Governmental underpayments, regulations combine with medical advances to drive rising hospital costs

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The spotlight is shining on health care costs. It’s an issue that generates newspaper headlines and debate among business leaders, policymakers and consumers. But for all of the arguments — and accusations — that emanate from this discussion, the facts are more complex than the dialogue often reflects.

California’s community hospitals are on the front-lines of our health care system. Hospitals deliver care to every patient in need — anytime of the day or night — whether or not the person has health insurance or the ability to pay. Hospital charges were established more than fifty years ago to cover the cost of patient care services, with an additional amount allocated to cover charity care, bad debt and future capital needs. When Congress created the Medicare and Medicaid programs in 1965, the federal government covered the cost of delivering services to the enrollees of both programs. Since that time, however, state and federal actions have been implemented, resulting in significant payment shortfalls, especially in the Medi-Cal (Medicaid) program. Medi-Cal reimburses hospitals only 78 percent of the cost to provide hospital care to the Medi-Cal beneficiaries. California ranks 51st nationally in Medicaid payments to health care providers per enrollee.

Over the years, the basis upon which hospital charges are established has evolved. Today, hospital prices are based on many factors — including government payment shortfalls, discounted health plan reimbursements, charity care, bad debt, county indigent patients, new technologies, labor costs and unfunded state and federal mandates.

In 2010, California hospitals provided $12.5 billion in uncompensated care. Of that amount, more than $3.6 billion was the result of Medicare payment shortfalls and $4.8 billion was attributable to underpayments from the Medi-Cal program. These inadequate government payments are set by the federal and state governments. These payment levels are expected to get even worse in the coming years as the federal government continues to ratchet back hospital payments in order to pay for health care reform and the state grapples with its own budget deficits.

When government programs fail to pay hospitals for the actual cost of caring for their beneficiaries, hospitals and other health care providers must shift these unreimbursed costs to the private sector by negotiating higher payments from private insurers and individuals who pay their bills directly. This “cost-shifting” is not a new phenomenon. It has existed for decades as Medi-Cal and Medicare have repeatedly reduced payments to hospitals and other providers. It is what former Governor Arnold Schwarzenegger termed the “hidden tax” and it affects every Californian who pays his/her bill directly or who has private health insurance. This hidden tax costs every California family more than $1,200 per year in extra health insurance premiums or in direct payments by the self-insured who have the ability to pay their bills.

California hospitals also face challenges posed by unfunded state mandates such as the state’s earthquake compliance standards — estimated by the independent RAND Corporation to cost as much as $110 billion. The rising costs for personnel, health information technology, medical equipment, prescription medications, medical education, special services such as trauma care and research generally are paid for by private insurance and self-insured individuals. Compensation to labor is the largest factor affecting hospital costs. According to a recent report by the American Hospital Association (AHA), nearly 60 cents of every dollar spent by hospitals goes to pay for wages and benefits to individuals who directly care for patients or support their care. In California, these figures are higher in part because of the state’s rigid nurse-to-patient ratio law — the only such universal mandate in the nation.

Other factors that drive up the cost of hospital care include an aging population, obesity, chronic conditions and behavior-induced illnesses. The acuity of hospital patients is rising as a result of these forces, thereby putting more pressure on the cost side of the health care equation.

Despite all of these cost drivers, hospital care as a percent of total spending on health care services and supplies has actually declined from 43 percent to 32 percent in 2010. Growth in spending in hospitals is less than the rise in costs for pharmaceuticals, home health and other services.

Many factors affect the consumption of health care services, which in turn lead to increased costs. The solution to this perplexing dilemma lies in collaborative efforts to bring together key stakeholders and patients in innovative ways to improve the availability and quality of care in a safe, cost-effective manner, improve healthy behavior in all individuals, and align incentives so that every person, whether he/she uses or provides health care, has a stake in changing the demand and supply sides of health care.

This challenge is not for the faint of heart. It requires visionary and practical solutions, alignment of financial and clinical incentives, commitment, collaboration, coordination and accountability.

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