



TEXAS HOSPITAL ASSOCIATION

Federal Health Care Reform: The Texas Perspective

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Texas hospitals agree with President Barack Obama and Congressional leaders that health care reform must be comprehensive. To achieve access to health care for all Americans – and be able to afford to finance it – health care practice and delivery must change. And health insurance practices must change to produce premium reductions. Texas hospitals support comprehensive reform, not just financing changes and reimbursement cuts disguised as reform.

The upfront costs for health care reform could be substantial, but a paradigm shift in our health care system is needed if we have any hope of realizing savings, improving health outcomes and creating better access to care in the long run. Reform needs to involve all stakeholders, and everyone should share in its financing. Hospitals are willing to do their part, and that includes sharing in the funding for universal coverage.

Public support for health care reform is waning, as Americans have growing concerns about how health care reform will benefit them personally, its costs and the role of government. This debate is coming at a time when Americans still are greatly concerned about the overall economy and the growing deficit.

Given Texas' significant financial vulnerability under *any* reform effort, the Texas Hospital Association is working with the Texas Congressional Delegation and the American Hospital Association to deal with Texas' unique issues:

- Coverage for illegal immigrants residing in the U.S. or alternative funding mechanisms for unreimbursed costs attributed to that population;
- The limited ability of Texas to finance federally required expansions of the state's Medicaid program;
- Continuation of resources to cover significant Medicaid and Medicare payment shortfalls;
- Mitigation of adverse impacts on rural hospitals; and
- Better articulation of other elements of reform that must be achieved to ensure expanded coverage, including:
 - physician payment reform that better aligns incentives and increases access to primary care;
 - meaningful health insurance reform;
 - the role and structure of the public plan, if any; and
 - identification of other revenue sources to finance coverage expansion.

Other issues that need to be further addressed include:

- End-of-life care,
- Charity care requirements for nonprofit hospitals,
- Limits on physician self-referral, hospital ownership and grandfather provisions,
- Liability reform, and
- Impact of Medicare fraud and abuse initiative (Recovery Audit Contractors program).

Texas Perspective on Key Reform Components

Texas hospitals have identified issues with some of the key components of reform being debated in Congress. The Texas Hospital Association perspective on each is provided:

Public Plan

- If a public plan is included, it should not underpay hospitals as Medicare and Medicaid already do, and it must not significantly impact payments from private insurance. Since private insurers often link their rates to public plans, underpayments from government programs can have a negative impact on private insurance.
- A public plan option should be limited to the uninsured, the self-employed and small businesses ... those who need a different alternative to get the health care coverage they need.
- Broadening the scope of such a plan beyond these categories threatens to cause a “run” on the plan, with people who have insurance simply signing up for the cheaper alternative, and with business owners being tempted to stop providing insurance because the public plan is available to their employees. Neither of these actions would further the goal of reducing the number of uninsured Americans.

Paying for Health Care Reform

- Hospitals can support redirection of supplemental payments for the uninsured (Disproportionate Share Hospital program funds) to actual reductions in uncompensated care. The trigger mechanism is critical to ensure that hospitals’ ability to provide health care services is not jeopardized if coverage targets are not reached.
- Even if coverage is expanded successfully, there still will be “gaps” in coverage that will result in uncompensated care and bad debt for hospitals (e.g., the remaining uninsured, undocumented immigrants, and Medicaid and Medicare underpayments). A need for DSH payments will remain to cover a shortfall in Medicaid payments and for care hospitals provide to those that remain uninsured.
- Reductions in Medicare market basket updates should consider the impact of reductions resulting from the Recovery Audit Contractors program. The impact on Medicare beneficiaries’ ability to access physicians and hospitals also should be considered.
- Hospitals oppose an Executive Branch Independent Medicare Advisory Commission that would have broad powers to set provider rates with little ability for Congress to intercede. While having health care experts and the Institutes of Medicine involved in developing details related to benefits and provider reimbursement, stakeholders should have input, and Congressional authority over federal agencies should not be usurped.

Rural Hospitals

- Texas has a large number of rural hospitals, and for many, Medicare and Medicaid represent 70 percent or more of their patients. Uninsured may represent only 10 percent. Rather than try to resolve rural needs with special programs, such as Critical Access or Sole Community hospital designations, a more efficient approach would be to **do away with the multiple special designations and establish blanket cost-based reimbursement for rural hospitals.**

Physician/Hospital Alignment

- To achieve efficiencies in care, improve quality and outcomes for patients, and use resources most appropriately, physician payment incentives need to be better aligned with hospitals' performance measures.
- Greater transparency for all providers will help achieve this goal.
- Variations in practice and utilization of resources can be addressed through the practice of evidence-based medicine.

Tax-exempt Status

- A hospital's tax-exempt status is based on the benefits it provides to the community, not just on caring for uninsured patients. A nonprofit hospital tailors its programs and services to the needs of its particular community and/or build on its strengths. For example, a hospital may serve its community through a concentration on caring for children or supporting research or teaching.
- Next year, tax-exempt hospitals will begin filing a new IRS form, Schedule H, which will provide a much more complete picture of the range and scope of programs, activities and practices in which hospitals are engaged.

Indirect Medical Education

- Hospitals play an important role in medical education. With the expansion in coverage and the pent-up demand for health services, the capacity of the system likely will be strained. More physicians will be needed, and IME helps support hospitals that participate in their education and training.

End-of-Life Care

- Reform must help Americans accept the reality of death, and make tough decisions about the kinds of treatments and interventions provided in end-of-life care. Broad public education is needed.
- Advance directives should be encouraged strongly.

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