The Changing Hospital Sector in Washington, D.C. Implications for the Poor
Testimony before the DC City Council, Committee on Human Services
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INTRODUCTION
The Urban Institute has recently issued a report entitled "The Changing Hospital Sector in Washington, DC: Implications for the Poor" based on research funded by the Robert Wood Johnson Foundation. Copies are available on the table by the door.

In this report, we discuss the structure of the DC hospital market, with respect to its 11 non-fed, acute care hospitals, how the market is changing, and hospital strategies for the future. We then look at how the changing hospital market is affecting care for the poor and uninsured and consider how the District might formulate a policy that responds to the needs of this constituency while also recognizing the needs of its insured residents and the challenges faced by the hospitals themselves.

The study conceived 4 years ago. Talk then was of a highly overbedded hospital market of severely financially stressed hospitals with pressure thought likely to rise rather than abate. As we have just heard, not much has changed in this regard. It was widely expected then that one or more hospitals would close.

Perhaps the most interesting finding of our study is the obvious one, none of the hospitals have closed. Major restructuring is nonetheless still expected and, based on the experience in other markets, change can occur rather quickly once it has begun. Other markets have had change precipitated by the entry of a for-profit entity or by a hospital merger, both of which, as you know, have now occurred in Washington.

THE DC HEALTH CARE MARKET
The DC health care market, like every market, has unique features. Perhaps most salient is the structure of its health insurance market. Washington has what could be called a bimodal health insurance pattern. On one end there is a professional class that is demanding in its health insurance and its health care. The Federal Employees Health Benefits Program has historically subsidized the high end of the insurance market. Other local employers are pushed to match the Fed offering in order to compete in the labor market.

At the other end, DC has a high number of uninsured and a high proportion of its population on Medicaid, as you have noted. Current estimates put the number of uninsured DC residents at about 80,000 and the number on Medicaid at 125,000 at any given time. Together these two groups represent well over one third of the city's population including well over half of its children.

HEALTH RESOURCES
Traditionally, the city's insurance structure and its position as the center of the metropolitan area have supported a very rich set of medical resources, with the number of healthcare professionals and hospital beds per capita far exceeding national averages. It is particularly unusual for a city of only half a million people to have so many tertiary care hospitals, that is, hospitals that provide a full range of services from primary care through high tech procedures. We have four, three of which have associated medical school facilities.

District hospitals currently draw some 30-40% of their patients from outside of the District but the suburban hospitals, such as Inova in Virginia and the Adventist system in Maryland are becoming more competitive with the District facilities in various specialties. In addition, the market for high tech services is becoming more regional with Johns Hopkins increasingly viewed as a competitor in the DC market.

The map on the inside cover of the report shows the location of the 11 study hospitals and the characteristics of the neighborhoods in which each is located.
While the mission that a hospital has chosen for itself is important the location of the hospital is a major determinant of the patients it serves and its payor mix, that is, the source of payment for its patients, including the patients who can't pay at all.

**MARKET FORCES**

Within this market DC hospitals are facing many of the same pressures that hospitals are facing all over the country. There is a shift in the preferred setting for the provision of care from inpatient to outpatient. In the market we see increased power of buyers of care relative to providers of care, and the changes in public insurance—Medicaid, Medicare—mirror the changes in the private sphere with declining reimbursement rates and increased management of care. Finally, there is nationally a rising number of uninsured.

The result is of all of these changes is that hospitals increasingly find themselves competing for a declining number of paying patients and rather than commanding their own prices as they have in the past they are more often negotiating hard for prices that will cover their costs or are simply accepting the price that is offered hoping to bring costs down to meet expected revenues. This pressure on revenues has meant that there is less of a financial cushion for non-reimbursed expenditures such as care for the uninsured. At the same time, demand for charity care is not decreasing.

Hospitals are being squeezed from all sides as we have just heard. While there is a fairly low penetration of managed care in DC relative to other comparable urban areas managed care is, nonetheless, an important contributor to the price pressure. Hospitals fear that Medicare may follow Medicaid’s lead and move further in the direction of managed care. Other price pressure comes from the private insurance plans who gain market leverage from the overbedded market. Recent consolidations in the insurance market have the potential to further increase the leverage that insurance plans have over providers. In addition, safety net support for hospitals serving Medicaid and uninsured patients through federal disproportionate share hospital (DSH) payments is scheduled to decline over time.

Each of the city’s hospitals is affected differently by the changing market, depending on its mission, history, location, payor mix, and current financial position. But, given the forces acting on the hospitals, no hospital has escaped the pressure and change is inevitable.

**ROLE OF POLICY**

In our research, we found that individual hospitals had developed strategies designed to ensure their individual survival. But what is good for individual hospitals is not necessarily good for the health system as a whole. Taking the broader view is the role of policy makers who need to be able to formulate policies that can guide change rather than react to a change once it has occurred.

The District has multiple interests in the hospital market and, through its choice of policy, it must balance its competing roles. In its role as a buyer of health care through its employees’ health plan and the Medicaid program and as an advocate for its insured citizens and its employers that also buy hospital care, its concern is that care be provided at the lowest price that is consistent with quality. In its role as a provider of health care through the Public Benefits Corporation (PBC) facilities and as an advocate for its poor and uninsured citizens, its concern is that necessary health care be available and affordable for all of its citizens and that hospitals that choose to provide care for the poor and uninsured not, as a result of that choice, be put at a competitive disadvantage in what is currently a highly competitive hospital market. Finally, the District has an interest in maintaining a favorable economic climate in the city. Hospitals, like other businesses, need to have a clear set of regulations under which they operate, regulations that are sufficient to ensure that the public interest in maintaining a favorable economic climate in the city. Hospitals, like other businesses, need to have a clear set of regulations under which they operate, regulations that are sufficient to ensure that the public interest is met, but that also facilitate rather than inhibit efficient operations in the hospital sector.

It is this need to foster affordability, accessibility, and efficiency that justifies public policy intervention in the hospital market. It is the imminence of change in the hospital sector that argues strongly for intervention soon.

**HOSPITAL STRATEGIES FOR CHANGE**

At bottom, there are two basic strategies. The hospitals can either cut costs or raise revenues. To date, DC hospitals have used strategies that might be characterized as rather old fashioned, that is, they’ve taken straightforward action, with each hospital acting on its own. All have changed management, trimmed staffing, improved collections and made other improvements. Pressures to save are intense, not quite at airline level yet of worrying about weight of paint on the plane, but they’re getting there.

Making more advanced changes requires capital investment or partners or both. These changes would include:

- Advanced management information systems
- Enhancements of facilities to attract physicians and patients
- Coordination of entire continuum of care.
- Intra-city mergers much discussed, but never realized.

The recent MedLantic merger with Helix involves a DC hospital and a Baltimore system. The new name won’t be out until January; I’m betting it won’t be Ant-ix. Just now, they’ve made a more complex economy—rolling their outstanding debt together and refinancing as a package. Within the city Washington Hospital Center (WHC) was rebuffed by George Washington (GW) before GW found its current for-profit partner. Greater Southeast made overtures to DC General and Howard without action.
Competition is rather old-fashioned, too, not for whole blocs of patients, but for one at a time. HMOs or self-insured employers are not moving entire populations from one hospital to another, they’re trying to keep people out of hospital and get lowest price they can from each hospital. Most payers will cover care in most hospitals. There seem to be relatively few tight networks of care that exclude lots of hospitals. One hospital executive noted that when managed care came in, they bid low in expectation of extra volume of patients channeled to them. They got the low price but not the extra patients.

Unfortunately for the uninsured, cutting uncompensated care is a relatively simple, low-tech economizing move. There is evidence that this has occurred, as uncompensated care has dropped in real dollars over 1991-96 and as a share of total hospital expenses. No hospital said they were targeting the uninsured for cuts, but none saw them as a target market, either.

All hospitals are paying a lot of attention to their target markets. Community hospitals seek a niche, tertiary ones seek to compete on quality and reputation and to maintain price differential over others. For example, in no particular order:

- Washington Hospital Center seeks to capitalize on its reputation as preeminent in trauma, burns, and cardiology.
- GW has obtained for-profit backing and is planning to build a new facility to woo back doctors who left during its period of great uncertainty.
- Hadley is located in a high-poverty area and has emphasized Medicare patients.
- Georgetown is emphasizing physician networks and seeking to attract northern Virginia patients.
- WHC, Georgetown, and GW are seeking to woo paying customers from overseas.
- The PBC running DC General is keeping all its options open as it seeks ways to accomplish its mission under its new quasi-public structure.

Almost everyone expects some closure or major realignments, no one expects to lose out.

**POSSIBLE SCENARIOS**

We don’t know exactly what will happen; we were surprised at resilience of hospitals to date. Consider three scenarios:

1. Continued independence and survival of all hospitals, with continued downsizing and other economies.
2. One or more facilities close, through merger or otherwise; the remainder face somewhat less competition.
3. Major realignment into systems, both within the city and across borders, probably especially into Maryland, as in the WHC-Helix merger recently announced. Maryland competition may intensify if rate setting there ended.

**PUBLIC POLICY**

No particular outcome is necessarily good or bad. The public interest is twofold:

(a) **efficient** delivery of hospital care through continued competition, and
(b) **equitable** access for uninsured through some mechanism.

Closure or mergers could eliminate unused beds and duplication of services, thus making the whole system more efficient. However, such apparent streamlining would also reduce competition and might lead to higher earnings rather than lower prices. Dare we say that some were a bit wistful about desiring less intense price competition?

Our focus is on the uninsured and the uncompensated care that they create for hospitals, but uncompensated care affects efficiency, too. To the extent that some hospitals by dint of location or otherwise, provide a lower share of free care, they are getting a free ride in price competition. And payers would benefit from change to increase the incentives for efficiency.

What public policies have traditionally protected the uninsured who are too poor to pay their own way? Basically, there are three:

- **nonprofit requirement** of 3% of adjusted revenues, funded from earnings,
- DC General **subsidy** as provider of last resort, and
- **DSH** funds for big safety net hospitals.

All have known problems. The 3% is hard to enforce where demand is low, and irrelevant where demand is high. Overall, of course, demand is higher, given almost 20% uninsured among under-65s. Even with the expansions in coverage, the District is contemplating, at least 60K will remain uncovered. Moreover, DSH funds are scheduled to decline. Finally, paying DSH or subsidies in big lumps doesn’t give hospitals incentives either to take an additional patient or to be efficient in patterns of care.

Uncompensated care is already down overall, as noted above. It’s a tempting target for reduction in that it does not require expensive new systems. And the more focus of hospital attention shifts to the market, the less attention there can be for non-paying patients. It’s simple logic that markets act to serve those with money to spend. Running a hospital is harder than ever—they have to compete ever harder for paying patients; they must strive to stay on payers’ list of approved hospitals at livable price, and they need to earn
net revenues to spend on improvements to stay competitive.

For DC, the crunch is likely to come via DC General and its parent PBC which are legally obligated to serve. Already, uncompensated care has shifted there—DC General has some 36% of total in latest statistics. Should there be a major change at one of the other 3 big providers of uncompensated care, DC General will face a very big leap in demand; it could precipitate a political or a budget crunch for the District government.

**Implications for DC Government**

Two final points about the implications for the District government. First, the timing of this project was on its own track, but the report comes during what seems a window of opportunity for action, with big changes already under way, as attested by this hearing. There seems a drive toward more coordinated, more forward-looking decision making in DC civil service. New initiatives are underway and under consideration in Medicaid.

The new arrangements between the PBC and the city are being hammered out, and the city generally seems to be making a fresh start both fiscally and politically, with talk of a return to more home rule and with a new mayor.

Second, there is a clear case for taking action. Without decisive decisions soon, the market will move on its own, with perhaps sudden changes. Then access for the poor will dwindle and quite possibly lead to a political-fiscal crisis for the city sometime rather soon.

It seems better to act in advance to re-engineer the safety net for the era of price competition. The traditional safety net may not yet be broken as much as was expected at the start of this project, but it’s certainly fraying. The top city priority in this area is reducing the uninsured—a very positive development since we finished our interviews. Still, this will leave 60,000 uninsured by city projections, not to mention the undocumented population and floaters.

As a first step, we suggest also that the city create explicit policy for the uninsured on which market actors can rely. The city can choose among options ranging from doing nothing, and then watching erosion in uncompensated care and growing problems for DC General, to implementing formal new payment structures for the uninsured.

Consider three potential principles for any new payment policy. First, some funding should follow patients so as to honor patient choice and reward providers actually serving each patient. Second, the most fundamental safety net function is to assure available capacity. This calls for some amount of core funding, for the PBC, other institutions, or both. Third, it is desirable to promote efficient delivery of charity, including substitution of ambulatory for inpatient care, but it’s hard to know how.

If such change is desired, we note that various models exist for raising and paying out charity funds. We have also brought another Urban Institute reports on the safety net in 17 communities in 13 states, not including DC. We have offered these reports and this briefing to help provide starting points for such public decision making. Now we open the floor for questions.