Minnesota Hospital Association

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The Honorable Max Baucus
Chair
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Charles Grassley
Ranking Member
Senate Finance Committee
219 Senate Office Building
Washington, DC 20510

Dear Chairman Baucus and Ranking Member Grassley:

On behalf of the 149 hospitals and 17 health system members of the Minnesota Hospital Association (MHA), we appreciate the opportunity to comment on the Senate Finance Committee's "Financing Comprehensive Health Care Reform: Proposed Health System Savings and Revenue Options." MHA appreciates the chance to offer input at the early stages of the legislative process and encourages the Committee to allow for similar opportunities as health reform legislation moves forward.

The Senate Finance Committee (SFC) proposed several different reforms for financing America's health system. Most troubling, are the SFC's proposals to impose unnecessary, premature and cost-additive requirements on charitable hospitals and to slash necessary funding for medical education and payments to hospitals who shoulder the greatest costs for providing care to the country's uninsured and government-insured residents.

After a detailed study of Minnesota hospitals' community benefit activities compared to the value of their tax-exempt status, the Minnesota Department of Health concluded that hospitals provide $125 million more in charitable activities and programs for our communities than they receive in tax-exempt advantages. Likewise, Minnesota's hospitals led the nation in unanimously agreeing to fair billing and collections practices, including fair pricing for the uninsured, when the issue was brought to their attention. Year after year, MHA documents the tremendous value hospitals provide in community benefit activities – almost $2 billion in fiscal year 2007 – and the Internal Revenue Service's new Form 990 Schedule H will add new transparency to this area. Accordingly, congressional action to impose new regulations before the Schedule H data is collected, let alone analyzed or publicly discussed, is premature and unnecessary. Its costs in accountants, auditors and attorneys will only serve to drive health care expenses higher without making any improvement in the quality of health care, improving patient safety, expanding health insurance coverage or alleviating the financial burden of employers and individuals. MHA urges the SFC to decline to adopt the proposals regarding hospitals' tax-exempt status and, instead, focus its efforts on the reforms and initiatives aimed at improving health care delivery, bringing health insurance to more Americans, and creating a payment system that aligns providers' and patients' best interests.

Another significant concern for MHA and its members are the suggestions to cut funding for medical education and hospitals that serve a high proportion of low-income patients. In its first policy options paper addressing delivery system reforms, the SFC appeared to acknowledge the need for additional, not less, resources for medical education especially for primary care and general surgeons in rural areas. None of the SFC's proposals, in this third policy options paper or its previous two papers, contains replacement sources of funding for these essential services. So, what that paper proposed to give, this paper takes away and suggests cutting even deeper.

Reasonable minds can disagree about whether current methods for financing medical education and care for low-income residents are the better than other alternatives. MHA looks forward to engaging the Committee in a discussion about and examination of other options. However, without identifying other sustainable, adequate sources of revenue for providers who take on these costly and necessary services – services that the newly reformed system's success will depend upon – MHA has grave concerns about the viability of the SFC's proposals and the devastating impact they could have on health care. MHA's concerns regarding these aspects of the Committee's suggestions are outlined in further detail below.

In Minnesota, MHA has counseled our policymakers that health care, while used on a patient-by-patient basis, is a community asset that benefits everyone. Also, MHA has taken the position that meaningful reform requires additional revenue, at least during a transition period, before long-term savings can be captured. Cuts to provider payments, whether through pay-for-performance, value-based purchasing withholds, suspension of rate rebasing or market basket updates, or shifting greater financial burdens to consumers through high deductible plans and increased cost sharing are strategies designed for failure because they can't simultaneously deliver the transformational changes in the delivery system and expanded insurance coverage necessary for successful health care reform. Accordingly, health care financing needs to identify new revenue sources and the sources of that funding should strike a balance between broad-based revenues spread fairly across as much of the population as possible, targeted revenues from behaviors that undermine the population's health, and user-generated revenues tied to the amount of services individuals consume. MHA hopes that the SFC will consider multiple options within each of these categories of revenue sources – small, broad-based revenue collection tools, targeted taxes or surcharges on behaviors that decrease population health and increase health care costs, and user fees typically paid in the form of insurance premiums, co-pays, deductibles, etc.

In considering various financing tools, it is important to avoid mechanisms that make appropriate, preventive, or cost-effective care financially inaccessible to anyone. Because society ultimately bears the costs associated with preventive or cost-effective care denied or delayed, those services should not be relied upon to generate revenue if doing so makes them unaffordable.

Finally, MHA urges the SFC to strive to design a financing system with preferences for leveraging existing health care infrastructure and maximizing its utility, rather than ignoring those existing assets and unintentionally creating incentives for new, duplicative or unnecessary capital investments. A new financing system that fails to recognize and leverage existing infrastructure capacity and injects incentives for new capital projects, boutiques or physician-owned hospitals will further increase overall health care costs, spread a strained workforce further and create destabilizing market forces without decreasing costs or improving health.

The financing options discussed in the Committee's policy paper are thought provoking and worthy of serious consideration and open debate. Admittedly, it is difficult for MHA to provide guidance and support or opposition to any particular financing option or collection of options without knowing how they will tie back to the policy options for delivery system reform and coverage expansions. A financing system that generates too little or too much revenue for the reforms chosen will be scrutinized and that scrutiny could undermine other beneficial policy changes. Therefore, we offer the following comments in the hope that they will be addressed in the congressional deliberations to come and we look forward to future opportunities to offer comments as further details combining policy reforms and the necessary financing tied to those reforms are available.

Improving Payment Accuracy through Adjusting Annual Market Basket Updates

Congress should retain market basket updates as a means to adjust provider payments to reflect economic, workforce and delivery changes. As the SFC considers options that might allow for refining future market basket updates to target perceived inequities in payments or imbalanced incentives, MHA urges the SFC to implement those refinements gradually to allow the market to respond in a more smooth and controlled manner instead of fast, destabilizing adjustments that often have more unintended consequences. This gradual implementation schedule is especially important at this point in history as the impacts of the current economic upheaval are still unfolding.

Likewise, MHA suggests that the SFC consider developing tools to use the market basket updates to address inequities in Medicare payments between various regions of the country. By increasing rates nationwide, the current market basket update process solidifies existing payment disparities. Previously, the Committee's policy options regarding delivery system reforms considered using value-based purchasing and payment withholds as a means to penalize inefficient or low-quality providers. As outlined, that proposal did not articulate a method to reward the most efficient, high-quality providers. By targeting larger market basket updates to highly efficient and currently underpaid areas of the country like the Midwest, the SFC could create a mechanism that would alleviate these disparities over time without the administrative costs and complexities of the payment withholds discussed in the other paper.

Updating Payment Rates for Home Health Services

In a comprehensively reformed health care system, the SFC might want to consider updating payment rates for many services lines, including those for which increased payments are necessary. While MHA does not oppose updated home health service payments per se, MHA is concerned that the Committee targeted its financing reforms at those services for which it intends to decrease payments and failed to consider or account for currently under-financed health care services. In particular, most hospitals in Minnesota must subsidize services such as trauma care, burn units, mental health care, chemical dependency treatment and other below-cost reimbursement areas. The Committee's proposals, however, do not adequately address the need for updating payment rates in these areas.

"Comprehensive" reform is not accomplished if the only payment rates Congress updates are those that are perceived to be high at this moment in time. Instead, comprehensive reform requires updating payment rates across the continuum of care to ensure that sufficient financing exists to meet the needs of the community without creating artificial incentives based on payment schemes or rates rather than patient needs.

As stated earlier, MHA supports implementing any payment updates gradually over multiple years.

Updating Payment Rates for Inpatient Services

The foundational premise of the SFC's discussion of disproportionate share hospital (DSH) and graduate medical education (GME) payments is that current payment rates exceed the actual costs of providing these services. At the same time, other reforms put forth by the SFC are based on the notion that current financing schemes pay too much for certain services, which proliferate in the market beyond what is necessary to efficiently meet demand. Following the SFC's reasoning, teaching hospitals and hospitals with high uncompensated care should be enjoying comparatively high margins and supply of those services should exceed what is necessary to meet demand. It is hard to imagine a state of affairs that could better demonstrate the fundamental miscalculation embedded in the SFC's recommendation.

Medical education has become unaffordable. It is unaffordable for the too-few students who graduate with crushing debt. It is unaffordable for the teaching hospitals that bear increased capital and operating costs to train the physicians that practice throughout the country. It is unaffordable for the hospitals who incur additional costs to compete with one another to attract the small number of new physicians, nurses, and other health care workers that our higher education system is able to produce.

The question the SFC should be asking is how to make medical education and training of tomorrow's workforce more affordable and sustainable for all the parties involved. The proposal to slash funding for graduate medical education will save some money in the short run at the long-term cost of exacerbating the physician shortage and significantly restricting the programs offered at teaching hospitals. Our country's entire health care system depends upon the work of teaching hospitals. Targeting cuts for teaching hospitals without another sustainable funding strategy will diminish an already stressed system that, in turn, will cause health care costs to increase and access to services to decrease as physicians and health care workers become even scarcer.

Likewise, cuts to DSH payments will further strain those hospitals that serve large numbers of low-income residents. Other reforms considered by the SFC promise to dramatically reduce the number of uninsured people in our country. As more and more patients have adequate health insurance, the need for DSH payments is likely to wither. However, anticipatory cuts to DSH payments before evidence of decreased need for these funds to support the health care safety net, would be premature and misguided. MHA suggests that the SFC table these cuts and reconsider them at a later date when evidence of the proposed reforms and how they have played out in the market can be examined so the DSH payment system can be reformed thoughtfully and in a manner designed to continue support where its needed and cut payments where need no longer exists.

Adjusting Reimbursement for High-Growth, Over-Valued Physician Services

The two sentences of proposed options are insufficient to allow MHA to offer meaningful comment.

More Appropriate Payment for Durable Medical Equipment

MHA supports the SFC's inclination to refrain from making payment reform proposals before studying the current payment rates and receiving expert advice about potential reforms. As the Committee explores options to change payments for durable medical equipment, MHA requests that appropriate incentives for innovation, health or quality of life improvement, and sufficient supply are considered in addition to costs so that the health care system continues to evolve in a manner that advances patients' interests.

Capturing Productivity Gains

The Committee's proposal reflects a repeated concern MHA has raised in each of its two previous comment letters: the reforms contemplated offer significant opportunity for those currently high-cost, inefficient providers, while putting little if any reward opportunities for already efficient, high-quality, low-cost providers like those in Minnesota. Federal efforts to expand coverage or calculate payments have historically followed the "no good deed goes unpunished" creed by withholding federal funding or failing to provide any reward for states or providers that made necessary changes for the public's benefit before the federal changes.

The proposal to adjust market basket updates for expected productivity gains may not be as threatening or disconcerting for providers that have significant capacity for productivity gains, but for those providers that already perform at nation-leading efficiency, such a proposal offers little good news and carry the potential for undeserved cuts.

The proposal outlined contains few details. MHA encourages the Committee to look for ways to ensure that highly productive providers are rewarded for their efforts, even if those efforts and investments were in place before these reforms are implemented.

Reducing Geographic Variation in Spending

MHA applauds the SFC's interest in addressing unnecessary geographic variations in health care spending. One benchmark that should be used to assess whether national health care reform efforts are successful is whether the health care financing system reduces and eventually eliminates geographic risk-adjusted payment disparities.

The Committee sets forth two options for consideration. The first option, reducing spending in areas where per beneficiary spending compared to the national average exceeds a certain threshold, is tailored to achieve the desired outcome. Benchmarking to a national average and decreasing payments to realign per beneficiary spending to a national standard will, over time, reduce geographic disparities.

The second option, however, would fail to reduce geographic disparities on its own. This option proposes to reduce payments to providers that exceed thresholds when compared to their peers in their own local area. Essentially, this option creates regional thresholds and consequently would allow existing payment variations between regions to continue unabated.

Again, however, MHA urges the SFC to consider options that not only impose financial consequences on high-cost providers, but also offer financial rewards for those providers who excel at delivering high-quality, low-cost care.

Making Beneficiary Contributions More Predictable

As with reducing geographic variations in provider payments, MHA also supports the SFC's inclination to address variations in beneficiary contributions. These market-leveling reforms, especially when combined with other reforms such as a national health insurance exchange, are important to ensure that stakeholders competing on an increasingly national basis have similar opportunities to succeed based on the value they offer to patients.

Minnesota hospitals applaud the Committee's interest in not only making the beneficiary costs more uniform, but also making them simpler for beneficiaries to understand and predict. Too often the complexity of cost-sharing requirements create additional stress for patients struggling to address their immediate health needs. Making cost-sharing obligations more predictable and simple will help alleviate this source of anxiety for our patients.

Options to Modify the Exclusion for Employer-Provided Health Coverage

The SFC recognizes the importance of employer-based health insurance in reaching the overall goals of expanding health coverage. As the Committee examines alternatives that are geared toward defining a level above which health insurance benefits become taxable, MHA cautions the Committee to avoid using another adjustable benefit set or insurance offering as the benchmark for that threshold. One of the options discussed by the SFC is to base the analysis of taxable benefits to the actuarial value of a benchmark plan. The risk to this strategy is that the benchmark plan's benefits can be adjusted, thereby impacting the taxability of benefits.

For example, assume the Federal Employee Health Benefit Program (FEHBP) standard option is used as the benchmark plan as suggested by the SFC and that plan is considered to have an actuarial value of $5,000 per year. Tax policy decisions are then made using this plan and its value as the benchmark, individuals and the employer-sponsored insurance market begins to respond and, then, the FEHBP plan is revised in a manner that reduces its actuarial value to $3,500. That reduction in benefits results in significant tax-policy implications for employers and individuals without the customary revenue regulatory comment period.

In short, the benchmark plan's benefit design suddenly becomes a matter of national tax policy, thereby radically expanding the scope and intensity of the issues surrounding its benefit structure. The risk for the health care system is that revenue streams become subject to easy manipulation and wild vacillations through one health plan's benefit design rather than congressional hearings or the IRS or CMS regulatory process.

Modify the Requirements for Tax-Exempt Hospitals

Minnesota hospitals have served as national leaders for their efforts to promote transparency and accountability regarding their tax-exempt status and the value that they provide to their communities. Although the proposals alluded to by the SFC lack details, they offer a glimpse of what the Committee might consider. Such proposals are unnecessary, premature and, if adopted, will increase overall health care spending without commensurate improvement in patient care. Accordingly, MHA encourages the Committee to reject these proposals at this time and focus its efforts on the reforms aimed at improving the quality of care, expanding coverage and making health care more affordable.

First, these proposed changes are unnecessary. Minnesota's charitable, tax-exempt hospitals, like many others throughout the country, embraced transparency of their community benefit activities. MHA produces an annual report of our hospital members' community benefit activities, and many of our individual members produce their own public reports. Year after year, those reports demonstrate the measurable, meaningful, charitable activities, programs and accomplishments that hospitals undertake in communities throughout the state.

As national leaders questioned whether charitable hospitals' community benefit activities merited their tax-exempt status – a question not posed to other nonprofit sectors with far less transparency or measurable community benefits – the Minnesota Department of Health conducted its own analysis. The department used a narrow definition of community benefits – one that was more restrictive than what the Internal Revenue Service has adopted for its new Schedule H – and an extremely broad definition of the value of tax-exempt status – one that included state and federal income tax benefits, real estate and sales tax exemptions, tax-exempt bonds, and the ability to receive tax-exempt donations. It compared the monetary value of hospitals' community benefit activities to the value of the tax-exempt status they enjoyed and concluded that ***Minnesota hospitals provided at least $125 million more in community benefits than the value of all of their tax-exempt advantages combined***.
Moreover, several years ago, every hospital in Minnesota agreed to standards of billing and collection practices, including a fair pricing methodology for patients without health insurance. This agreement, the first of its kind in the country, paved the way for hospitals in many other states to adopt similar standards and protocols. As a result, uninsured patients in Minnesota and elsewhere in the country no longer bear the unintended hardship of the current system's charge-based payment system and, instead, benefit from the negotiating power of hospitals' largest commercial payers.

Because of these voluntary efforts on the part of Minnesota's non-profit hospitals, the proposals suggested by the SFC are unnecessary. In fact, Minnesota hospitals have demonstrated that they respond appropriately when concerns or inequities in the current system are brought forward. Federal regulatory actions are unnecessary.

In addition, the proposals contemplated by the Committee are premature. The new Form 990 and its new Schedule H are early in their implementation. The information that will be collected through that process has not had an opportunity to demonstrate the impact it will have without congressional action. Consumers, advocates, academics and regulators have not had even one year's data to analyze. The SFC should allow that process to unfold, let the data speak and let the markets respond beyond leaping to new regulations, thresholds and requirements.

This is especially important given the other substantial reforms the Committee is considering, especially those that are aimed at expanding coverage and altering revenue streams for hospitals. If the SFC pushes new charity care and community benefit thresholds and expands coverage to previously uninsured patients while simultaneously disrupting hospitals' revenue stream and cash flow with new withholds and rate cuts, the impact on hospitals could be far more disruptive than the Committee intends. Instead, MHA urges the SFC to table decisions regarding tax-exempt organization standards until the new transparency of Schedule H and the impact of other health care reforms are known.

Finally, the proposed changes will increase overall health care spending without improving patient care. None of the proposals outlined by the SFC or suggested earlier by Senator Grassley are designed to improve patient care. All of them, however, will increase costs for hospitals as their accountants, auditors, attorneys and other back-office personnel invest more time and resources to accommodate the new regulations. Likewise, the IRS and other federal agencies will require additional funding to promulgate the implementing rules and regulations, retrain their staff, update forms and, of course, invest in auditing, compliance investigations and litigation. All of these additional expenses will push the health care system's budget higher and higher without being used to improve patient safety, increase the quality of patient care, insure more patients, or reduce the financial burdens on individuals and employers.

Accordingly, MHA urges the SFC to focus its agenda and efforts on the goals most pertinent to successful health care reform: improving patient care, expanding health insurance coverage, and aligning the payment system to reduce geographic disparities and reward efficiency and quality instead of volume. Hospitals' tax-exempt status and the need for any future regulations in that area can be pursued when the data from the new Schedule H and the impacts from comprehensive health reform show that a need for such regulations exists.

MHA appreciates the opportunity to offer these comments at this stage in the legislative process and looks forward to future opportunities to respond to other proposals from the Committee, as well as the ultimate bills and amendments aimed at enacting the best ideas for improving Americans' health and America's health system. If you have any questions regarding these comments, please contact Ann Gibson, director of federal relations at (651) 603-3527 or anngibson@mnhospitals.org.

Sincerely,

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