Issue Brief

Hospital Finance 101

THE Center FOR Health Affairs®

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On any given day in the United States, hospitals provide care to countless patients. Their task is not easy. Balancing their mission to serve all who come through their doors while simultaneously generating revenues to sustain their operations remains a challenge, especially in today's environment.

The financial pressures felt by hospitals in Northeast Ohio are no different – and the stakes are high. Our hospitals provide essential nationally and internationally renowned services for patients. They are also crucial to a local economy that has witnessed a declining manufacturing sector over the years. In fact, healthcare employment has grown consistently for the last decade in our region, and hospitals rank among the largest employers in every county in Northeast Ohio.

Unfortunately, the public is often unaware of the enormous challenges that threaten the very existence of local community hospitals, particularly those located in urban areas. Misperceptions about healthcare financing and operations can impede the public's appreciation of hospitals for what they truly are – community assets.

Following is a 30,000-foot view of hospital finance that is intended to shed some light on a complex system and provide a clear explanation of how hospitals generate revenue, what their expenses are, what factors influence hospitals' ability to deliver upon their mission, and how payer and service mix affect hospitals' financial viability.

How are hospital services paid for?

Typically, the bulk of a hospital bill is not paid for directly by the patient, but rather by an entity that provides health insurance, commonly termed the payer. In the United States, third-party payers fall into two main categories: private and government.

Private Payers

Nearly 70 percent of the U.S. population is covered by private insurance provided either through an employer or purchased directly by an individual.[1] Under employer-based coverage, employers contract with insurance companies to offer health insurance to their employees, and the employee and employer share the cost of the insurance premium. Employer-based health insurance covers more than 61 percent of the U.S. population.[2]

While the majority of those who are privately insured receive coverage through their employer, individuals who are self-employed or do not receive health insurance through their employers can also purchase health insurance directly from an insurance company. More than 9 percent of the U.S. population is covered by direct-purchase insurance.[3]

Government Payers

To provide a safety net, government programs provide health insurance for specific populations that might otherwise have difficulty obtaining coverage. Medicare and Medicaid, the two largest government payers, together cover one quarter of the U.S. population.

Medicare

Nationwide, more than 40 million people are enrolled to receive benefits through Medicare.[5]

In Ohio, 1.7 million people were covered by Medicare in 2002.[6]

A federal program established in 1965, Medicare is generally available to people age 65 and over as well as to certain persons under age 65 with disabilities or with end-stage renal disease. In the past, hospitals were reimbursed under Medicare based on the cost of care.[4] In an effort to contain costs, in 1983 the federal government switched to reimbursing healthcare providers using a prospective payment system for inpatient services. Under this system there are predetermined, fixed amounts that the federal government agrees to pay based on a patient's diagnosis and treatment. Since 2001, Medicare outpatient services have also been reimbursed using a prospective payment system.

Medicaid

Nationally, 40 million people are enrolled in Medicaid.[10]

Almost 15 percent of Ohioans, approximately 1.7 million people, are covered by Medicaid.[11]

Also established in 1965, Medicaid is a joint federal/state program that provides health insurance to eligible low-income and medically vulnerable people. States administer the program under broad federal guidelines specifying minimum coverage standards. Ohio sets eligibility guidelines for pregnant women at 150 percent of the federal poverty level, which is more generous than federal law requires.

Ohio Medicaid Income Eligibility Guidelines

Eligibility At a Glance[7]

Who's Covered?	Income Eligibility Guidelines
Children (up to age 19)	200% Federal Poverty Level (FPL)
Pregnant Women	150% FPL
Parents	100% FPL
Individuals with Disabilities	64% FPL[8]
Ohioans aged 65 or Older	64% FPL[9]

Source: The Ohio Department of Job and Family Services.
Office of Ohio Health Plans Fact Sheet. May 2003.
Note: In 2003, the federal poverty level was $15,260 for a family of three.

In Ohio, the federal government pays roughly 60 percent and the state government pays about 40 percent of Medicaid costs. As under Medicare, healthcare providers are generally reimbursed for inpatient care of Medicaid recipients based on a prospective payment system. Reimbursement methods for outpatient services vary across the states. In Ohio, healthcare providers are primarily reimbursed for outpatient services based on a percentage of the charge. Certain outpatient services, such as lab work, are reimbursed based on fees developed by the state.[12]

Self pay

The small percentage of uninsured individuals who have the ability to pay for some or all of their hospital costs out-of-pocket fall into the final payer group: self pay. There are many reasons why people find themselves in the undesirable situation of having to pay for the majority of their hospital expenses out-of-pocket. For some, private insurance may not be available through their employer. For others, private insurance may be offered by the employer, but the employee premium may be too expensive. Regardless of the reason, this group of payers does not have private insurance, does not qualify for government programs and tends to include a large portion of the working poor.

What are the sources of hospital revenues & expenses?

As with any other economic entity, hospitals must carefully balance their sources of revenue and their expenses. Intuitively, reimbursement for patient care is hospitals' primary source of revenue and their workforce is their largest expense, but other factors come into play on both sides of the ledger.

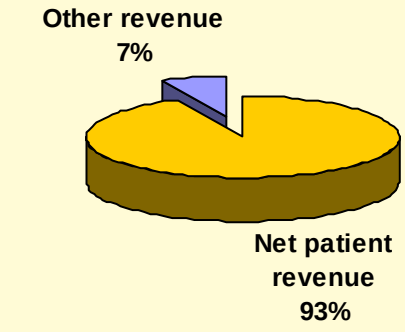
Revenues

In general, hospital revenues come from four sources:[13]

- Patient care services, both inpatient and outpatient
- Non-patient care services
- Investment income
- Grants and donations

'Room and board' for patients admitted to a hospital, medications, X-rays, physical therapy, and other support services are all examples of patient care services. In 2002, 93 percent of U.S. hospitals' net revenues came from delivering patient care, while all other sources accounted for just 7 percent of total net revenues.[14]

2002 U.S. Hospital Revenue Sources



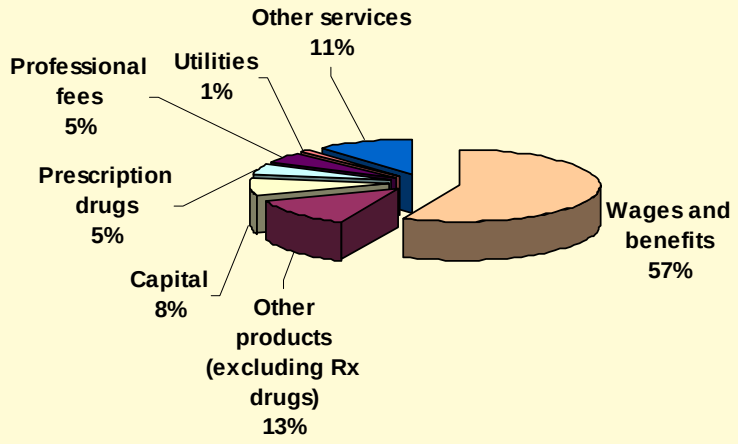
Source: American Hospital Association. Hospital Statistics: 2004 Edition. Health Forum LLC, 2004.
Note: Includes hospital and nursing home units.

While reimbursement for services is the primary source of revenue for hospitals, payers typically do not pay the full or gross charge for a service. It is also not uncommon for different payers to pay different rates for identical services. This is because insurance companies and government programs negotiate reduced rates with hospitals. Nationally in 2002, payers negotiated rates averaging about 42 percent of hospitals' charges, and in Ohio payers negotiated rates averaging 47 percent of charges.[15] As a result, hospitals often lose money on patient care. For example, in 2001, net patient service revenue for Northeast Ohio hospitals was roughly $75 million less than the cost of providing that care – before uncompensated care costs were even accounted for.[16]

Non-patient care services, such as parking garages, cafeterias and gift shops, create additional revenue for hospitals. Another revenue source, investment income, provides hospitals with the opportunity to maximize gains. However, the poor performance of the stock markets in recent years has affected both investment returns and the number of grants and donations for all types of non-profits,

including hospitals. While grants and donations provide a necessary revenue stream, it is typically difficult for hospitals to predict what amount of their revenues will come from this source.

Percent of Total Hospital Costs by Type of Expense



Source: PricewaterhouseCoopers.
Cost of Caring: Key Drivers of Growth in Spending on Hospital Care. February 19, 2003.

Expenses

Hospitals depend on a highly trained workforce to provide the advanced level of care and service that patients depend upon. As a result, labor costs, by far, are hospitals' largest expense. Wages and benefits account for more than 57 percent of all hospital expenses. Thirteen percent is spent on other products. Capital spending (described below) accounts for 8 percent of expenses while prescription drugs and professional fees each make up 5 percent of all costs. Utilities and other services account for the remaining 12 percent of hospital expenses.[17]

What factors drive hospital costs?

Due to the pressures from payers over the last several years to ratchet down reimbursement, hospitals vigilantly monitor the many additional elements that drive their costs. New technologies, costs resulting from workforce shortages and medical malpractice insurance spikes are some of these elements.

Workforce shortages

Because a hospital's workforce is its largest expense, it is not surprising that the healthcare labor shortage is a significant driver of costs. With 84 percent of hospitals reporting shortages of registered nurses, hospitals are developing creative strategies to fill these vacancies.[18] But shortages are not limited to the field of nursing. Hospitals are reporting shortages in other fields, including imaging technicians, pharmacists, laboratory technicians and billers/coders.[19]

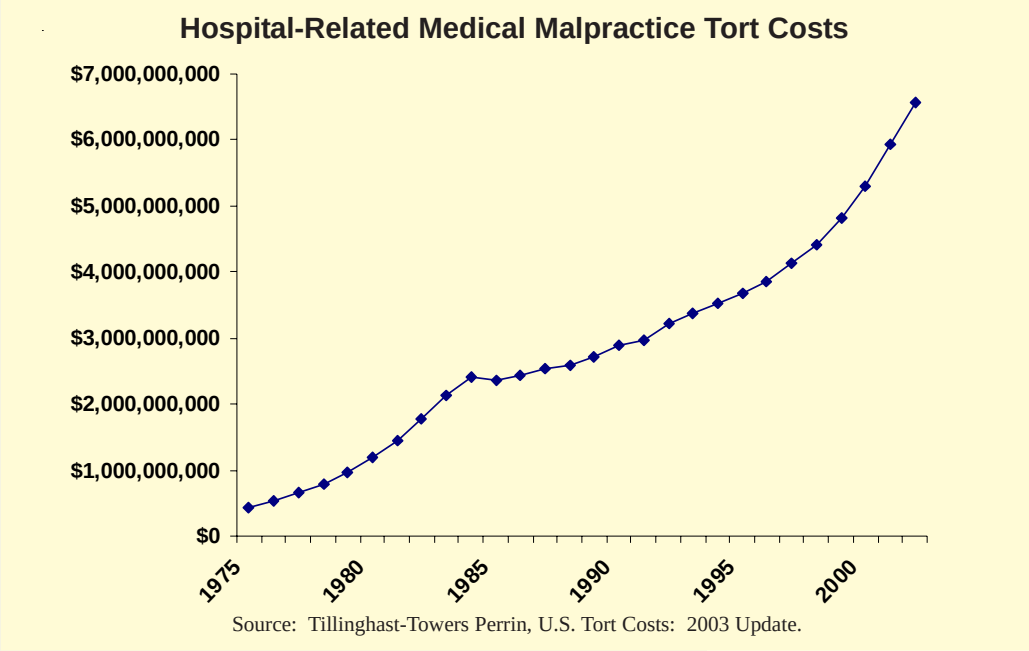
Filling these vacancies is a top priority for hospitals, but one that comes at a cost. To recruit registered nurses, 41 percent of hospitals pay sign-on bonuses that typically range from $1,000 to $5,000. More than one in two hospitals use agency or traveling nurses to fill registered nurse vacancies and typically pay agencies at least 20 percent above what they pay staff nurses.[20]

Medical malpractice

In recent years, healthcare providers nationwide have seen a dramatic rise in costs associated with medical malpractice insurance. A number of factors have contributed to this. Many believe premiums were artificially low in the 1990s as a result of the large number of insurers competing for business. The downturn in investment markets, profits from which had supported insurers' underwriting, also have played a role. However, spikes in lawsuit settlements and jury awards are arguably the most influential factor.

In 2002 medical malpractice tort costs, which include administrative and legal defense costs as well as jury awards and lawsuit settlements, were over $6.5 billion for U.S. hospitals, more than double the roughly $3.2 billion paid in 1992.[21] As jury awards rose, malpractice insurance premiums began to rise for both hospitals and physicians. More than 85 percent of hospitals nationally have faced increases of 10 percent or greater in professional liability premiums.[22] Doctors in high-risk fields such as obstetrics, neurology and emergency medicine face the highest increases in premiums. For instance, at least one insurance company in Cuyahoga County doubled its medical liability insurance rates for obstetricians over an 18-month year period.[23]

Rate hikes like this and the ensuing consequences have led the American Medical Association to rank Ohio and 18 other states as being in a medical liability insurance crisis. Anecdotal evidence supports this claim with frequent media coverage of doctors retiring early, leaving practice, and moving to states with lower liability insurance. These trends could compound the workforce shortages hospitals are currently reporting and threaten patients' ability to access care.



Source: Tillinghast-Towers Perrin, U.S. Tort Costs: 2003 Update.

Capital costs

To improve patient access and quality of care, hospitals are constantly investing in the newest technologies and ensuring that their buildings are able to meet the demand for services. Hospitals incur capital costs, otherwise known as borrowed money, to pay for most big-ticket items. Following are some of the most common sources of capital expenditures:

- Information technology advances: In 2001, U.S. healthcare providers, including hospitals, spent more than $20 billion on information technology (IT).[24] Advances in information technology hold promise for reducing medical errors, improving communication, reducing long-term costs and providing a greater quality of care for patients.

- Medical technology advances: Hospitals are also taking advantage of medical technologies that provide new ways of diagnosing and treating patients. In many cases this enables a broader array of patients to receive care that was previously too invasive or dangerous given their condition.[25] As with information technology, medical technology comes with at

times staggering costs to hospitals. Whereas traditional X-ray machines cost $175,000, the newer CAT scan machines can cost $1 million.[26]

- Facilities construction: Technological advancements, coupled with the growing demand for services due to an aging U.S. population, are contributing to the need for hospitals to maintain state-of-the-art facilities.[27] Simply accessing the capital to finance needed facilities updates is becoming difficult for hospitals as they are faced with increasingly higher interest rates that translate into higher overall costs for hospitals.[28]

Where does uncompensated care come in?

Uncompensated care is care that is provided but for which payment is not received, or is only partially received. Uncompensated care can include losses that result from free/charity care, government shortfalls and bad debts.

Community hospitals treat all patients who walk through their doors, regardless of their ability to pay. Recognizing the vast number of uninsured that need hospital services but do not have the means to pay their hospital bills, hospitals provide a certain amount of free, or charity, care each year for which they do not expect to be reimbursed. They are also required under state law to provide basic, medically necessary services to individuals at or below the federal poverty line.[29]

Depending on an area's demographics, some hospitals serve a higher proportion of indigent patients (Medicaid, uninsured and people below the federal poverty level). Recognizing the burden facing hospitals that serve high numbers of indigent patients, the federal government created the Disproportionate Share Hospital (DSH) program.

This program is meant to provide some additional dollars for hospitals that serve a disproportionately large number of indigent patients, but the funding does not fully cover hospitals' losses. In Ohio, hospitals pay into the state's DSH program, called the Hospital Care Assurance Program, and this helps draw down matching federal DSH funds. Funds are then distributed back to hospitals based on a formula that accounts for the percent of care provided to indigent patients.[34]

Bad debt results from a failure to receive payments from patients who have the ability but are unwilling to pay hospitals for all or a portion of the services they receive. This can include, for example, insurance co-payments and deductibles. While bad debt is often considered separately from charity care because of the difference in the patients' ability to pay, it is still a form of uncompensated care. Hospitals incur significant costs trying to collect pennies on the dollar for care provided to these patients. Bad debts present an enormous challenge for hospitals because they cannot always accurately forecast what percent of expected reimbursement won't be received.

Unfortunately, as indicated above, it is not uncommon for hospitals to experience losses even on care they are paid for, due to insufficient levels of reimbursement. Often Medicare and Medicaid fall short of covering the cost of providing care. In 2000, more than half of U.S. hospitals lost money serving Medicare patients and nearly three quarters lost money serving Medicaid patients.[30] These shortfalls are also considered a component of hospitals' uncompensated care.

Taken together, the amount of uncompensated care provided by hospitals is staggering. In 2001, U.S. hospitals provided $21.5 billion in uncompensated care resulting from charity care and bad debt.[31] That same year Ohio hospitals provided $716 million in uncompensated care from charity care, bad debt and Medicaid shortfalls,[32] with almost $237 million of that occurring in Northeast Ohio hospitals.[33]

What are payer mix and service mix?

Because of variations in reimbursement rates based on who is paying and what services are being provided, hospitals can face wide variations in their financial viability. Examining hospitals' payer mix and service mix can illuminate why some hospitals have more difficulty maintaining a positive bottom line than others.

"When you boil all the statistics and data down, the two essential elements that determine a hospital's ability to remain viable are payer mix and service mix."

Bill Ryan,
President & CEO
The Center for Health Affairs

Payer mix

Payer mix describes the proportion of reimbursement a hospital receives from different payers. A hospital's payer mix tends to be linked to the demographics of the surrounding community. For example, a community with a large elderly population would result in a payer mix that leans more toward Medicare, while large numbers of people living below the poverty line would likely result in a payer mix more heavily weighted toward Medicaid. County demographics provide some useful information for understanding the payer mix in Northeast Ohio hospitals.

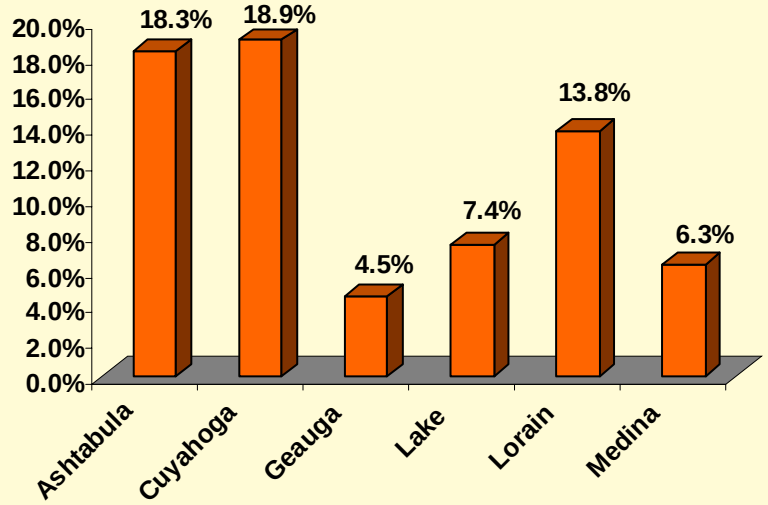
Selected Demographics For Northeast Ohio Counties

	Percent below poverty (1999)	Persons 65 years old and over (2000)
Ashtabula	12.1%	14.7%
Cuyahoga	13.1%	15.6%
Geauga	4.6%	12.0%
Lake	5.1%	14.1%
Lorain	9.0%	12.5%
Medina	4.6%	10.5%
Ohio	10.6%	13.3%
U.S.	12.4%	12.4%

Source: U.S. Census Bureau. State and County Quick Facts.

A comparison of poverty statistics with actual Medicaid enrollment in six Northeast Ohio counties shows that the Medicaid population in each county mirrors the poverty statistics presented above. Ashtabula and Cuyahoga have the highest poverty rates of the six counties and also the largest Medicaid enrollments. Based on this information we would expect hospitals in Ashtabula and Cuyahoga counties to see a higher percentage of Medicaid patients than hospitals in the other four counties.

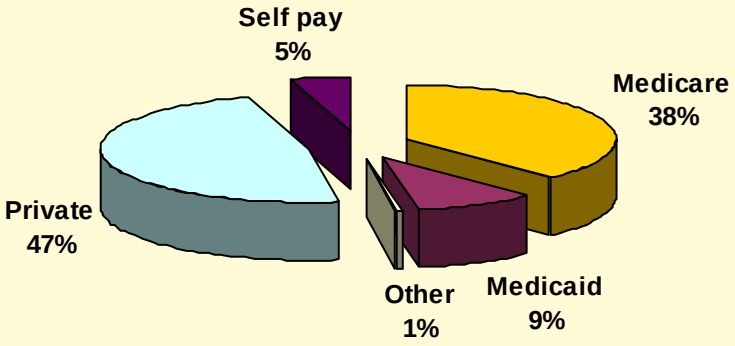
Percent of Population Enrolled in Medicaid in 6 Northeast Ohio Counties - FY 2001



Source: Office of Ohio Health Plans. Ohio Medicaid Report. January 2003 Update.

While demographics provide a framework in which to understand payer mix, they do not paint a complete picture. For example, people do not always visit a hospital located in their county of residence. So what does the payer mix look like for Northeast Ohio? In 2002, the payer mix for the region's hospitals, in the aggregate, consisted of a relatively even split of government and private payers and a small percent of self-pay patients.

2002 Northeast Ohio Hospitals Payer Mix



Source: The Center for Health Affairs. 2002 Uncompensated Care Survey.
Note: Based on gross revenue before adjustments.

Keep in mind that payer mix varies across hospitals. Inner-city and rural hospitals, which tend to see a higher proportion of Medicaid and uninsured patients, clearly operate at a disadvantage with regard to payer mix compared to suburban hospitals.

Service mix

Payer mix is just one part of the equation. Equally important to a hospital's bottom line is the mix of services it provides, because some services tend to be reimbursed more favorably than others. In general, reimbursement for surgical care is more profitable than medical care. On the flip side, hospitals tend to lose money on emergency departments, trauma units, burn units and intensive care units.

Community hospitals are driven by their mission to provide a variety of services to their communities, some of which are more profitable to their bottom line than others. Recently there has been controversy in the medical world around the growth of specialty care providers, also referred to as niche or boutique providers. These providers, which include heart hospitals, orthopedic hospitals and imaging centers, offer a limited set of profitable services. By specializing in the most lucrative services, niche providers drain more profitable services away from community hospitals, making it harder for community hospitals to support unprofitable but necessary community services, such as emergency departments.[35]

How do hospitals stay out of red ink?

As any business must, hospitals keep a close eye on their books to ensure their revenues are not outpaced by their expenses. It can be difficult to understand how hospitals stay out of red ink given their commitment to providing care regardless of a patient's ability to pay and ensuring the availability of services, such as those mentioned above, that tend to lose money. To do so, hospitals rely heavily on those same specialties that recently have been attracting niche providers, such as cardiac and orthopedic services. By developing these more profitable services, hospitals can offset losses incurred by those that are not reimbursed as favorably. Hospitals also have depended significantly on their ability to negotiate more favorable rates with private insurers to make up for losses experienced under reimbursement by government payers as well as uncompensated care.

"If there were a blueprint for financial success, all hospitals would replicate it, but there truly isn't a one-size-fits-all approach."

Richard Fox
Chief Financial Officer
The Center for Health Affairs

Also important is investment income. Hospitals use both long-term and short-term investment strategies to generate additional revenues. For example, a hospital that has a construction bill due in 90 days might use a short-term investment strategy to maximize returns. Hospitals also often benefit from endowments as part of a longer term investment strategy. The role of philanthropy in the world of hospital finance cannot be overstated – hospitals often depend on significant grants and donations and the investment returns they yield to maintain their bottom lines.

Hospitals also employ a wide variety of cost-saving strategies to help their bottom line. For example, many hospitals turn to group purchasing of supplies to keep costs down. Capitalizing on the resources available in the community can also decrease hospital expenses. Volunteers often help hospitals run gift shops, manage help desks and even interact with hospital patients, freeing up resources that can be spent elsewhere.

What is the significance of all this?

Healthcare is a growing segment of the economy, and predictions are that this trend will only continue. There is a heightening awareness that as the baby boomers begin to move into their retirement years there will be ramifications within the healthcare system. The resulting increase in the demand for healthcare services will stress already short-staffed healthcare providers and a shift in payers will occur as this population moves from private insurance into Medicare. There also is no indication that there will be an abatement in the public demand for constant advancement in technologies and treatments.

Serious consideration must be given to how the healthcare system in this country is going to be able to continue meeting the needs and expectations placed upon it.

This brief, the first in a series to be published over the coming year, sets the context for these impending changes as well as for evaluating some of the much-talked-about issues facing providers right now, such as the increasing numbers of the uninsured, rising medical malpractice insurance costs and the emergence of niche hospitals.

A basic understanding of hospital finance and the impact of these factors is crucial as leaders continue to create policy that shapes healthcare financing. Already in this country there is a significant issue regarding access to care by vulnerable populations. If aspects of the system further stress hospitals and force more closures, as has occurred nationwide and right here in Northeast Ohio, it will only serve to exacerbate the problems of those already facing difficulties in accessing care.

The Center for Health Affairs is a hospital trade association representing 35 hospitals in Northeast Ohio and serving those organizations and others through a variety of advocacy and business management services. CHA also works to educate the public on issues that affect the delivery of healthcare. Formed by a visionary group of hospital leaders more than 85 years ago, CHA continues to operate on the principle that by working together hospitals can ensure the availability and accessibility of healthcare services. For more on CHA and to download additional copies of this brief, go to www.chanet.org.

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Endnotes

[1] Some privately insured individuals also qualify for Medicare and/or Medicaid benefits.
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