

## **“Health Care Scene in California and the Future”**

by

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### **Introduction**

California hospitals are major community organizations, providing a wide range of patient services and programs that benefit the residents in their communities. As hospitals deliver more services in non-inpatient settings, outreach activities and community interaction increasingly are becoming an integral part of their everyday activities. Improving quality and community health status are high priorities for California hospitals. Similarly, physicians throughout the state are dedicated to improving the health of the population and providing high-quality medical care.

The energy crisis with soaring prices in 2001 put the state in chaos. Some experts predict that a water shortage will cripple California in this decade. Few people recognize that another crisis of even greater magnitude is on the horizon: meltdown of California hospitals. Indicators too compelling to ignore are fast approaching: nursing and other workforce shortages; inadequate government payments; unfunded seismic mandates; financial starvation from private payers; lack of access to capital; uncompensated care; emergency department (ED) and trauma center breakdowns; rising pharmacy and technology costs; unfunded regulatory standards; and energy costs head the list. Never before in the history of health care has such a confluence of adverse forces centered on hospitals.

### **Medicare**

The health care market continues to experience profound changes. Underpayments from governmental payers and private health plans are reaching the crisis level. In 1997, the federal Balanced Budget Act (BBA) imposed on hospitals more than \$60 billion in Medicare payment cuts for the years 1998 through 2002. This law translated into direct Medicare payment cuts of more than \$6 billion to California hospitals. In 1999, the Balanced Budget Refinement Act (BBRA) reduced the cuts by approximately 7 percent, primarily in the areas of home health, skilled nursing, indirect medical education and hospital outpatient services. In 2000, the Benefits Improvement and Protection Act (BIPA) reduced the BBA cuts by 11 percent. Combined, approximately 18 percent relief from BBA was obtained. Still, BBA will cut Medicare and Medicaid payments to California hospitals by almost \$5 billion through 2005. The federal budget deficit for 2003 is projected to be \$80 billion, creating more pressure to reduce payments

again. The Administration has proposed severe cuts in payments to hospitals in order to fund a Medicare prescription drug benefit and increased payments to other providers.

Beyond the direct Medicare payments on behalf of fee-for-service (FFS) patients, Medicare capitated health plans cover nearly half of the state's elderly. By comparison, less than 20 percent of the nation's over 65 population are enrolled in capitated plans. Medicare health plans, generally, pay hospitals less than Medicare pays for FFS patients. Thus, the impact of heavy Medicare managed care penetration further penalizes California's hospitals.

Medicare cutbacks are impacting hospitals' ability to deliver services and the situation is deteriorating. Medicare payments will become even more important as the population ages and the number of residents 65 and over increases.

### **Medi-Cal**

Medi-Cal is a worse payer than Medicare. Since 1982, California Medi-Cal payments have dropped in comparison to Medicaid programs in the other states. According to the Governor's January budget for 2002-2003, California's Medi-Cal expenditures per eligible in federal fiscal year 1998 were \$2,693, compared to the United States average of \$3,895 and New York average of \$6,759. California ranks last among the 10 most populous states in expenditures per eligible, and 48<sup>th</sup> nationwide. California is among the most generous states with respect to eligibility, exceeded only by New York and Georgia. Yet, California is near the bottom on the payment side of the equation.

As in Medicare, California has the highest proportion and number of Medicaid beneficiaries enrolled in capitated plans. Also similar to Medicare, Medi-Cal health plans generally pay hospitals less than Medi-Cal pays for FFS inpatient care. Medi-Cal FFS outpatient payments cover less than 40 percent of the cost of outpatient care. In 1998, CHA won a lawsuit against the state because the Medi-Cal outpatient payments are too low and inconsistent with the law. A settlement, negotiated in December 2000, resulted in a 30 percent increase on July 1, 2001, followed by three successive annual increases of 3-1/3 percent. Even after these increases, Medi-Cal will be paying only half of the actual cost of hospital outpatient care in 2005.

Approximately one-fourth of California hospitals, sometimes called the safety net, qualify for Medi-Cal disproportionate-share hospital (DSH) funds. Federal law sets the maximum amount of federal DSH matching funds available to each state. In 1997-1998, the amount available to California was \$1.1 billion. The federal funds available are down to \$1 billion in 2001-2002 and are scheduled to drop below \$900 million by 2003.

### **Private Sector**

Health plan payments to hospitals dropped or remained level for most of the years between 1993 and 1998. Pressures increased to the boiling point and a few health plans have made adjustments to some hospitals and physician groups. Payment levels from many private payers are suppressed. Further, some of the private health plans have delayed payments, denied claims, requested extensive back-up information and taken other actions to the disadvantage of hospitals

and physicians. These unfair payment patterns are being addressed by the Department of Managed Health Care (DMHC), as a result of the passage of AB 1455 (Scott) in 2000. We hope that this new law will bring a halt to the unfair payment patterns.

Some health plans have created schemes to further cut payments to hospitals and transfer more financial responsibility to patients. Tiering of hospitals, making patients pay higher out-of-pocket deductibles and co-payments when they choose “non-preferred” hospitals, and promoting individual choice are gaining popularity. The real impact, however, is more bad debts for hospitals; adverse selection; failure to recognize the costs of trauma care, medical education, research, uncompensated care, etc. The relationship between health plans and hospitals will continue to deteriorate as long as incentives for predatory practices exist.

Recent developments are pushing us to the ballot box. Disenchantment with managed care by nearly every stakeholder, intervention by elected officials, public warfare between health plans and providers, and the transferring of risk to patients are examples. The latest “short-term” scheme, under the guise of consumer choice, is “transaction facilitation” or more commonly known on the farm, “pass the buck and duck.”

The last days of the late great managed care experiment probably will change the practices of health plans. Some plans envision the next phase to be built on “consumer choice,” “greater consumer financial participation” and “information distribution.” They feel that their future is to become “purveyors of information” and “facilitators of decisions by consumers.”

Health plans draw an interesting analogy between mutual funds and the health plans of the future. For most consumers, investing directly in the stock market by picking individual stocks is a daunting and totally unrealistic prospect. The market is completely bewildering to the average consumer. That’s what gave rise to the mutual fund concept. The mutual fund operators organize and structure choices and options for the consumer. They make information available to the consumer, and lay out a series of options and possibilities, and explain to the consumer what the pros and cons are for every possibility. They facilitate the transaction. They make choices available to fit almost any personal profile, from people who want nothing but money market funds to people who are willing to invest in start-up companies and junk bonds. At the end of the day, it’s still the consumer’s money, and he or she has to make the decision and bear the risk. But they have received valuable guidance and supporting information which helps them make that decision.

Health plans see themselves evolving into a facilitator role. By organizing groups or sets of physicians and hospitals, and making available the associated cost, quality, access data, health plans will be helping consumers make decisions that reflect their own personal values and preferences.

While this “short-term,” pie-in-the-sky strategy may be attractive to health plans, it will be detrimental to all other parties in the health care equation. Adverse selection will dominate, bad debts will increase, patient dissatisfaction will expand and providers will be blamed. In other words, health plans will transfer their responsibilities to patients and providers by trying to play a “Switzerland” role in the delivery and financing of health care.

The future of health plans under these types of schemes is called into question by such self-serving actions. Although the jury is out on the latest fad of “facilitation,” the verdict can be predicted.

### **Seismic Compliance (Chapter 740, Statutes of 1994)**

Following the January 1994 Northridge earthquake in Los Angeles, SB 1953 was enacted. The law amended the original seismic statute that was enacted in 1971. This unfunded mandate requires all hospitals to comply with new seismic construction standards by 2008, with full facility construction compliance by 2030. The cost of replacing or retrofitting all non-compliant hospital buildings will exceed \$24 billion, more than the undepreciated value of all existing hospital buildings. Simply put, such capital does not exist. How hospitals can obtain funds to comply with this unfunded mandate remains a mystery. State and federal support must be made available or the 2008 deadline must be adjusted. The 2002-2003 state budget deficit of \$23.6 billion precludes a bond issue. There is no doubt that patients will not have access to hospital services. We are headed for a train wreck in hospital capacity and services unless changes are made.

### **Trauma Centers and Emergency Services**

There are 45 trauma centers in California. Most of the other hospitals operate an ED. The three levels of EDs are comprehensive, basic and stand-by. Most trauma centers and EDs lose money. They must be open and available 24 hours every day. In addition to the facilities, equipment and hospital personnel that are required, physicians must be available in the hospital or on-call. Personnel shortages and the lack of physician coverage make it difficult for hospital EDs to remain open. Statewide, hospitals are losing more than \$400 million annually operating trauma centers and EDs. Further, hospitals are paying physicians more than \$250 million each year to maintain on-call availability. As the financial, space and human resources vise closes in, hospitals will be forced to go on diversion with increasing frequency. In such instances, emergency patients must be treated at other hospitals. However, these problems are statewide and soon patients may be unable to obtain timely emergency care.

### **Workforce**

Hospitals employ more than 400,000 Californians. However, severe shortages exist in nursing, pharmacy, laboratory, radiology, social service and specialty and technical areas. By far, the largest vacancy is in nursing. These shortages have developed over time and cannot be resolved overnight. CHA is sponsoring legislation to increase the number of registered nurse student positions; streamline the educational processes and vertical mobility; and provide scholarships and loans to qualified students. In departments with fewer employees, the loss of a pharmacist, laboratory technologist, etc., can be even more problematic than losing one nurse.

Nurse staffing ratios will be imposed on hospitals pursuant to a law enacted in 2000. Costs will increase as a result of such ratios; financial pressures on hospitals will be exacerbated. Regardless of cost implications, a sufficient number of new nurses is not available. Consequently, hospital services will be curtailed and patients will not have access to needed

health care. Hospitals already are forced to shut down units or services temporarily because nurses are not available to staff the services. Emergency and special services are the most vulnerable. The regulatory process is expected to be completed in 2003, with the ratios being effective by July 2003.

Talk is plentiful but expanding the number of health care workers is being ignored for the most part. It costs more to train students in the health care professions and higher education institutions are reluctant to take on the job. Hospitals are subsidizing nursing and other programs to help close the gap between supply and demand. Of all the crises facing hospitals, the shortage of health care workers may be the most difficult. Besides funding, many other issues must be addressed in the educational institutions and in hospitals.

### **Year 2000**

All hospitals had to prepare for the year 2000. Diagnostic and therapeutic equipment could not and did not fail on January 1, 2000. Y2K compliance actions cost California hospitals more than \$1 billion in unplanned expenditures. Some hospitals are still trying to recover from this unbudgeted expense.

### **Energy**

Almost all hospitals are faced with huge increases in their base electrical rates. Many hospitals are paying significant rate increases in their electricity bills. In addition, natural gas prices have more than doubled. Hospitals must remain open continuously and thus cannot avoid using electricity and natural gas. Hospitals are limited to 200 hours per year in the use of their stand-by diesel-powered generators. When hospitals use their own generators, they usually do not have the capacity to operate the entire facility. Consequently, services must be curtailed. In some instances, diversion of patients is required. Although the price of energy has abated, the costs remain substantially higher than the pre-2001 levels.

### **Low Level Radioactive Waste**

Nearly two decades ago, Congress enacted a law that requires each state, individually or collectively with other states, to create approved low level radioactive waste (LLRW) storage sites. Even though the deadline for bringing the LLRW storage sites on-line has passed, most states have not implemented the law. Delays are due to lawsuits from environmental groups, anti-nuclear groups and consumer organizations. Funding and red tape also are contributing factors.

Meanwhile, the future of nuclear medicine hangs in the balance. In many instances, alternatives to nuclear medicine applications do not exist. Unless the safe storage of LLRW is not achieved, many worthwhile applications of low-level radioactive materials will be threatened.

## **HIPAA**

In 1996, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA), also known as the Kennedy-Kassebaum Act. HIPAA provides protection for employees that change jobs and contains other requirements that ensure that individuals with health insurance are treated fairly. HIPAA also establishes significant transaction, privacy, security, confidentiality, reporting and compliance requirements. Many of these new standards require system changes for hospitals and physicians. To comply with HIPAA, California hospitals will spend up to \$3.5 billion by 2003. Yet, there is no increase in Medicare payments or in any other program to cover these dramatic new costs.

## **The Leapfrog Group**

The Leapfrog Group, a coalition of business interests, has developed three “quality leaps” that are being promoted for hospitals. These “leaps” are being pursued in California by the Pacific Business Group on Health (PBGH). They are:

- Use of computerized prescription systems (computer physician order entry – CPOE);
- Selection of hospitals with the best results or extensive experience for select high-risk conditions and procedures (evidence-based hospital referral); and
- Staffing intensive care units (ICUs) with specialists trained in critical care.

While these initiatives are designed to reduce medical mistakes, they are expensive. For example, CPOE costs more than \$1 million per hospital for installation. On-going operating costs are significant. Similarly, ICU intensivists are costly, not to mention the scarcity of these specially trained physicians. All hospitals strive to improve the quality of care they deliver. Improving quality can be costly and all payers must recognize the cost increases in their payments to hospitals.

Recently, Medicare is being used as leverage for requiring CPOE in hospitals. One-upmanship between the private sector and the government will create an unfunded arms race in the name of safety or quality. While the goal is laudable, affordability must be considered.

## **Immigration**

More than one-half of the nation’s five million undocumented immigrants reside in California. Hospitals lose hundreds of millions of dollars treating these individuals. The federal government is responsible for immigration policies and steps must be taken to provide for federal payments to hospitals and physicians that treat undocumented immigrants. Legislation is being pursued in Washington, D.C., to provide payments to hospitals, physicians and ambulance services. However, the federal deficit and post-September 11, 2001, reaction, make federal funding remote. Meanwhile, hospitals and physicians in California continue to carry the brunt of unfunded care for undocumented residents.

## **Hospital Finances**

Patient revenues to hospitals for services rendered have been ratcheted down for two decades. The actual patient margin (operating income) in 2001 was a negative 4.24 percent, according to the California Office of Statewide Health Planning and Development (OSHPD). Patient revenue to hospitals increased by only 2.3 percent from 1996 to 2001; OSHPD's figures show actual patient revenues to be \$27,585,744,363 in 1996 and \$34,159,208,037 in 2001. The actual cost of uncompensated care, as reported by OSHPD, rose from \$1,836,426,643 in 1998 to \$3,479,790,976 in 2001, a staggering 89 percent increase. The increase in uncompensated care rose 17 percent from 2000 to 2001.

More than 62 percent of California hospitals operate in the red. Non-operating revenue, including grants, gifts, bequeaths, investment income and limited tax revenues for a few public hospitals, are the only backstop to keep some of these hospitals operating. As payment pressures from government and private payers intensify, the ability of hospitals to treat uninsured and non-paying patients diminishes. The overall economy may be doing better, but payments to hospitals for patient care have been moving in the opposite direction.

Unfunded state and federal mandates, regressive market forces, workforce shortages, rising costs of new technology and pharmaceutical products, aging and growing population, pressures of uninsured patients and skyrocketing energy costs must be addressed. The energy crisis of 2001 will pale in comparison to the shortage of hospital services unless impending financial, seismic and workforce issues are addressed.

## **Hospital Closures**

For the past decade, an average of six hospitals has closed each year. Losing the hospitals in many communities is bad; the loss of their emergency departments is even worse. Each hospital that is forced to close or downgrade its emergency department creates more pressure on the remaining emergency departments and trauma centers, not to mention the negative impact on patients requiring emergency care.

## **Value**

“Uncompensated care” is the sum of charity care and bad debt, as defined herein. “Charity care” is the portion of hospital patient care provided that is not paid for by a governmental payer (contractual allowance), or is beyond the patient's ability to pay. It can include co-insurance and deductibles. “Bad debt” is the portion of hospital care provided that is not paid for by a third-party payer and is within the patient's ability to pay, but is not paid. “Underpayments” mean the shortfalls created by inadequate payments from payers to cover the reasonable costs of services provided. “Contractual allowance” is the difference between charges, less co-insurance and deductibles, and the amount of governmental payments.

The term “charity care” is not uniformly defined by either the federal or state governments, nor are activities related to the term uniformly recorded or reported. Since patients may be shifted to other categories, bad debt for example, it is more accurate and consistent to rely upon

uncompensated care, underpayments, stand-by availability, contractual allowances, education, research and community benefit as indicators of a hospital's value.

Attempting to separately identify charity care as a measure of a hospital's service to the uninsured is as flawed as describing an elephant by looking only at the animal's trunk. In order to obtain a complete picture of a hospital's "value to the community," many factors must be considered beyond uncompensated care and underpayments. The availability of services to the community, economic impact of the hospital in the community, social contributions of the institution, health status improvements and improved quality of life in the community are among the added benefits of hospitals. The value of a hospital is further measured by its tangible and intangible services, contributions, community outreach, educational programs, standby availability, research and quality. For-profit hospitals also contribute to the community's well being through the payment of property and other taxes.

"Community benefit" defined in California law (Section 127345 {c}, Health and Safety Code) for not-for-profit hospitals, means a hospital's activities that are intended to address community needs and priorities primarily through disease prevention and improvement of health status.

### **Future**

CHA's vision is an "optimally healthy society." CHA's goal is for "every Californian to have equitable access to affordable, medically necessary, high-quality health care." In order to achieve the vision and goal, several steps must be taken:

- State, federal and local government payments to health care providers and health plans must be adequate and timely.
- Funds and financial assistance must be provided for hospital projects that are required by SB 1953 (1994), the Hospital Facilities Seismic Safety Act, or the 2008 deadline must be altered.
- Private third-party payers must adequately pay hospitals and physicians for all covered services in a timely manner.
- Support for the safety net must be increased and stabilized.
- Coverage for Californians should be maximized in the private and public sectors.
- More health care workers must be trained to serve our diverse and aging population.
- Incentives among providers and between providers and payers must be aligned. Patients also must play a role in balancing the supply and demand sides of the health care equation.
- Hospitals and their communities must determine their own goals, priorities and accountabilities.

### **Summary**

California hospitals are experiencing severe financial stress and unprecedented workforce shortages. Evidence of these pressures is verified by the downgrading of hospitals' bond ratings,

hospital closures and cutbacks in service. The challenge is to maintain quality and access in this increasingly adverse and complex environment.

By comparison, California's health care delivery system is underfinanced. Capitation premiums in California are 30 percent lower than most other states. Governmental payments are lower also, and there are fewer health care workers per capita in the state.

All of these factors influence the viability of California hospitals. Unless the trends cited above are reversed, many California residents will not receive health care when they are ill or injured. Hospitals are working to improve their practices internally and maximize their efficiency. State and federal changes also must be made to preserve hospital services for every Californian.

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