

The Financing of Health Care

If there is one constant in health care, it is concern about the cost of medical treatment. Health care spending increased by roughly 7.2 percent nationwide between 2003 and 2004. According to the [Center for Studying Health System Change](#), hospital outpatient and prescription drugs are the biggest drivers of these increases.

The increase in overall health care spending has been fueled by several factors, including increased utilization of services, increased costs for providing services (including the cost of staffing, technology, drugs and other products), population growth and an increasing population of seniors, who tend to require higher intensity medical treatment.

As we have said in the past, “health care costs” means different things to different people.

- To most privately-insured persons, the cost of health care is the amount of the copayment, deductible and other out-of-pocket expenses they incur when they see a doctor or require hospitalization.
- To an employer, it’s the cost of insurance for workers.
- To an insurer, it’s the amount paid for medical treatment for its insureds.
- To a self-insured business or local government, it’s the amount they pay directly for medical treatment for their employees.
- To Medicare and Medicaid program administrators, it’s budget outlays for services to beneficiaries.

To providers, health care costs means the cost of all that goes into providing medical treatment – wages and benefits for staff, medical liability insurance, the price of utilities, prescription drugs and other necessary products and services, the cost of new technology and other capital improvements and the expense of complying with regulatory requirements.

MHA member facilities share the public’s concern about rising health care costs. As major employers, health care facilities have faced the same pressures caused by health insurance premiums as businesses all over Montana. In addition, providers have faced continual reductions in reimbursement rates as public and private insurers have attempted to reduce their health care outlays.

The Public Policy Debate...

Over the years, public policymakers have tried a variety of strategies to curb the growth in health care spending. In the 1970's, the federal and state governments relied on health planning programs to limit costs by limiting the number of providers and the spread of technology.

In the 1980's, cost containment strategies shifted to limiting payments. The federal government instituted diagnosis-related groups –DRGs – as the payment mechanism for the Medicare program. In the 1990's, Congress attempted to reduce Medicare spending by limiting provider payment increases to less than the rate of inflation.

The [Medicare Modernization Act of 2003 \(MMA\)](#) included the first pay-for-performance mandate, a requirement that hospitals report data from certain quality indicators to be eligible for a payment update equal to the full market basket inflation rate. By improving quality, proponents argued, Medicare would reduce its overall expenditures and get greater value for the money it spends.

Meanwhile, the MMA also restructured Medicare managed care – now called Medicare Advantage – in an attempt to encourage more beneficiaries to enroll in these plans, thus shifting more of Medicare's risk to the private insurance market.

Today's debate focuses on what has been called “consumer-directed health care.” In essence, this model requires participants to purchase a catastrophic health insurance policy – one with a deductible typically in the \$5,000 to \$10,000 range. This policy is coupled with a health savings account (HSA), a tax-exempt account that can be used to pay the deductible and insurance premiums.

As its name implies, in this model, the burden for paying for health care is shifted to the consumer.

Some policymakers believe this new model will bring market incentives more directly into health care. When consumers have to pay a greater share of the price of health care, they will make decisions that keep their costs down.

For this model to work, [consumers must have the information they need to make informed choices about their health care](#) – hence the recent interest in providing additional pricing information to consumers.

In addition, providers must have the means to collect payments for the services they provide when the patient's share is below the threshold for the insurer to pay. If patients don't pay, providers' only choice will be to raise rates.

Throughout the debate over health care costs, MHA has advocated several core policies:

- Payers – especially major government payers – should pay for the reasonable costs of treating their beneficiaries. An end to cost-shifting would mean more stability in the price of health insurance for everyone else.
- Insurance plans must balance plan design and provider contracts to assure reasonable access to treatment locally, pay providers in a timely fashion and protect beneficiaries from unreasonable economic risk.

- Employers should continue their efforts to provide employer-sponsored health coverage. Tax policy should continue to support group health coverage.

The Bottom Line

Hospitals, collectively, managed to barely cover the cost of serving patients in 2005, which means that hospitals are not overcharging for the services they provide.

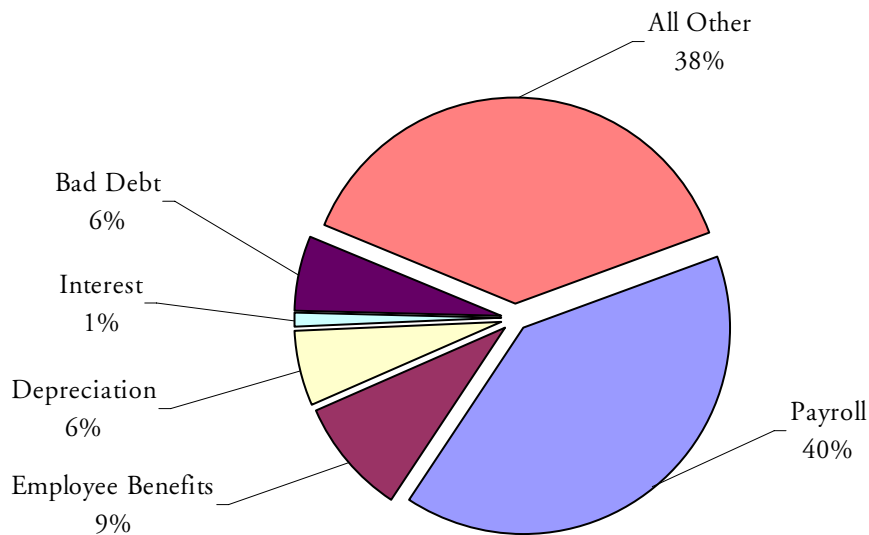
To close the gap between payments and the cost of providing care, hospitals obtain revenue from a variety of other services. Rent for office space, meals sold to visitors and other operations help provide a small profit margin. For county- or district-owned facilities, tax subsidies often make up for operational losses.

Meanwhile, health care facilities continue to work hard to control their expenses and to keep their rate increases to minimal levels – at or below 5 percent for hospitals over the past several years.

That’s the good news. The bad news is that as Montana’s population ages – and uses more health

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Hospital Expenses



Hospital expenses consist largely of payroll and benefit costs, plus the costs of medical supplies used to care for patients. Rising health costs reflect greater and more intense utilization of hospital care combined with persistent shortages of trained health care professionals. While many focus on the investment by hospitals in plant and high tech equipment, just 7 percent of hospital costs are related to capital costs. Historically hospitals spend about 10 percent of their costs on capital outlays.

Source: AHA/MHA Survey of Hospitals, 2005.

Financial Highlights - Montana Statewide

	2005	2004
Funds Available		
Charges for Inpatient Services	\$1,551,993,467	\$1,436,688,278
Charges for Outpatient Services	1,296,933,451	1,134,140,147
Funds from Other Operations	63,130,277	65,406,268
Funds from Tax Subsidies	3,773,360	4,107,129
Funds from Nonoperating Activities	45,326,977	39,885,143
Total	\$2,961,157,532	\$2,680,226,965
Full Payment Not Received From		
Medicare	\$649,645,336	\$592,113,901
Medicaid	138,886,794	113,997,612
Other Government	34,046,052	24,257,426
Other Payers	214,804,489	132,933,086
All Other Discounts	29,330,281	29,351,069
Charity Services	59,568,094	42,377,240
Total Revenue Deductions	1,067,620,484	935,030,334
Total Funds Available	\$1,893,537,048	\$1,745,196,631
Funds Spent		
Salaries, Wages	\$719,518,327	\$675,996,466
Employee Benefits	163,583,528	151,955,922
Depreciation	101,122,562	95,550,986
Interest	16,602,485	16,405,507
Bad Debt	102,482,960	96,280,538
Medicaid Bed Tax	11,141,200	8,757,917
All Other Expenses	660,606,898	587,587,761
 Total Funds Set Aside for Future Services (including Investments)	 \$118,479,088	 \$112,661,534
 Total Funds Spent	 \$1,893,537,048	 \$1,745,196,631
Patient Service Margin	0.35%	0.20%
Total Margin**	6.67%	6.90%

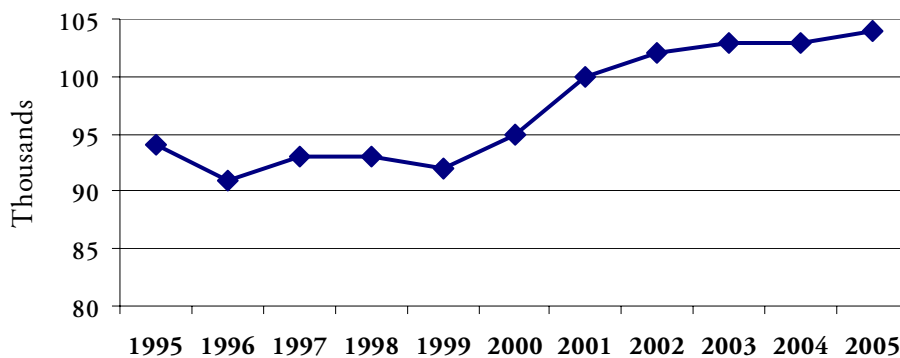
**The operating margin differs from the patient service margin by including revenues earned from sources other than patient treatment, such as rent, meals served to visitors, etc.

Source: AHA/MHA Annual Survey of Hospitals, 2005.

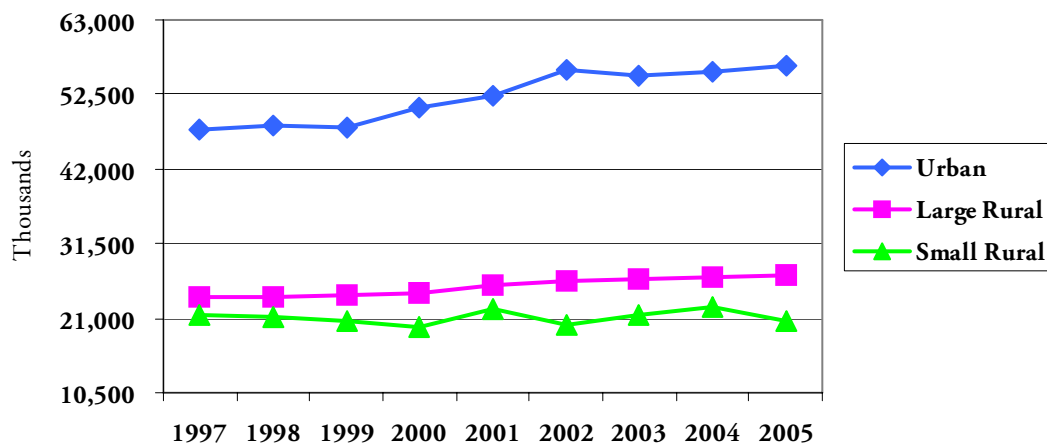
With two exceptions, hospitals in Montana are licensed as non-profit organizations. Despite the non-profit label, being non-profit does not mean operating at a loss. Hospitals, like any business entity, must earn at least a 5 percent margin to maintain its services and have funds to reinvest in operations, equipment and employee salaries and benefits. As was the case in 2004, hospitals collected payments from their patients that barely covered the cost to deliver care. Hospital profit margins were bolstered by a variety of other operating activities such as renting office space, selling meals to hospital visitors and other similar activities. Taxpayers provided a small amount of revenue to support local hospitals.

Non-profit hospitals provided over \$160 million of uncompensated care to Montana residents who either did not, or could not, pay for their care. Charity costs jumped by \$17 million or 40% in one year. Bad debt expense increased by \$6.2 million, or about 6.4 percent. Providing free or discounted care to uninsured and low-income Montanans is one way that non-profit hospitals provide a benefit to their community in exchange for exemption from taxes.

Hospital Admissions Statewide

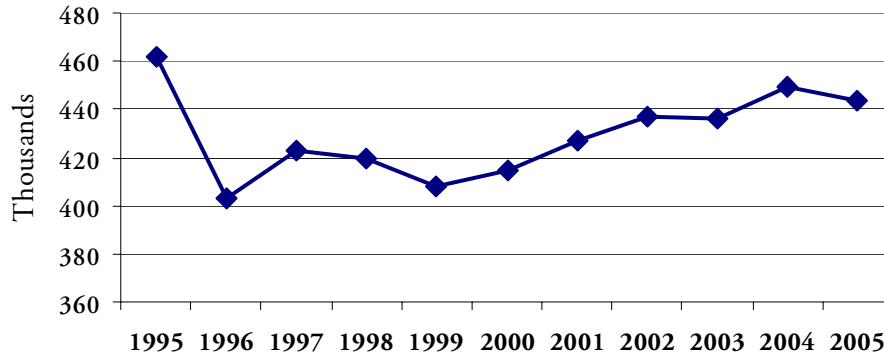


Hospital Admissions by Facility Size



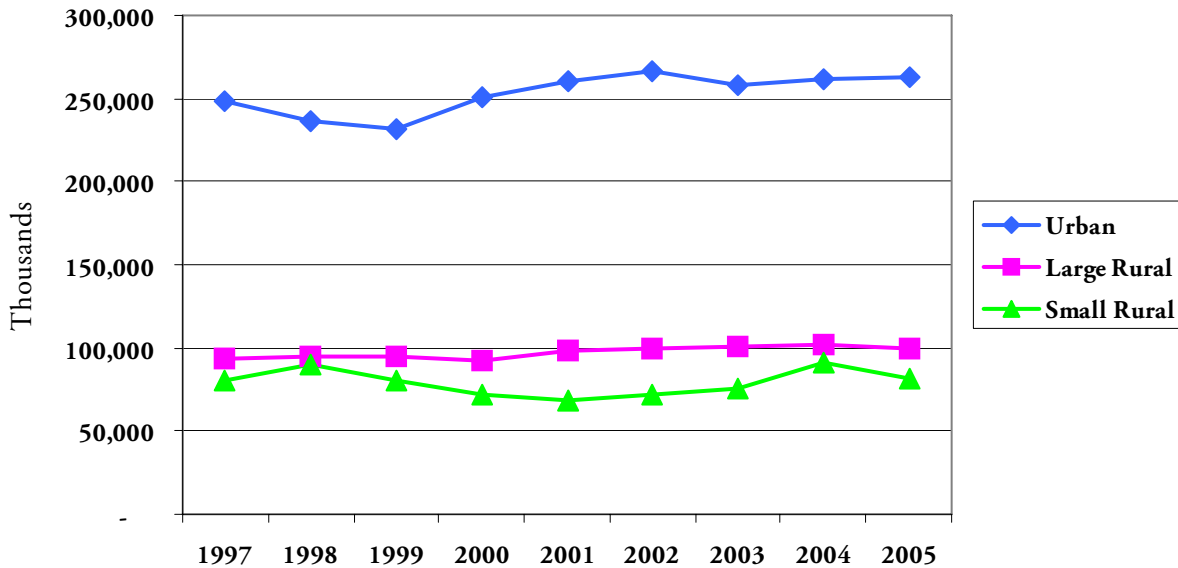
Source: AHA/IMHA Annual Survey of Hospitals, 2005.

Inpatient Days Statewide



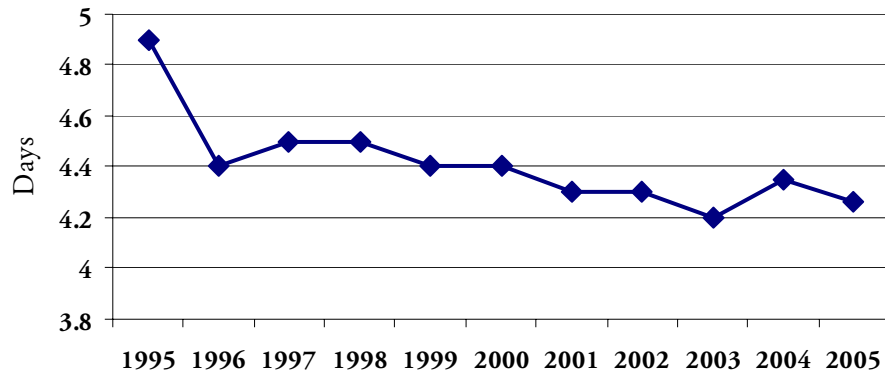
Hospitals saw total inpatient days decrease slightly over 2004, after several years of modest growth in service volume. This decline in patient days occurred even though total admissions increased in 2005. Hospitals continue to manage patient days in the hospital as a key strategy to hold down health costs.

Hospital Inpatient Days by Facility Size

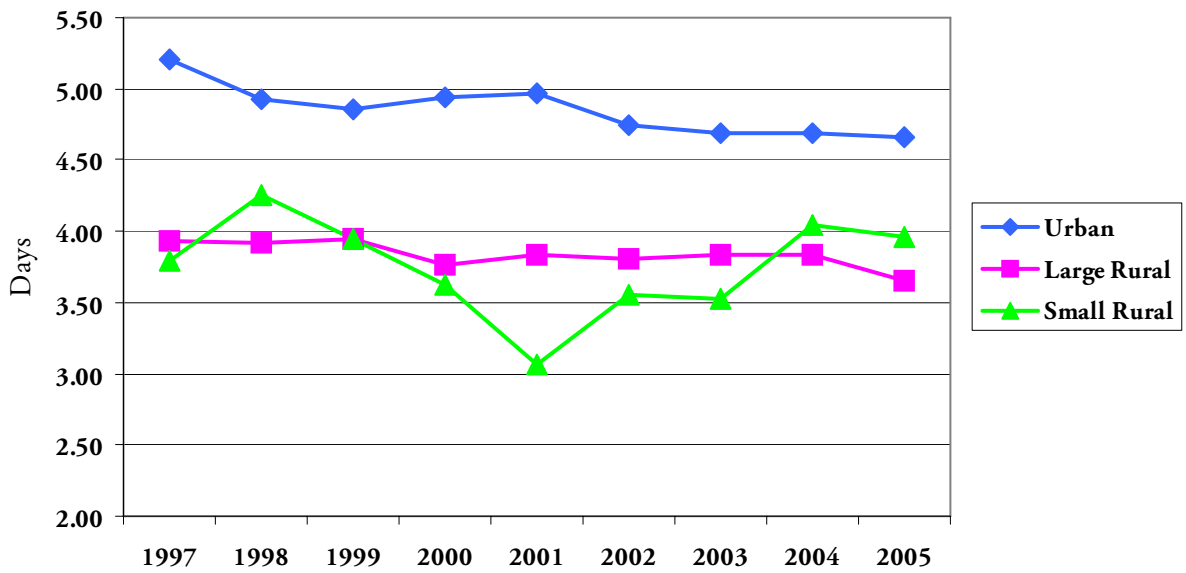


Source: AHA/MHA Annual Survey of Hospitals, 2005.

Length of Stay Statewide



Length of Stay by Facility Size



Source: AHA/MHA Annual Survey of Hospitals, 2005.

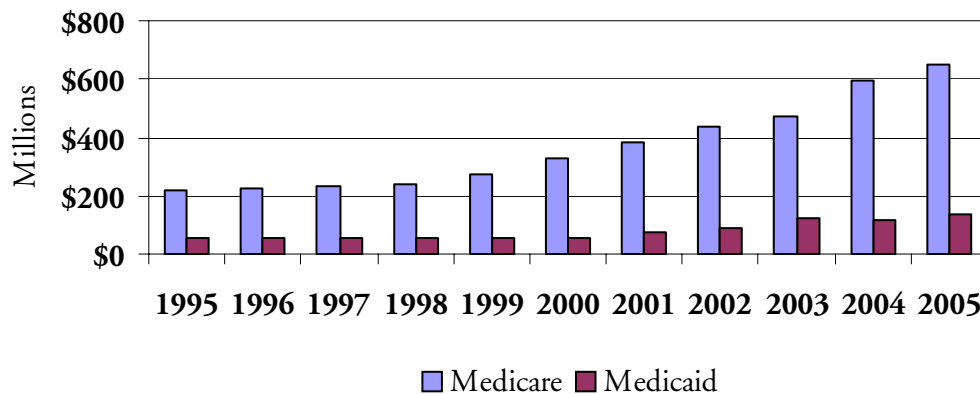
The discounts demanded by the Medicare and Medicaid programs are one reason for skyrocketing health insurance costs. The chart reports ever-increasing discounts from full charges that go to government programs.

These discounts, the difference between what a hospital charges for services and the amount government pays for care, grow larger every year.

The moderation of the discount provided to Medicaid is the result of the hospital utilization fee that helps reduce the gap between Medicaid's payments and hospitals' actual costs.

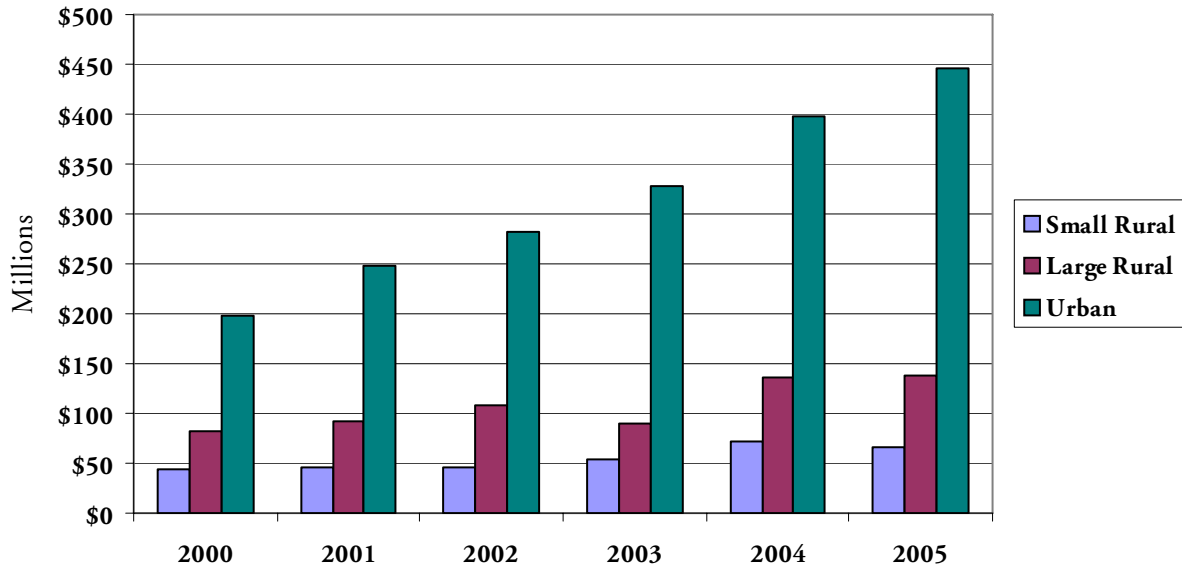
When government programs don't pay the full cost for beneficiary services, the loss is passed onto other consumers, primarily onto employers and individuals who purchase insurance, and those who pay their medical costs out of their own pockets.

Medicare/Medicaid Discounts Statewide

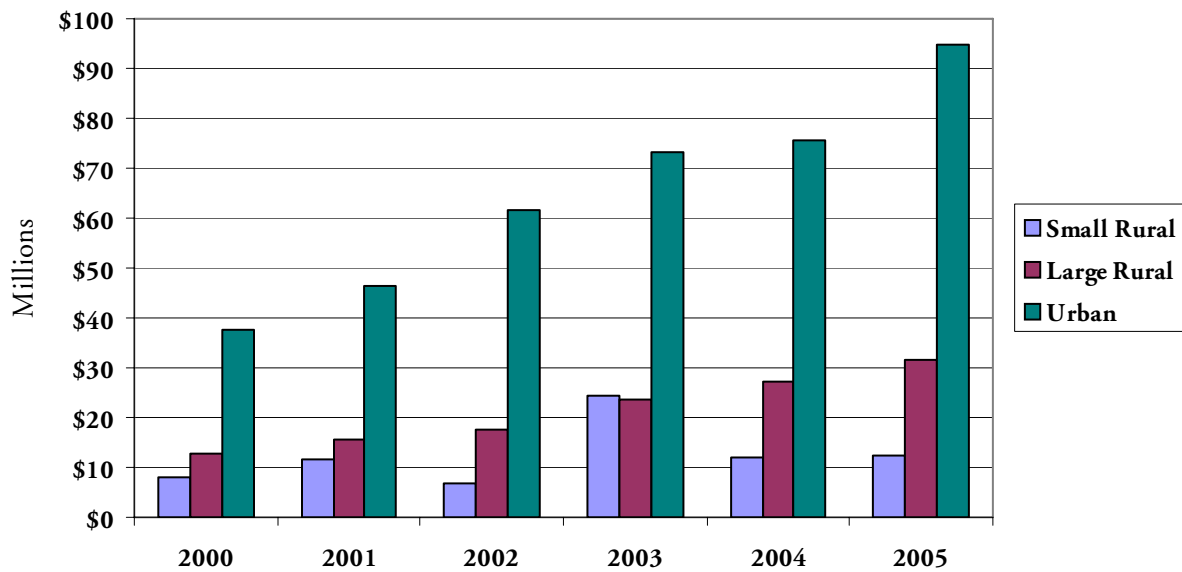


Source: AHA/MHA Annual Survey of Hospitals, 2005.

Hospital Medicare Discounts by Facility Size

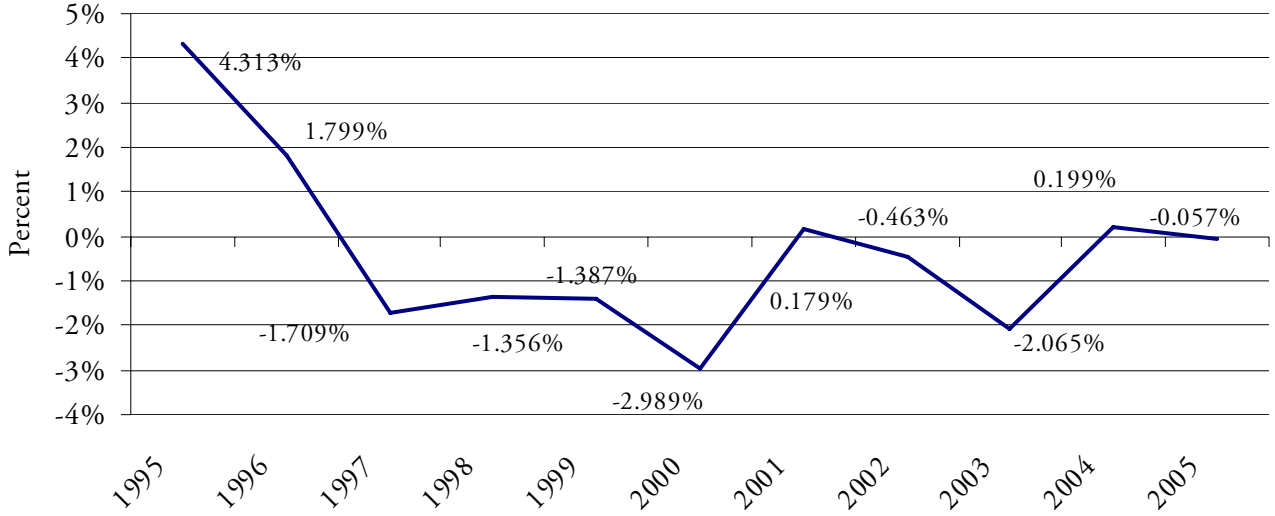


Hospital Medicaid Discounts by Facility Size

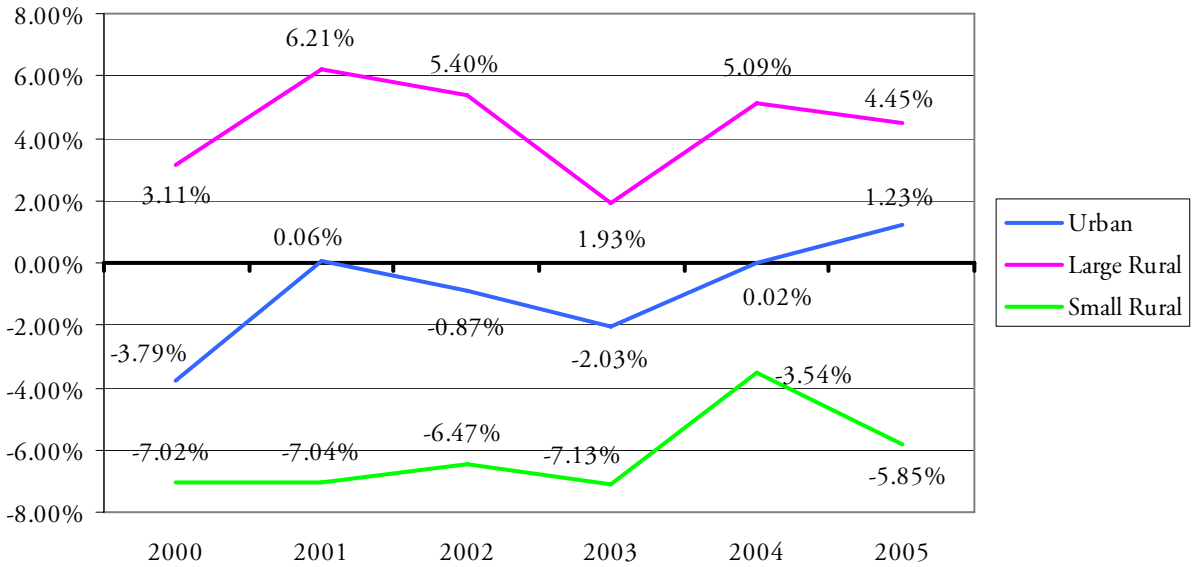


Source: AHA/MHA Annual Survey of Hospitals, 2005.

Patient Service Margin Statewide



Hospital Patient Service Margin by Facility Size



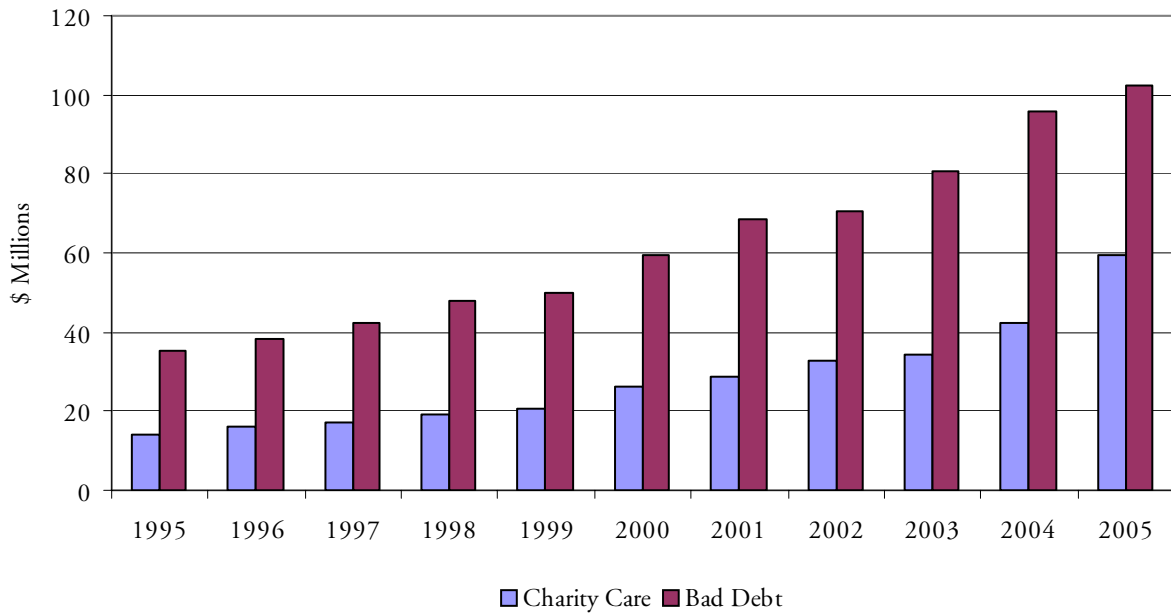
Source: AHA/MHA Annual Survey of Hospitals, 2005.

Patient service margin is a key indicator that measures hospital profitability. An ideal margin for patient care is about 5 percent, meaning that hospitals would receive 5 percent more than their costs for caring for patients.

Although most patients feel they are paying high prices for their care, this indicator shows that hospitals aren't overcharging for these services. In fact, in most years, hospitals barely cover their patient care costs, or lose money providing services.

Although the patient service margin is nearly zero, hospitals make some money from other operations, such as renting office space or selling meals in the cafeteria. Some hospitals receive interest payments on investments and savings. Hospitals owned by counties or hospital districts often receive subsidies from local government.

Bad Debt & Charity Care Statewide



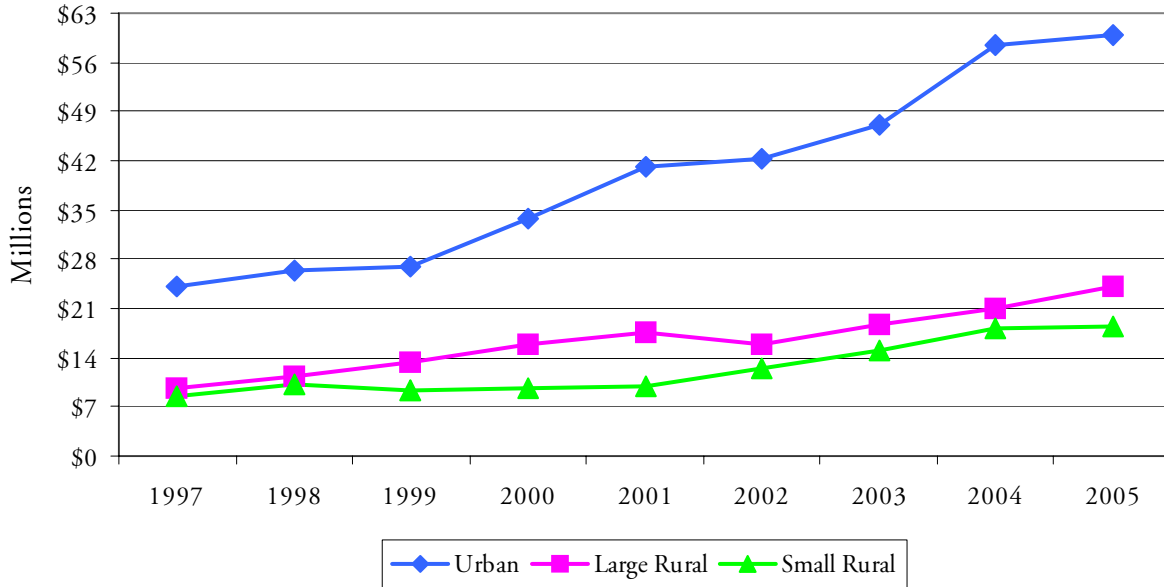
Source: AHAIMHA Annual Survey of Hospitals, 2005.

Charity care and bad debt continue to grow each year as more Americans lose their health insurance coverage or fall below federal poverty guidelines. Most people believe that government programs foot the bill for low-income people. But Medicare only covers the elderly and some disabled people, while Medicaid covers low-income beneficiaries who meet other criteria for gaining coverage, including being aged, blind, disabled, pregnant or having dependent children.

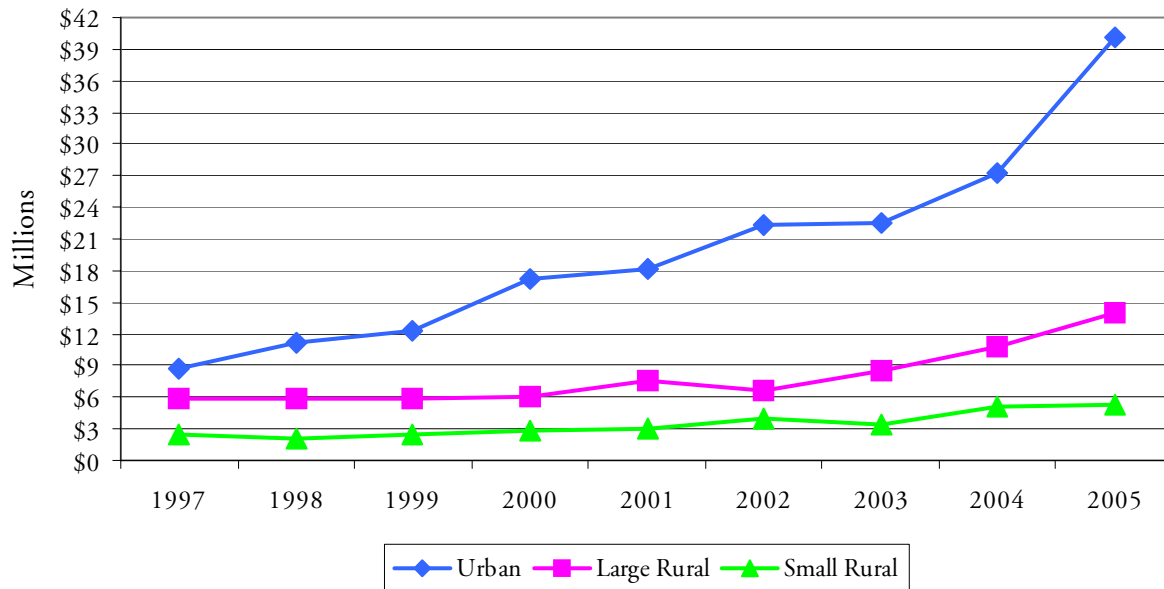
Hospitals provide free or discounted price care for those who have limited means, but aren't covered by government insurance plans. In 2006, that amount of free care topped \$160 million, three times more than was provided in 1995.

Free care is not free. When patients can't, or won't, pay for their care, the costs are shifted onto those who do pay. Like growing discounts for government programs, these higher uncompensated care costs are shifted to those who do pay, making their health care costs even higher.

Bad Debt by Facility Size

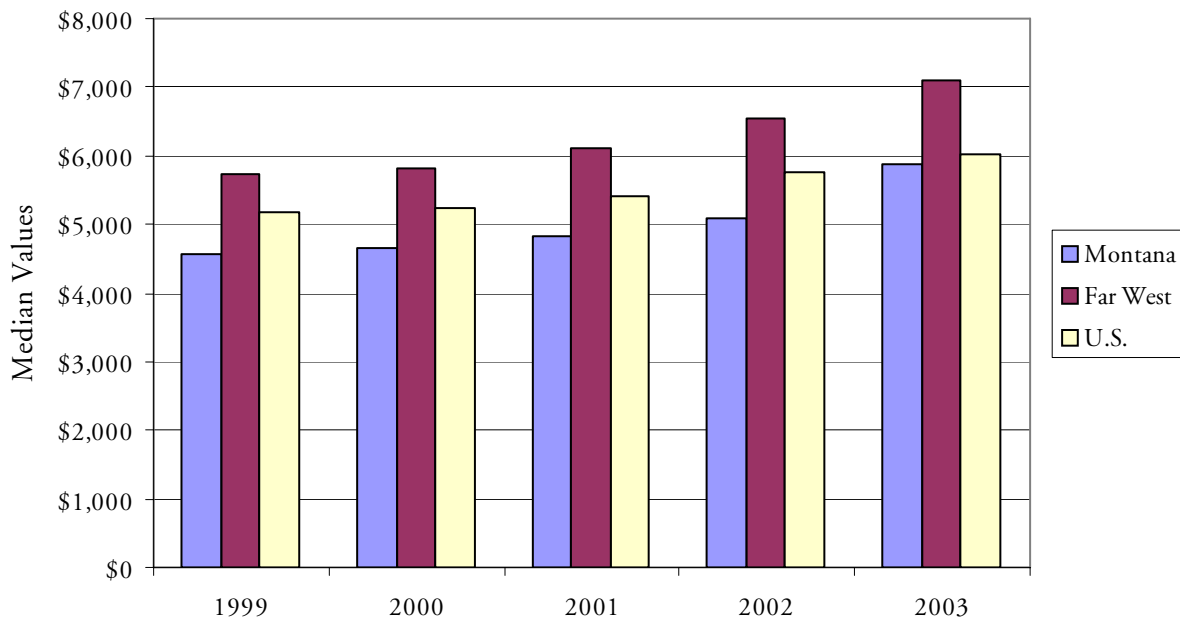


Charity Care by Facility Size



Source: AHA/MHA Annual Survey of Hospitals, 2005.

Inpatient Cost Per Discharge

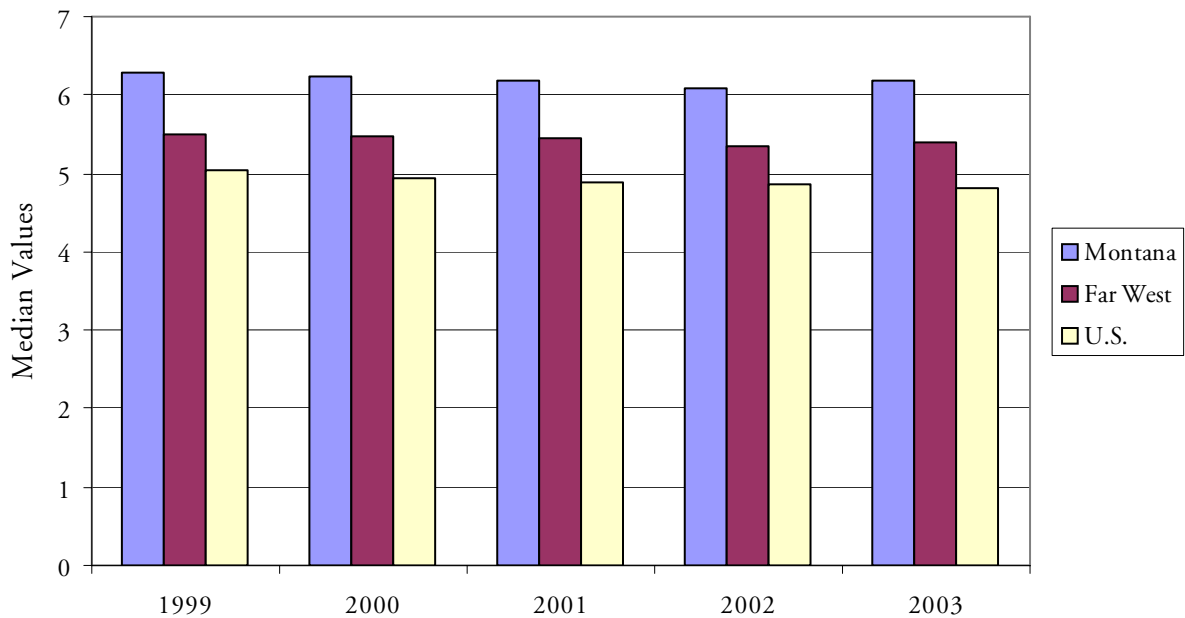


Inpatient Cost Per Discharge Using Medicare Cost Report Indicators Median Value

	1999	2000	2001	2002	2003
Montana	\$4,567	\$4,652	\$4,836	\$5,100	\$5,887
Far West	\$5,735	\$5,810	\$6,118	\$6,558	\$7,092
U.S.	\$5,190	\$5,236	\$5,424	\$5,759	\$6,021
Idaho	\$4,317	\$4,402	\$4,977	\$5,166	\$5,705
Wyoming	\$4,810	\$5,120	\$5,870	\$5,899	\$6,564
North Dakota	\$4,586	\$4,772	\$4,946	\$5,575	\$5,623
South Dakota	\$4,274	\$4,464	\$4,946	\$5,147	\$5,567
Washington	\$5,263	\$5,476	\$5,563	\$5,969	\$6,521
Oregon	\$5,217	\$5,530	\$5,678	\$5,591	\$6,064

Source: *Almanac of Hospital Financial and Operating Indicators, 2005.*

FTEs per Occupied Bed

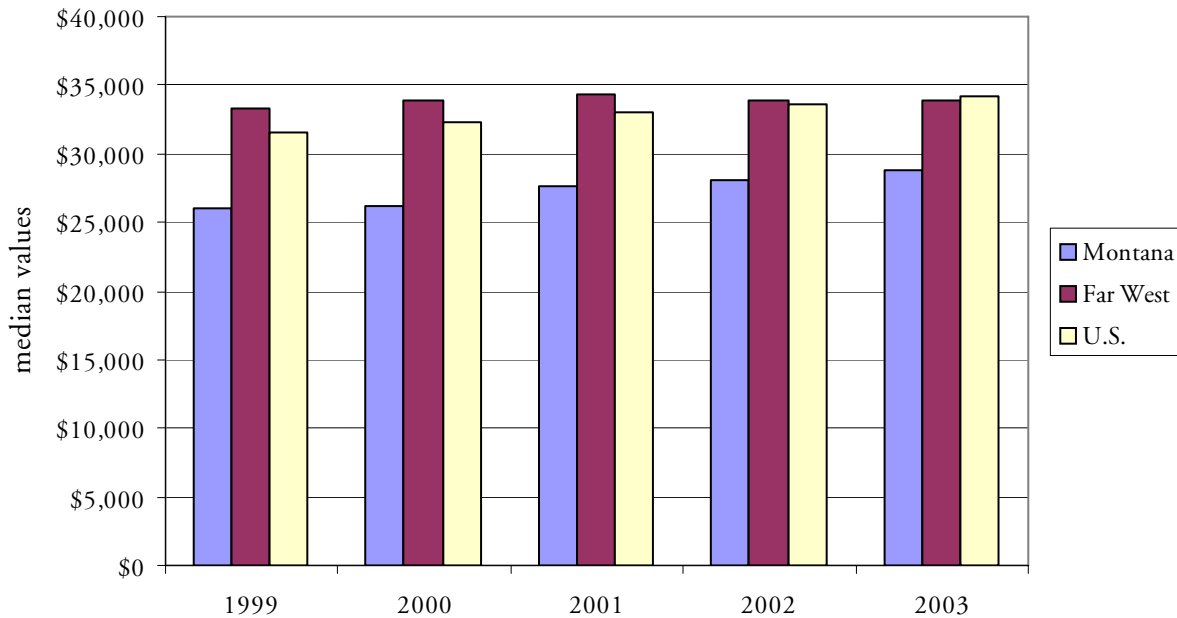


FTEs per Occupied Bed Using Medicare Cost Report Indicators Median Value

	1999	2000	2001	2002	2003
Montana	6.3	6.24	6.19	6.09	6.19
Far West	5.5	5.48	5.45	5.35	5.4
U.S.	5.03	4.93	4.88	4.85	4.82
Idaho	6.27	5.43	5.87	6.09	5.85
Wyoming	6.07	5.97	6.00	5.78	6.38
North Dakota	3.97	4.13	4.03	3.81	4.02
South Dakota	5.18	5.41	5.29	5.37	5.49
Washington	5.91	5.69	5.81	5.41	5.62
Oregon	6.15	5.91	5.9	6.09	5.98

Source: *Almanac of Hospital Financial and Operating Indicators, 2005.*

Salary per FTE

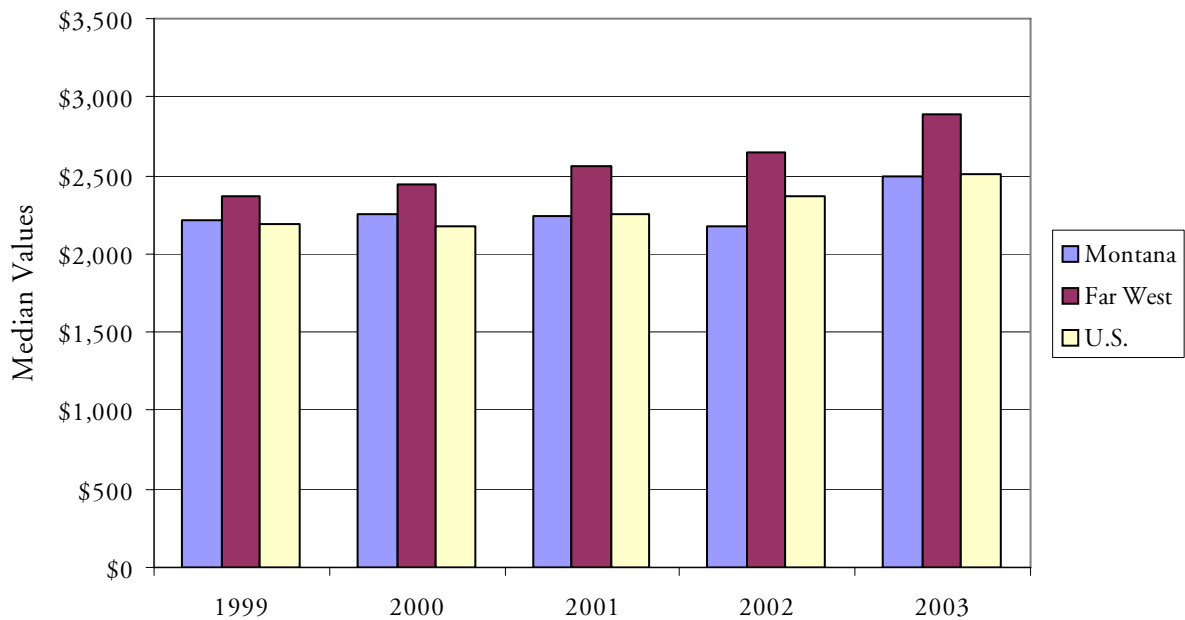


Salary per FTE Using Medicare Cost Report Indicators Median Value

	1999	2000	2001	2002	2003
Montana	\$26,056	\$26,205	\$27,684	\$28,027	\$28,783
Far West	\$33,353	\$33,848	\$34,284	\$33,925	\$33,829
U.S.	\$31,624	\$32,348	\$33,027	\$33,648	\$34,157
Idaho	\$29,689	\$32,631	\$31,172	\$33,282	\$34,649
Wyoming	\$29,047	\$30,484	\$33,076	\$34,964	\$36,047
North Dakota	\$26,734	\$26,958	\$27,043	\$28,559	\$31,321
South Dakota	\$26,432	\$25,855	\$28,548	\$27,864	\$31,846
Washington	\$36,165	\$34,638	\$36,050	\$33,051	\$33,552
Oregon	\$35,344	\$35,487	\$35,168	\$32,169	\$33,773

Source: *Almanac of Hospital Financial and Operating Indicators, 2005.*

Salary per Discharge



Salaries per Discharge Using Medicare Cost Report Indicators Median Values

	1999	2000	2001	2002	2003
Montana	\$2,209	\$2,259	\$2,243	\$2,181	\$2,492
Far West	\$2,365	\$2,450	\$2,558	\$2,647	\$2,893
U.S.	\$2,188	\$2,181	\$2,248	\$2,363	\$2,503
Idaho	\$1,901	\$1,909	\$2,091	\$2,426	\$2,508
Wyoming	\$2,298	\$2,384	\$2,546	\$2,470	\$2,709
North Dakota	\$2,248	\$2,186	\$2,437	\$2,510	\$2,923
South Dakota	\$2,127	\$1,996	\$2,473	\$2,282	\$2,629
Washington	\$2,281	\$2,345	\$2,484	\$2,529	\$2,920
Oregon	\$2,312	\$2,443	\$2,369	\$2,545	\$2,479

Source: *Almanac of Hospital Financial and Operating Indicators, 2005.*

General Service Costs per Discharge

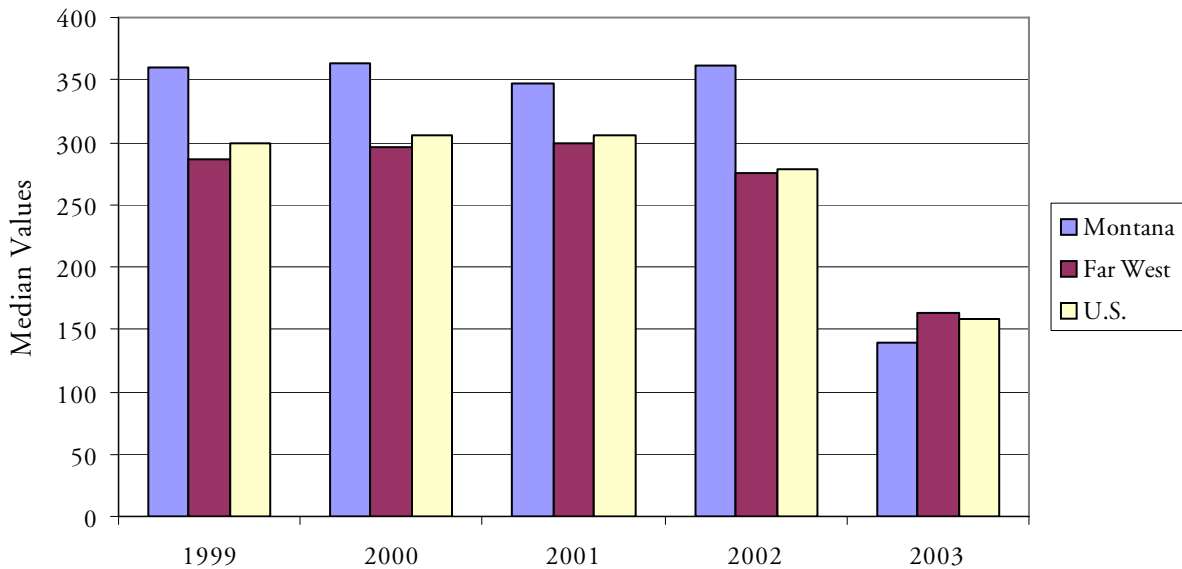


General Service Costs per Discharge Using Medicare Cost Report Indicators Median Values

	1999	2000	2001	2002	2003
Montana	\$1,883	\$1,749	\$1,832	\$1,818	\$2,091
Far West	\$2,237	\$2,269	\$2,416	\$2,528	\$2,772
U.S.	\$2,009	\$2,025	\$2,092	\$2,241	\$2,386
Idaho	\$1,530	\$1,604	\$1,864	\$1,928	\$2,246
Wyoming	\$1,893	\$1,891	\$2,329	\$2,116	\$2,368
North Dakota	\$1,793	\$1,639	\$1,946	\$2,086	\$2,109
South Dakota	\$1,473	\$1,433	\$1,814	\$1,793	\$1,966
Washington	\$1,903	\$1,977	\$2,098	\$2,248	\$2,760
Oregon	\$2,030	\$2,153	\$2,127	\$2,131	\$2,342

Source: Almanac of Hospital Financial and Operating Indicators, 2005.

**Capital Costs per Discharge
(Adjusted for Wage Index & Case Mix)**



**Capital Costs per Discharge
Using Medicare Cost Report Indicators
Median Values**

	1999	2000	2001	2002	2003
Montana	\$360	\$364	\$348	\$362	\$139
Far West	\$287	\$296	\$299	\$275	\$164
U.S.	\$299	\$306	\$306	\$279	\$159
Idaho	\$289	\$297	\$315	\$364	\$123
Wyoming	\$362	\$401	\$458	\$410	\$186
North Dakota	\$367	\$331	\$282	\$355	\$170
South Dakota	\$379	\$376	\$433	\$382	\$164
Washington	\$288	\$291	\$309	\$191	\$113
Oregon	\$281	\$281	\$268	\$208	\$148

Source: *Almanac of Hospital Financial and Operating Indicators, 2005.*

Montana Peer Groups

Urban

Benefis Healthcare
Billings Clinic
Community Medical Center
St. Patrick Hospital
St. Vincent Healthcare

Lg Rural

Bozeman Deaconess Hospital
Holy Rosary Healthcare
Northern Montana Hospital
Northwest Healthcare
St. James Healthcare
St. Peters Hospital

Sm Rural

Barrett Hospital & HealthCare
Beartooth Hospital
Big Horn Co Memorial Hospital
Big Sandy Medical Center
Broadwater Health Center
Central MT Medical Center
Clark Fork Valley Hospital
Community Hospital of Anaconda
Dahl Memorial Healthcare
Daniels Memorial Hospital
Fallon Medical Complex
Frances Mahon Deaconess Hospital
Garfield County Health Center
Glendive Medical Center
Granite County Memorial MAF
Health Center Northwest
Liberty County Hospital
Livingston Memorial Hospital
Madison Valley Hospital
Marcus Daly Memorial Hospital
Marias Medical Center
McCone County Health Center
Mineral Community Hospital
Missouri River Medical Center
Mountainview Medical Center
NE MT Health Svcs (Trinity Hospital)
North Valley Hospital
Northern Rockies Medical Center
Phillips County Medical Center
Pioneer Medical Center
Pondera Medical Center
Poplar Community Hospital
Powell Co Medical Center
Prairie Community MAF
Roosevelt Memorial Medical Center
Rosebud Health Care Center
Roundup Memorial Hospital
Ruby Valley Hospital
Sheridan Memorial Hospital
Sidney Health Center
St. John's Lutheran Hospital
St. Joseph Hospital
St. Luke Community Hospital
Stillwater Community Hospital
Teton Medical Center
Wheatland Memorial Hospital