

Statement
“Health Care Scene in California”

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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 and rolling blackouts has the state in chaos. Few people believe another crisis of even greater magnitude is on the horizon. Some experts predict that an impending water shortage will cripple California. Those of us in the health care field know that a hospital meltdown is imminent. Indicators too compelling to ignore are fast approaching: nursing and other workforce shortages; unfunded seismic mandates; financial starvation and lack of access to capital; uncompensated care; emergency and trauma breakdowns; regulatory standards; and energy costs head the list. Never before in the history of hospitals has such a composite 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. Most of the payment reductions and reforms were end-loaded, that is, the bulk of the payment cuts are occurring in 2001 and 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. Last year, the Benefits Improvement and Protection Act (BIPA) reduced the cuts by 11 percent. Combined, approximately 18 percent relief from the BBA was obtained.

Still, the BBA will cut Medicare and Medicaid payments to California hospitals by almost \$5 billion through 2005.

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 a capitated plan. 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 2001 budget for 2001-2002, 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 48th 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 that are 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, will result 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 approximately 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 which are available to each state. In 1997-1998, the amount available to California was \$1.1 billion. The federal funds available are down to \$1.0 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 private payers are so suppressed that hospitals have no sources to recover their costs. Further, private health plans have delayed payments, denied claims, requested extensive back-up information and played a variety of other

games 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. DMHC is in the process of adopting regulations pursuant to AB 1455. We hope that this new law will bring a halt to the unfair payment patterns of many of the commercial health plans that contract with hospitals.

Seismic Compliance (Chapter 740, Statutes of 1994)

Following the January 1994 Northridge earthquake, 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. Senator Joseph Dunn (D-Santa Ana) is the author of SB 928, a bill that calls for a state general obligation bond to cover one-third of the 2008 deadline construction and retrofit costs. SB 892 by Senator Jackie Speier (D-Hillsborough) provides a five-year extension to the 2008 deadline for certain hospital buildings. The energy crisis and other financial pressures on the state make a bond issue problematic. There is no doubt that patients will not have access to hospital services unless changes are enacted. We are headed for a train wreck and legislative action is needed this year.

Trauma Centers and Emergency Services

There are 43 trauma centers in California. Most of the other hospitals operate an emergency department (ED). The three levels of EDs are comprehensive, basic and stand-by. Virtually every trauma center and ED loses 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 \$300 million annually operating trauma centers and EDs. Further, hospitals are paying physicians more than \$200 million each year to maintain on-call availability. As the financial 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. Legislation is pending to provide hospitals and physicians some financial relief, although enactment is uncertain.

Workforce

Hospitals employ more than 400,000 Californians. Yet, severe shortages exist in nursing, pharmacy, radiology, social service and specialty areas. By far, the largest vacancy rate 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.

Nurse staffing ratios will be imposed on hospitals, beginning January 1, 2002. If the costs increase as a result of such ratios, financial pressures on hospitals will be exacerbated. Regardless of cost implications, the nurses are not available. Consequently, hospital services will be curtailed and patients will not have access to needed services. Hospitals already are forced to shut down units or services temporarily because nurses are not available to staff the services.

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 expense.

Energy

Almost all hospitals are faced with huge increases in their base electrical rates. Many hospitals are experiencing up to 1000-plus percentage rate increases in their electricity bills, primarily due to penalties imposed under interruptible contracts. 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. CHA has petitioned the California Public Utilities Commission to adopt a uniform rate increase and avoid shifting residential or other electrical costs to essential users such as hospitals.

HIPAA

In 1996, Congress enacted the Health Insurance Protection 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 privacy, confidentiality, reporting and compliance requirements. Many of these new standards require system changes for hospitals and physicians. To comply with HIPAA, California hospitals will have to spend up to \$3.5 billion by 2005. Yet, there is no increase in Medicare payments or in any other program to cover these dramatic new costs.

Hospital Finances

Patient revenues to hospitals for services rendered have been ratcheted down for two decades. The actual patient margin (operating income) in 2000 was a negative 5.82 percent, according to the California State Office of Statewide Health Planning and Development (OSHPD). Patient

revenue to hospitals increased by only 15.6 percent from 1996 to 2000; OSHPD's figures show actual revenues to be \$27,585,744,363 in 1996 and \$31,890,027,298 in 2000. The actual cost of uncompensated care, as reported by OSHPD, rose from \$1,836,426,643 in 1998 to \$2,958,428,167 in 2000, a staggering 61.1 percent increase.

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 booming, but payments to hospitals for patient care have been moving in the opposite direction.

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

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 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, stand-by 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 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 population.
- Incentives among providers and between providers and payers must be aligned.
- 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 downgradings 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. California has the highest proportion of undocumented residents and uninsured of all states. Half of the nation’s 4 million undocumented persons reside in California.

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.

CHA is working to help hospitals 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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