifiable groups -- homeless, disabled or mentally ill people and substance abusers. Many are in their early 60s, not quite old enough for Medicare.

"We're still going to be carrying a burden of providing coverage for them," Barnett said. He added that he considers it unlikely that many such patients will get and keep any kind of insurance.

The nine patients who made 2,678 emergency room visits to Travis County hospitals in six years fall into that category, according to a study by the Integrated Care Collaboration, which said seven of them had a mental illness, eight abused alcohol or drugs and three were homeless.

Barnett favors national catastrophic insurance for vulnerable patients. The policies would be designed to rescue safety-net hospitals and rehabilitation centers that often become places of first and last resort.

Seton, which belongs to Ascension Health, the nation's largest nonprofit health system, is economically stable, in contrast to some big-city and rural hospitals. Its children's hospital opened in 2007 with the help of \$86 million in contributions. The system paid for two new hospitals without borrowing, justifying the use of cash reserves because of rising need. The area's population is projected to grow nearly 60 percent to 2.7 million by 2020.

To reduce costs, Seton spends \$1.5 million a year to operate a call center where nurses ask questions and recommend a course of action. One recent month, nurses did telephone assessments of 2,987 callers and reduced emergency room trips by 12.1 percent from the monthly average. By Seton's estimate, the center saves as much as \$10 for every \$1 it costs.

On another front, Seton cut down significantly on birth trauma by changing protocols. The shift lowered the number of birth injuries and the average length of stay from 15.8 days to 3.4 days. The hospital's costs for birth complications fell from \$1.7 million in 2001 to \$19,591 in 2007, and the amounts billed dropped from \$4.5 million to \$66,000.

Barnett is the first to assert that hospitals can find efficiencies, but he said decisions made on Capitol Hill this autumn will say much about the industry's future success and solvency. Beyond the fears he cited, he said he worries about changes not yet devised or understood.

"Margins are so fragile in health care," Barnett said, "that small, negative, unintended consequences can have a dramatic impact."

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