A Report on California Hospitals, the Economy and Health Care Reform

This report is based on the results of a CHA survey of hospital chief financial officers conducted in the second quarter of 2009 as a follow-up to an original study conducted in the fourth quarter of 2008.

California hospitals are on the frontlines of the health care system, providing life-saving care to all patients regardless of their ability to pay. But the nation’s health care system is broken, and the current economic crisis has left an estimated 47 million Americans — including nearly 7 million Californians — uninsured. Lack of health care coverage not only affects these individuals, but also the emergency rooms and trauma centers who care for them.

The economic situation facing California hospitals makes clear the pressing need for comprehensive health care reform. Meaningful health care reform should improve equitable access to affordable, medically necessary, high-quality care for all — and it should be paid for by all.

Hospitals and the Recession

The current recession is taking its toll on California hospitals. In the second part of an ongoing evaluation of the impact of the economic crisis on California hospitals, CHA found that California’s rising unemployment rate, the loss of job-based health coverage, increased enrollment in Medi-Cal and an increase in charity care have resulted in continued erosion of hospitals’ finances, thereby reducing their ability to provide health care services. California hospitals are in an unsustainable situation.

The unemployment rate in California is significantly greater than the rest of the nation, and California continues to report a considerably higher proportion of uninsured residents and lower rates of employer-based coverage than the nation as a whole.
Prior to the economic crisis, the state reported a seasonally adjusted unemployment rate of approximately 7.8 percent, compared to 6.2 percent for the national average. Now, as of June 2009, California’s unemployment rate has skyrocketed to 11.6 percent, compared to 9.5 percent nationally. Survey results indicate that 57 percent of hospitals report an increase in the number of emergency room visits provided in 2009 for uninsured patients.

According to state reports, hospitals are on track for providing $120 million more in charity care in 2009 than they provided in the previous year. At the same time, bad-debt expenses rose 14 percent due to patients’ inability to cover their cost of care, even if they have health coverage. Finally, according to more than 58 percent of hospitals that responded to the CHA survey, the difficult financial times have also caused the number of elective procedures to decline in 2009. This is particularly difficult for hospitals because elective procedures help cover the costs of uncompensated care.

Combined with the revenue losses, increased charity care and bad-debt costs, hospitals’ investment losses have weakened balance sheets and diminished other sources of income. Fifty-two percent of respondents indicate a decrease in available cash, with almost one-third of hospitals reporting that the decrease is significant. As a result, many hospitals have indicated that compliance with covenants on borrowing is difficult or impossible, resulting in increased interest rates. More than 28 percent of hospitals reported that their interest costs have increased in 2009. State reports reflect an increase in hospital costs of 7.6 percent, in part due to the increased cost of borrowing.

### Hospitals and Medicare/Medicaid Underfunding

This economic crisis has hit hospitals from all angles. Hospitals, once considered “recession proof,” are vulnerable and suffering under the stress of continued financial pressures. Thirty-seven percent of California hospitals report negative total margins and the statewide aggregate operating margin is negative .5 percent. In CHA’s recent evaluation, 45 percent of hospitals report an expected decline in operating margins throughout 2009. In large part, this is due to the continued underfunding of government-run programs, such as Medicare and Medicaid.

**Calendar year 2008** reflects more than $11.3 billion in uncompensated care provided by the state’s hospitals, with $3.7 billion attributable to the Medicare program and $4.1 billion to Medi-Cal. Reports indicate that uncompensated care losses comprise 6 percent of hospital costs nationally, yet in California, uncompensated care costs equal 17 percent of total operating expenses. As more Californians become unemployed and lose employer-based health coverage, more people need services through the Medi-Cal program. Through the first quarter of 2009, 51 percent of hospitals reported an increase in the number of patients covered by Medi-Cal compared to the same period last year. The shift from employer-based coverage to government programs is detrimental to the long-term viability of many California hospitals.

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### Percent of Hospitals Reporting Impact of Economic Crisis

- **Decrease in patient admissions**: 51%
- **Decrease in elective procedures**: 58%
- **Increase in bad debt and charity care**: 60%
- **Increase in uninsured visits to the ER**: 57%
**Responsible Health Care Reform**

California hospitals support meaningful health care reform that improves equitable access to affordable, medically necessary, high-quality care for all. Efforts to share financial responsibility will be important to the long-term success of reform and to the important relationship between health care and the state’s and nation’s economic recovery.

**Universal Coverage**

Universal coverage is the foundation on which reform, fairness and cost control will be built. The lack of coverage has proven to be a significant barrier to accessing preventive health care services and receiving treatment for chronic conditions. Recent studies have linked lack of health coverage to a severe decline in health status, particularly among those with chronic health problems. Individuals without a routine source of health care often use hospital emergency departments as the entry point to primary and other health care services. These services are the most expensive and often the least efficient point of entry into the system when primary and preventive care would have helped the patient if they had been available.

Establishing universal coverage will not only provide patients with access to the most appropriate care in the most appropriate setting, it will ease the burden on the private sector, which now must help compensate for underpayments by the public programs.

CHA supports both an individual requirement to maintain basic coverage, as well as strong incentives for continuing current employer-based coverage. Aggressive market reforms will be necessary to enable individuals to attain coverage at fair and reasonable rates.

CHA makes three recommendations to Congress regarding universal coverage:

1) Adopt a uniform, essential benefit package that is community-rated and universally available from all payers, with transparency of premiums for the essential benefit package.
2) Support universal employer and individual participation.
3) Create governmental support in varying degrees for all people through tax policies, subsidies and sponsorship.

**Issues of Concern**

Four areas of the current health care reform debate are of particular concern to hospitals: designing of a public plan, narrowing a readmissions policy, preventing redistribution of current Medicare funding (geographic variation) and maintaining congressional oversight.

**Public Plan**

While willing to do their part to sustain high-quality care, hospitals must be appropriately reimbursed for services. Current Medicare and Medicaid reimbursement rates chronically underfund hospitals. In general, California hospitals are paid 84 percent of their costs by Medicare. Almost two-thirds of all California hospitals provide Medicare services at a loss. A new public plan based on Medicare rates would perpetuate the current problem of underfunding. California hospitals cannot survive with these margins and, therefore, support more localized plans with privately negotiated rates.

**Readmissions Policy**

California hospitals support payment incentives focused on improving quality patient care and patient safety. A responsible readmissions policy must adequately recognize that certain readmissions are appropriate or beyond the control of the hospital. California hospitals can support policies that focus payment reductions on unplanned and preventable readmissions for reasons related to the initial admission. An appropriate readmission policy must also “risk-adjust” so hospitals are not punished for treating more complex patients. Discouraging care by reducing payment for more complex and critically ill patients may reduce access to care for these individuals.

**Geographic Variation**

Medicare payments are based on a variety of factors related to a patient’s diagnosis, as well as the cost of providing care. The cost of care can vary widely across the country due to factors such as labor and real estate costs, hospital mission (care for the uninsured, teaching programs), health status, demographics and

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other socio-economic factors. California has historically been a relatively high-cost state. More rural and generally southern states have been relatively low-cost states.

Geographic variation in Medicare payments is an area ripe for research and clarification; proposed studies will provide important information. However, payment policy changes to shift Medicare payments from one state to another must not be at the sole discretion of the secretary of Health and Human Services and without review of Congress. Maintaining a “hold harmless” clause in geographic variation Medicare policies is vital to protecting California providers from dramatic shifts in Medicare payments to smaller, less urban states. California cannot afford to become a “donor” state.

Congressional Oversight

California hospitals oppose establishing an executive branch entity, such as the Independent Medicare Advisory Council (IMAC). It is an unprecedented and inappropriate cession of authority from Congress to the executive branch that would likely lead to significant payment cuts to California hospitals and would abrogate Congress’ authority over a program that touches the lives of millions of Californians. The IMAC proposal would allow a new federal entity to target provider rates. The council would be appointed by the president to determine future Medicare payments to providers. The president would then present the council’s recommendations to Congress, which would vote on the recommendations, requiring a two-thirds vote to overturn the proposed payment rates. If Congress cannot agree or does not act within 30 days, the council’s recommendations would be implemented without congressional consent.

Conclusion

California hospitals face significant financial challenges as a result of the economic downturn and are committed to meaningful health care reform that will improve equitable access to affordable, medically necessary, high-quality care for all.

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