

Health Care Reform: What It Means for North Carolina's Hospitals

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For more than a year, one could not turn on the television or read a newspaper without seeing something about health care reform. Subsequently, although to a lesser degree, the same kinds of political discussions returned to the public domain in conjunction with this year's off-cycle elections. Regardless of what happens politically in the future, the March 2010 passage of the Affordable Care Act (ACA) will profoundly affect how hospitals fulfill their missions in North Carolina communities. Because hospitals are both health care providers and employers, they face significant challenges and remarkable opportunities, particularly to improve quality, increase access, and reduce cost, as implementation of the ACA moves forward over the next several years.

At Carolinas HealthCare System, we believe reform is necessary. And while many in our industry were skeptical, we supported a decision by the American Hospital Association to accept a \$155 billion cut to hospital reimbursements, spread over 10 years, to reduce the cost of health care and expand coverage for the uninsured. Why? The memory of the provider cuts that were part of the Balanced Budget Act of 1997 is still vivid for us. Nonetheless, what is known about the true impact of reform, outside of this \$155 billion contribution, pales in comparison to what is not known. We will continue to work toward real delivery reform and cost reduction even though this law requires so many changes to America's complex health care infrastructure that there are certain to be many unforeseen consequences.

Throughout the health care reform debate, one issue remained clear. The United States has far too many citizens without health insurance, and that greatly affects access to essential health services. Across the nation, too many people have delayed addressing critical health needs because they

did not have insurance and could not afford to pay for care out-of-pocket. Providing millions of Americans access to health insurance coverage will benefit not just patients but also, in theory, every health care provider in North Carolina.

North Carolina's hospitals have a unique responsibility to provide care to all people who reach their doorsteps and need essential services, whether the individuals have coverage or not. Unlike most other businesses, hospitals provide much of that care at a reimbursement rate that is less than the cost to provide the service and, in some cases, get paid nothing. A significant portion of hospitals' reimbursement rates are not negotiated because government payers like Medicaid and Medicare provide nonnegotiable reimbursement. It is estimated that 50% of the anticipated expansion of coverage in North Carolina will be through the state's Medicaid program. Although we applaud expanded access, it is alarming to see such a dramatic increase in our dependence on a program that already reimburses less than the cost of providing care. The North Carolina Department of Health and Human Services estimates that by 2014, hundreds of thousands of people could be added to the Medicaid rolls, a number equivalent to the combined population of 67 of North Carolina's 100 counties [1]. In addition, this expansion in Medicaid would impose additional demands on a state budget already stressed by recessionary conditions. The federal government will pick up most of the expansion costs for the first few years, but the Medicaid program itself will be challenged to find enough providers to see the additional patients.

One of the most formidable challenges for hospitals—and it is not a new one—comes from what their partners in business refer to as the “cost shift.” Cost shifting is the inevitable result of a system that imposes on private payers the need to compensate for the impact of less-than-cost payers (eg, Medicaid and Medicare). The reality is that hospitals, like any other business, must have a margin to continue to operate. Today, almost 75% of North Carolina's hospitals have a margin of less than 5%, with about one-third of those having a negative margin (North Carolina Hospital Administration Advocacy Needs Data Initiative, unpublished report, May 13, 2010). If programs like Medicaid do not pay the actual cost

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of providing care, someone else must pay. The businesses that provide private insurance to their employees bear the brunt of cost shifting, which is, in effect, an unlegislated tax on patients with private insurance.

Under the ACA, employers can choose to stop providing employee coverage and instead pay a \$2,000 annual penalty per employee. Employees would then be eligible for either Medicaid or an exchange option, depending on their individual incomes. The exchange will likely reimburse at levels below those of most commercial carriers. Consequently, if businesses find it more economical to pay a fine than to provide coverage, hospitals will be looking at an increasing number of patients whose low reimbursement rates add strain to already stressed budgets. This of course enhances the opportunity for a vicious cycle by which government must provide additional subsidies to keep people insured, with no way to pay for those subsidies except by reducing payments to providers, raising taxes, or doing both.

The real question is whether North Carolina can successfully adapt, given the huge budget challenges that have impacted appropriations for several years running. If states are forced to fund expansion by cutting provider rates, providers will not ultimately benefit from expanded "coverage" but will in fact be harmed. This is exactly what happened in Tennessee several years ago, when an experiment in expanded Medicaid coverage virtually devastated the finances of health care providers. In fact, the current model in Massachusetts expanded coverage to everyone without funding that expansion, and the federal government now must step in to subsidize or bail out some of the state's larger hospitals.

Aside from lowering costs and expanding access, one of the principal goals of reform is to improve the overall quality of care for patients. North Carolina's hospitals support and participate in quality initiatives, such as those offered through the North Carolina Hospital Association's Center for Hospital Quality and Patient Safety. Clinicians have also undertaken numerous initiatives to improve the quality of care. Nonetheless, more must still be done to be innovative and creative in the quality arena in order to improve outcomes across the state. Additionally, there is a pressing need in our state and in the nation to focus more intently on the importance of personal choice and responsibility as variables that significantly impact individual health. New models of health care must be structured in a way that encourages much more preventive care and health improvements, while still providing the highest quality of care after someone becomes ill. Expanded health coverage will, it is hoped, allow the transition from a primary focus on people who are sick to improving access for people who want to remain well. This transition gives all providers, not simply hospitals, the opportunity to make improvements that will pay off over the long run. The changes offer a promise of healthier students, healthier workers, and a business environment where companies choose to do business.

Providers want to deliver high-quality, efficient care that benefits patients, and the government needs to be sure that models actually work before they mandate them. One important aspect of the new law is its emphasis of the medical home model. North Carolina was a national leader in developing a medical home model of care, called Community Care of North Carolina (CCNC). Under this model, service providers actively collaborate to improve patients' health. The new law includes many other demonstration projects of this nature, which is a positive development as long as it does not induce a premature rush to adopt unproven programs.

Although the bill was crafted mostly by people who have spent years developing health policy positions, it was not written by people who diagnose disease and treat patients on a daily basis. The massive amount of regulation that is following the passage of the ACA also lacks real clinical experience among its initial drafters. As new regulations are drafted and adopted, it is critical that physicians and other frontline health care professionals are consulted and allowed to comment on issues that impact quality, access, and cost. It is also very important that patients and health care professionals speak out when regulation becomes a barrier rather than an incentive to providing high-quality, cost-efficient care.

All providers will have to work with federal and state agencies with oversight jurisdiction to construct legal and efficient ways of working together, even including communicating with one another about a patient's care. The interaction between providers and patients is often the cradle for significant innovation in the delivery of health care. Not infrequently (even prior to health care reform), there are regulatory walls between where providers are now and where they need to be on the path to true clinical integration, where care is improved and cost is reduced. The legal and regulatory barriers that make it difficult for providers across the continuum to work together must be removed or relaxed.

Although hospitals are grateful for the increased coverage that will become available to millions of Americans, they do have serious concerns about their ability to remain economically viable as individuals make their way to physician practices and emergency departments. In other words, the increased coverage sounds great, but the ability to fund it at the federal or state level is uncertain.

In terms of employment, hospitals are among the few businesses still hiring both entry-level personnel and highly specialized, highly compensated professionals. However, it is difficult to see how hospitals can hire enough clinicians to accommodate the increases in utilization expected during the next 10 years. Patients' utilization of services will drive costs in 2 areas. First, the cost of providing care will increase as more people seek access to services that were previously unavailable to them. Utilization will increase. Second, North Carolina will have to train more professionals to deliver that care. At a time when community college and university bud-

gets are constrained and enrollment costs are increasing, North Carolina will struggle to train enough nurses and physicians to treat patients.

North Carolina, which is already experiencing a shortage of primary care physicians, faces even greater pressures from the impact of soon-to-retire baby boomers, along with the millions of newly insured individuals. Hospitals look forward to participating in training a new generation of physicians, nurses, and allied health professionals who have a critical role in transforming the nation's health care infrastructure. Carolinas Medical Center, like North Carolina's 4 other academic medical centers, is doing all it can to generate the workforce necessary to address the state's needs. Expansion of medical school enrollment is certainly one way to address the shortage of physicians. But without expanding access to postgraduate medical education training slots and increasing enrollment in community college-based allied-health programs and university-based health-professional training programs, North Carolina residents are going to face a serious access problem. Newly insured individuals will have an insurance card that implies they have access to essential health services, but they may not be able to find a provider who can take another patient.

Hospitals, like other providers, are faced with finding a balance as they attempt to protect their safety net status, while facing the dual challenges of increased demand and reduced compensation. The goal of hospitals, above all, is

to continue providing high-quality care while protecting their role as engines of economic development and stability in their communities and across the state. North Carolina's hospitals are not waiting on a repeal of the new health reform law, and they are not counting on replacement legislation. The hospitals are working to make sure their delivery systems are flexible enough to adjust to the most significant paradigm shift to have affected the field. One of the great ironies of health care reform is that hospitals are seen as the economic driver in many communities, yet they face substantial reductions in payments at a time when utilization and service expectations are forecast to increase. My comments here are largely about cost because the ACA is really more about payment reform than about true health care delivery reform. True health care delivery reform must come from providers, not from elected officials.

Unlike other businesses, hospitals do not migrate to other countries—they do not outsource jobs. Historically, the economics of the hospital industry have been based on hospitals' ability to address community needs locally. While hospitals will change the way they do business, their successes in the past have always been tied to their ability to adapt in a dynamic field. North Carolina's hospitals are determined to find a path forward that will positively transform the industry and the care delivered to communities.

We hope, like all of you, that this grand experiment works. NCMJ

REFERENCE

1. Kaiser Family Foundation. Key questions about Medicaid and its role in state/federal budgets and health reform. <http://www.kff.org/medicaid/upload/8139.pdf>. Published January 2011. Accessed February 9, 2011.