Hospitals Face New Price Pressures

BY JANE HIEBERT-WHITE

Hospitals find themselves in an increasingly competitive environment, facing price pressures from both the private and the public payer sectors. "The funding environment out there is tough and getting tougher," said James D. Bentley, American Hospital Association (AHA) senior vice president, in an interview. What does this tough environment portend for hospitals, for their safety-net mission, and for the prospects of expanding the healthcare safety net to more of America's uninsured?

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Response to Market Pressures

As hospitals face price pressures from private-sector payers and a price freeze from Medicare under the new Balanced Budget Act (BBA), they will need to redouble their efforts to cut costs. Although most hospitals are currently posting large positive margins, analysts wonder what impact such price pressures will have on future margins. According to Gerard Anderson, professor of economics at Johns Hopkins University, the current data show no "large categories of hospitals that are doing poorly. What's happening, however, is that, in order to maintain these margins, hospitals are having to adapt at a much faster pace than they have in the past. They have to jump through many more hoops. In the end, it looks like they're doing fine, but they have had to work a lot harder.

"It is not clear whether hospitals will be able to find productivity gains to maintain these profit margins," said Anderson, who is director of the Center for Hospital Finance and Management at Hopkins.

For Catholic hospitals, price pressure means becoming "much more efficient at what we're doing—cutting costs, but not in a way that jeopardizes patient care or our mission," said William Cox, executive vice president of the Catholic Health Association (CHA), in an interview. "By restructuring themselves—developing coalitions with other Catholic healthcare organizations, with other non-Catholic healthcare organizations, and with physician groups—they should theoretically become more efficient while retaining their capacity to fulfill their missions. Hospitals are going to have to change. They can't maintain the status quo," Cox warned.

Yet for all the merging and collaborating that has already taken place among hospitals, there has to date been little effect on hospital occupancy rates. The merging has yet to squeeze out excess hospital capacity across the United States. "I think it takes a while for competition to have an effect on capacity," Cox said. "Hospitals are very resilient organizations. There are a lot of steps they can take before reducing capacity."

Bruce Vladeck, who recently left his post as administrator of the Health Care Financing Administration (HCFA), looks at hospital occupancy from a community perspective. "To talk about cutting hospital capacity by 30 to 40 percent is a meaningless statement," he said in an interview. "We don't work in the aggregate. Hospitals are tied to communities and to individual healthcare. While the number of one-hospital towns and counties is clearly going to increase [due to market pressures and mergers], I don't see the number of *zero*-hospital counties growing." For now, "the big guys are buying up the little guys and not closing them. They're putting capital back into them to form a beachhead in new markets, dump their second-best surgeon there, and so on," said Vladeck. But a significant reduction in hospital capacity is not yet part of the picture, he maintains.

Indeed, new data show that as hospital mergers take place in more highly concentrated healthcare markets, the price savings that accrue to the local healthcare consumer remain minimal or even negative—which raises questions about the consumer benefit of such merger activity. Results from a national study of 122 horizontal hospital mergers between 1986 and 1994 show that both the mean price and cost increases among the merging hospitals were about 7 percent lower than for nonmerging hospitals.[1] However, mergers in more concentrated healthcare market areas had a slight price

increase (1.4 percent) instead of a price decrease. The researchers, led by economist Robert Connor of the University of Minnesota, conclude: "Considering these two opposing trends, healthcare markets with a balance of market power between providers and purchasers, either with a few large providers who face aggressive price negotiation from a few large buyers or with many smaller providers competing for the business of many smaller buyers, may have lower prices than those markets where providers' market power exceeds buyers' market power."

Maintaining Mission

Hospitals that seek to maintain their safety-net mission as providers of care to the poor, the uninsured, and the underinsured are especially vulnerable to the new price pressures. AHA's Bentley pointed to the cuts in disproportionate share hospital (DSH) payments under Medicare and Medicaid in the BBA as a harbinger of bad news for safety-net hospitals: "The social message here is that it is okay to cut funding for the uninsured. This strikes us as a pretty scary message. In a difficult revenue climate, it now appears to have, on the surface, an anti-uninsured funding climate." Bentley acknowledged that "part of the reason Congress did that is that they were not satisfied with the DSH program. But this sends a mixed message" to healthcare providers and the American people.

CHA's Cox, who is also concerned about the DSH funding cuts, said, "No one is really looking at the impact these cuts could have on hospitals serving disproportionately large number of poor and uninsured people. We need to keep a careful eye on those facilities; there could be an impact in terms of the access uninsured people have to healthcare."

Even before these cuts in DSH funding take effect, overall access to healthcare appears to be declining. A new national survey found that 24 percent of American families reported more difficulty than three years previously in getting medical care. The figure was 30 percent for families with incomes below the poverty line. The survey also found that more people without insurance (43 percent) reported more difficulty in getting access to healthcare (only 21 percent with private health insurance reported more difficulty). The survey was part of the large Community Tracking Study conducted by the Center for Studying Health System Change, a Washington, DC-based research group funded by the Robert Wood Johnson Foundation. The survey was conducted in 1996 and 1997 and included 43,771 persons in 23,554 families.[2]

A look at uncompensated hospital care trends, another measure of the strength of the healthcare safety net, also shows a darkening picture. Peter J. Cunningham and Ha T. Tu, researchers for the Center for Studying Health System Change, reported that despite an increase in the number of uninsured people, hospital uncompensated care costs have stagnated in the 1990s. During the 1980s, uncompensated care costs rose substantially. The researchers also found that uncompensated care costs in the 1990s have become more concentrated among public hospitals and others that provide disproportionately high levels of uncompensated care, thus qualifying for DSH funding.

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In looking at the overall slowdown in and concentration of hospital uncompensated care costs among select providers, Cunningham and Tu write: "Perhaps the most plausible explanation is that market pressures faced by hospitals have constrained their ability and willingness to provide uncompensated care in recent years."[3] They warn: "If private hospitals become increasingly limited in their ability and willingness to provide uncompensated care, it will be difficult for public hospitals to make up the difference."

A study by researchers at RAND confirms that as competitive market pressure mounts, hospital uncompensated care levels may be threatened. Overall, hospital uncompensated care increased from $6.1 billion in 1983 to $17.5 billion in 1995. In real terms, this represents a 150 percent increase in uncompensated care costs for the nation's hospitals. However, if one looks at uncompensated care costs per uninsured person, the trend line is down. The RAND researchers report that "for every dollar of uncompensated costs per insured person, thirty-six cents of uncompensated care were generated per uninsured person in 1994 versus forty-two cents in 1984."[4]

Joyce Mann and her RAND colleagues then looked at uncompensated care trends according to levels of competition and health maintenance organization (HMO) penetration in local areas. Although they found increased levels of uncompensated care in the more competitive markets, they noted that hospitals in such markets tend to be bigger in size, to be located in large cities, to have a larger Medicaid mix, and to include more public and major teaching hospitals—precisely those hospitals that tend to provide more uncompensated care. Thus, on average, uncompensated care accounted for 7.4 percent of expenses among hospitals in the most competitive markets, compared with 5.3 percent in the least competitive markets.

However, the researchers also found that "on average, uncompensated care takes up a smaller portion of hospital expenses in areas with more extensive HMO penetration (7.6 percent versus

10.5 percent in less competitive markets.)" Thus Mann and her colleagues conclude, "It is not necessarily competition per se that will induce reductions in uncompensated care. Rather, it is the combination of competition plus greater price sensitivity introduced by managed care that could lead to pressures to slow the growth of uncompensated care." Indeed, the researchers found that "the greater the degree of HMO penetration, the lower the provision of uncompensated care relative to the hospital's size, with the effect being stronger in the most competitive markets."

CHA's Cox anticipates an increased need for hospitals to maintain a safety-net mission: "Because of price competition in healthcare, managed care's ability to reduce cost-shifting, and the capacity of insurers generally to risk select, we're going to see a continuing increase in the uninsured, despite efforts being made in the context of the current [federal] budget" to insure more children.

AHA's Bentley suggests that all hospitals need to be concerned about maintaining the safety net, not just the large, public, traditional "safety-net hospitals." He warned, "If nonsafety-net hospitals don't do anything [to help with the problem of the uninsured], it puts your local safety-net hospital at greater risk" of financial failure. This could then lead to greater problems with access to care and increased strain on other local hospitals. The good news, however, is that so far "we don't see any dramatic reductions in 1996 of hospitals abandoning their traditional mission," said Johns Hopkins's Anderson, who has kept tabs on the latest hospital financial trends.

Prospects For Expanding Coverage

Policymakers and policy analysts alike find the prospects for expanding the safety net of healthcare coverage to more uninsured Americans rather slim as we enter 1998. Even though the BBA extends insurance coverage to more children, former HCFA Administrator Vladeck said, "I think we'll be hard-pressed to keep what we've got [in terms of the percentage of insured Americans]—especially if the economy goes south." On the day of the Vladeck interview, the Dow Jones Index dropped 550 points. Vladeck noted that a strong economy has helped insurance projections to date. Now, with the market more questionable, the prospects for broadening healthcare coverage are less bright. Said Vladeck, "The scary thing is that these economic times are as good as one can have for awhile . . . . And we've made no dent in the number of uninsured."

Gail Wilensky, former HCFA administrator under President George Bush and the current chairperson of the Medicare Prospective Payment Assessment Commission (MedPAC), said in an interview that the insurance expansions for children in the BBA tend to fill in the healthcare insurance gaps in an uneven manner. The BBA aims to insure children in families with incomes up to 300 percent above the federal poverty line. "I wish they had filled in all the poverty gaps before moving to 200 to 300 percent of the poverty level. I'm concerned about a program that doesn't do it for all" Americans and leaves out many adults below the poverty level, she said.

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Children represented a politically palatable group to receive expanded healthcare coverage. Going beyond children will be more difficult. Economist Robert Reischauer, director of the Congressional Budget Office during the 1993-94 healthcare reform debate and currently a senior fellow at the Brookings Institution, said in an interview: "We've already taken a major step for the most sympathetic of the uninsured, and it will take some time to digest that step. Expanding coverage to other groups is more problematic and will be more contentious." He added: "The data show that most of the growth of the uninsured occurred among children anyway. And numbers are what keep the debate alive . . . though one can always argue with the numbers."

Part of the problem with expanding coverage to uninsured adults is that "it is harder to define who the people are," said AHA's Bentley. "It is harder to make sure we're not just substituting one stream of money for another; and it is harder to administer." Among the groups that some policymakers are considering are the temporarily unemployed and the early retiree population. Rep. Fortney H. "Pete" Stark, D-CA, for example, is drafting a bill that would begin to let people buy into Medicare. Said Bentley, "He's trying and gets high marks for effort, but the implementation side is tough."

CHA remains committed to universal healthcare coverage. However, "this is not a position that garners a great deal of interest on Capitol Hill right now," said Cox. "So we've been focusing on ways to expand access and coverage incrementally." For instance, CHA is encouraging member hospitals to become actively involved in making sure that children get signed up for the new State Health Insurance Program authorized by the BBA.

Princeton economist Uwe Reinhardt predicted in an interview that "capitated managed care is the only hope we have to ever have universal coverage." Although Reinhardt believes that "Americans are unusually nice people and that there is a largeness in the American soul that is astounding, ultimately politicians need budgetary closure at the beginning of the year. They need to know how

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will explore what it means to be *accountable* for a ministry and what resources should be available to lay leaders for their personal and ministerial development.

The meeting will begin to identify the core elements sponsors must value, regardless of the "who" or "how" of sponsorship. One of the core elements of sponsorship may well be a deeper grounding in the theology of ministry. But CHA, rather than assuming this, will respond with appropriate resources after the needs are identified by the process.

The January meeting will also incorporate the foundational work accomplished at CHA's Sponsor Forum a year ago. We believe that, although it is tempting to seek quick answers, facile responses to complex questions about ministry and sponsorship are likely to be unproductive in the long run. CHA's role is to facilitate an evolving process (after all, the Church has debated questions regarding ministry for centuries). We believe that careful exploration of the skills and experiences of successful sponsors will provide a strong foundation to sustain healthcare as a ministry of the Church into the next millennium. □

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much kindness will cost them." Hence the attraction of capitated managed care, where one can tell the politician what healthcare costs to expect. Reinhardt bolsters his case by pointing to the growth of Medicaid managed care: "Until that deal came along, Medicaid didn't expand. Now it's expanding in some states."

However, all predictions, even those made by seasoned policymakers and expert policy observers, are fraught with risk. "I had predicted the number of uninsured would go down," Reischauer wryly observed, "so I'm still smarting from being wrong."

As we enter 1998, the message from Washington policy observers seems to be:

- Redouble your efforts on cost cutting
- Watch closely to see what impact all the reforms in the BBA have on the health system
- Do not expect any major policy changes anytime soon

Incremental reform continues to be the watchword. The healthcare reform debate on universal coverage "was a very bitter experience for a lot of people on both sides of the issue," said Cox. But, ever hopeful, Cox suggested that if the Medicare Health Care Reform Commission set up by the BBA really does delve into the issue of reforming health insurance for the elderly, "it may not be able to avoid getting back into larger discussions of the uninsured." □

NOTES

1. Robert A. Connor, Roger D. Feldman, Bryan E. Dowd, and Tiffany A. Radcliff, "Which Types of Hospital Mergers Save Consumers Money?" *Health Affairs*, November-December 1997, pp. 62-74.
2. Cara Lesser and Peter J. Cunningham, "Access to Care: Is It Improving or Declining?" *Data Bulletin*, Center for Health System Change, Fall 1997.
3. Peter J. Cunningham and Ha T. Tu, "A Changing Picture of Uncompensated Care," *Health Affairs*, July-August 1997, pp, 167-175.
4. Joyce M. Mann, et al., "A Profile of Uncompensated Hospital Care, 1983-1995," *Health Affairs*, July-August 1997, pp. 223-232.