Healthcare on the Brink: An Integrated Solution to Illinois' Health Care Crises

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Introduction

One of the most important duties of state government is to promote access to healthcare services. States use a variety of rules and regulations to achieve this goal, including directly subsidizing providers, making public insurance programs available, requiring nonprofit entities to provide community benefits (including charity care), and engaging in facility planning. These rules and regulations are not working. Many hospitals, especially those in established inner cities and older rural areas, are stretched to the limit trying to serve the uninsured and underinsured. At the same time, hospitals in burgeoning areas face substantial barriers to providing new services to meet the needs of their growing communities.

We propose an integrated solution to these access problems. Our proposal has 4 main features:

1) Simplification of the Certificate of Need (CON) process so as to facilitate addition of new services where needed, while protecting current providers from excessive and unfair competition

2) Requiring providers who receive CON to allocate a small percentage of their capital investment towards the provision of charity care

3) Requiring all nonprofit providers to allocate a small percentage of their annual revenue towards the provision of charity care

4) A "Floor and Trade" system that encourages providers to to find the best ways to provide charity care, rather than funneling revenues through the state

Access Problems Facing the Illinois Healthcare System

According to the Urban Institute and the Kaiser Commission, there were 1.5 million uninsured Illinois residents in 2006. Many of the uninsured receive charity care, especially from nonprofit hospitals, county hospitals, and community health centers. But many others face crippling medical bills. Other medically indigent are covered by Medicaid, but chronic underfunding of Medicaid has left provider payment lagging behind payments from Medicare and private insurance. As a result, many providers are reluctant to treat Medicaid patients. Those providers who do provide substantial care for the indigent struggle to make ends meet.

Access problems are not limited to the indigent population. Growth in many prosperous areas of the state has left local populations without local providers. The Illinois Health Facilities Planning Board regulates growth through the Certificate of Need process. This process has been

deemed necessary to rationalize growth and protect existing providers from unfair competition. While the Board has approved several new hospitals and other large projects in the past few years, the CON process remains costly, cumbersome and time consuming, with construction of new facilities lagging growth in demand.

Some might recommend abolishing CON. While abolishing CON could improve access to care in growing areas of the state, it might further harm access for the indigent. Many new healthcare organizations such as specialty hospitals add to the competitive mix but do not necessarily serve the indigent.[1] To the extent that these organizations siphon off well-insured patients, they may leave established providers with inadequate financial resources to provide charity care. The potential exit of established, full-service providers would also have deleterious effects on access to appropriate care for all patients.

We offer a solution that simultaneously addresses the access needs of the indigent and of the residents of growing, prosperous communities. In the rest of this report, we describe the historical foundations for our proposal and give our specific recommendations for dealing with the access crisis.

The History of the Safety Net

It has long been recognized that nonprofit hospitals play a vital role in the healthcare safety net. In exchange for their nonprofit status, hospitals are expected to provide a commensurate level of community benefits. This special role for nonprofits was institutionalized in 1948 with the enactment of the federal Hill-Burton program. Under Hill-Burton, nonprofit hospitals received federal subsidies and, in exchange, were required to meet specific charity care targets. Hill-Burton obligations expired decades ago.

Illinois' nonprofit hospitals today devote about 14 percent of their revenues to providing "community benefits." Of this, less than 1 percent goes towards charity care. This relatively small level of charity care, combined with a growing number of uninsured, places an extraordinary strain on those providers whose missions dictate that they care for the uninsured regardless of financial considerations.

A Simple Solution

Nonprofit providers (not just hospitals) should once again be a major part of the healthcare safety net. We propose offering all nonprofit providers the following options for meeting enhanced obligations for charity care:

> 1) *Payment to State*: Allocate a minimum of 2.5 percent of revenue towards charity care, in the form of a payment to the state.[2]

[1] For-profit providers pay taxes that help meet many government objectives.

[2] An exemption is provided to nonprofit providers that can show that the tax breaks they receive amount to less than 3 percent of revenue. The allocation for these providers will be on a sliding scale.

or

2) *Floor and Trade*: Directly provide charity care in the amount of 2 percent of revenue or direct these funds to other nonprofit providers of their choice

Our proposal will immediately quadruple charity care provided or financed by hospitals from $250 million to $1 billion annually, and will likely increase charity care provided by other nonprofit providers.[3] We expect most providers to select the "Floor and Trade" option, keeping decisions about how to meet the needs of uninsured patients in their own hands. This may also encourage partnerships between providers in more prosperous areas and providers in economically disadvantaged areas.

Fixing CON

The CON program was developed at a time when unfettered healthcare competition often led to costly duplication and other inefficiencies. Supporters of CON argued that any delays in construction of new facilities were offset by the efficiencies that result from planning oversight. Yet supporters of CON acknowledge that the system is cumbersome. Providers must produce excessive and often useless information. There is no need for detailed financial forecasts, for example, when bond agencies perform similar financial analyses. There is also no point in testimonials from physicians in support of utilization projections when they are never validated after the fact.

The healthcare system has evolved to the point where competition often helps consumers. By protecting providers, CON may be harming consumers. Of course, many analysts remain concerned about some of the worst aspects of competition. For example, there is some evidence that specialty hospitals may "cream skim" the most profitable patients. Ambulatory surgery centers might do the same, although the research here is lacking. Such cream skimming may exacerbate the problem of the safety net if it draws away resources from providers who might have used the money to provide charity care.

CON also provides an unfair advantage to holders of bed licenses, especially when the licenses were granted decades ago and the beds are unstaffed today. These providers can block entry by competitors without themselves taking steps to meet growing needs. Finally, CON spending thresholds are too low, standing in the way of small projects unlikely to have appreciable impacts on competition.

This discussion suggests that we need sensible CON reform that makes it easier for providers to meet growing and changing demands while at the same time protecting the vital safety net. We offer the following recommendations:

[3] Data on charity care by other nonprofits was not available to us.

1) Increase the dollar threshold for CON review, with a built-in annual inflation adjustment.

2) Eliminate burdensome aspects of CON review such as detailed financial and utilization projections.

3) Base need projections on actual service availability, rather than licensed availability.

4) Ban CON approval for specialty hospitals.[4]

5) Tie CON approval to charity care, as follows:

· Providers who win CON have a one-time charity care obligation equal to 2 percent of capital costs. This may be paid over the course of ten years.
· Providers who win CON have an additional ten year charity care obligation that is based on a percentage of revenues. This obligation will depend on the amount of Medicaid services provided. For example, this obligation will equal zero for providers with Medicaid patient shares above 30 percent, and 2 percent for providers with Medicaid patient shares under 10 percent. This is in addition to any nonprofit charity care obligations described above.
· Providers may meet these obligations by making a direct payment to the state, or by using the "floor and trade" system described above.
· Providers who instead use the "floor and trade" system reduce their obligations by 20 percent (e.g., instead of 2 percent, the obligation would be 1.6 percent.)

Conclusion

The proposals we offer are "win-win" for providers, patients, and taxpayers. Patients and taxpayers win will enjoy enhanced access without additional taxes or government bureaucracy. Providers will be liberated from the most cumbersome aspects of CON in exchange for a modest expenditure for charity care. And while some nonprofit providers will have to reallocate community benefit expenditures towards charity care, they are free to do so as they see fit. Our proposal is also likely to benefit providers in economically disadvantaged areas. The collapse of these essential safety net providers would have harmful repercussions for the entire system of healthcare in Illinois.

[4]There is some concern that ambulatory surgery centers may siphon off profitable patients at the expense of safety net hospitals. On the other hand, an outright ban on free-standing ASCs would give hospitals exclusive rights to ambulatory surgery. As there is no research to weigh these concerns, we propose subjecting new ASCs to the same safety net obligations as other CON applicants.