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### The Realities of Healthcare Costs

By Gregory Burfitt

America is in the midst of a great debate that will determine the fate and structure of the healthcare delivery system for the United States now and for future generations. The largest driving factor that will require us to move toward this change is the high cost of health care. Politicians rant about out-of-control healthcare costs, which the Obama administration projects will increase by 60 percent over the next 10 years and are rising at three times the rate of inflation. Some economists express concerns that health care could someday consume 20 percent of the nation's gross domestic product (GDP).

There are several realities about healthcare costs that must be understood if we are to avoid the risk of developing a reformed program that is worse and more expensive than our present system. The most striking reality is that the same government that proposes to solve the current healthcare dilemma is the very entity that has contributed to our healthcare cost problem and amplified it over the past 45 years. Here are the facts and realities behind our healthcare cost discussion.

#### Reality No. 1: The healthcare product being purchased today is not the same product of the past.

The discussion about the rapid rise in healthcare costs takes place without regard to the differences in quality, convenience, breadth of services, access, or overall quality of life that have occurred. Americans have always wanted the best care, and no one leaves America for Canada to receive better health care. The next time you are in a hospital, look around you. The person delivering that expensive aspirin to your private room is highly trained and surrounded by expensive equipment, inspected regularly, to ensure that any potential emergency can be handled with the best possible outcome. This equipment and technology available is second to none. In other countries, virtually all hospitals have diagnostic equipment available only on a regional basis, and certain criteria or wait periods exist before access to this equipment may be granted. The result of this specialized

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technology and the advanced skill of physicians is the ability to rapidly return patients to their lengthy productive lives, leading to a decrease in time spent away from work and family and a corresponding increase in national productivity (which is never calculated into the healthcare cost discussions). There are many reasons that the United States is more productive than other countries. An integral part of that calculation is the timely, high-quality health care that is provided to its citizens.

**Reality No. 2: Healthcare costs and healthcare charges (or prices) are not the same thing.**

Charges are the list price for healthcare services received. Politicians often use the terms “cost” and “charges” interchangeably. Medicare requires by law that there can only be one charge schedule for an organization. As a result, most billing statements received by consumers reflect charges, not costs, and not the amount of revenue actually received by the hospital or physician. The bill that you open does not reflect the amount the hospital actually receives from the insurance company or the federal government. The only patients who are expected to pay charges are patients who are without insurance or other contracts.

Actual cost increases are not the only reason for the rise in the amount of our nation’s GDP that is spent on healthcare. Our population is living longer, and their demand for services has increased. The improvement in the death rate for major diseases such as heart disease and cancer has resulted in people living long enough to develop chronic diseases that require treatment over the longer term. Illegal or undocumented aliens typically do not have access to insurance, and the expense of their treatment must be assumed by the rest of society.

**Reality No. 3: Most patients and insurance companies do not pay charges.**

The patients who are expected to pay charges are those who are without insurance or other contracts, and represent less than 10 percent of the total patient volume. This category includes undocumented aliens, individuals who can pay for their care but choose not to (their bills often fall under “bad debt”), and people who can purchase insurance, but choose not to. Because of intense political pressure and concerns of discrimination, most uninsured patients are now routinely offered discounts. At most facilities, this is calculated on an income-scaled basis. Deductibles and co-pays are usually calculated from the charges, which inflates the patient’s responsibility for co-pays by as much as 50 percent to 70 percent. It is not uncommon for the patient to pay more to the provider than their insurance company or third-party payer. This issue could easily be corrected by lawmakers without radically changing our healthcare system.

**Reality No. 4: The federal government does not pay the full**

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The federal government currently underpays the actual costs incurred by these programs by \$88 billion annually. For Medicare, this equates to paying approximately \$.89 out of every dollar of cost incurred. The Medicare program originally paid actual costs along with additional funds allocated for technology, bad debt, capital costs, and additional nursing costs incurred in providing care to senior citizens. It only took a few years of operation for the Medicare program to delete these additional real-cost expenditures from the reimbursement process. The original program was designed to provide care for people over 65 after retirement. The original cost projections for the program were made when the average life expectancy was 70 years of age. The average life expectancy has now grown to 75, which has significantly increased the cost of the program to the federal government and the taxpayer.

The Medicaid program is operated by states and is funded through state budgets and federal matching funds. The funding and level of benefits provided, and the qualification levels for participation, vary by state. The amount of funding provided for the operation of the program also varies widely by state. The typical state Medicaid program pays about 50 percent of the actual costs experienced in providing care to its recipients. To participate in the Medicaid program, states must provide a set minimum group of services. Although these services are required by the federal government, many are not funded by the federal government. These unfunded services are known as unfunded mandates. Most states struggle with the Medicaid program because the greatest use of the program occurs when unemployment is up and state revenues are down. Governors at a recent national meeting expressed concern that the proposed changes to our healthcare system would further shift cost and service responsibility to the states without corresponding financing being provided. In other words, there would likely be additional unfunded mandates down the road.

**Reality No. 5: The greatest reason for the rapid rise in healthcare charges is the federal government's underpayment for services provided to Medicare patients, resulting in cost shifting to other payers.**

In the typical hospital, 50 percent of patients are Medicare patients, 5 percent are Medicaid patients, and 5 percent are charity and bad debt. The payment received by the provider of care for each of these groups is less than the provider's actual costs. This means that the patients with contracts from insurance companies and third-party providers and the 10 percent of patients without contracts must pick up this deficit in order for the hospital or physician's office to remain solvent.

Contract patients represent 35 percent of most hospitals' activity levels. These are the only patients for which normal market forces

prevail. Dominant insurers with large volumes of patients can negotiate great discount rates from providers. Providers with a dominant market position, critical services, or wide geographic distribution can negotiate better rates with insurers. The payment methodology varies widely and includes payments based on percentage discount off of charges, diagnosis-related group (DRG) payments, flat-rate payments, and cost plus reimbursement arrangements. For years the benchmark for negotiation has been the Medicare reimbursement rate, which is lower than costs. Most contracted payers negotiate rates that are between 130 percent and 150 percent of the Medicare rate. Most negotiated contracts have terms of three years to five years, which means if there are rapid changes in costs during that period, the provider will suffer in the short term. This explains why there are cyclical changes in the inflation rate of healthcare charges. An institution or physician must break even financially over time, and ideally would have at least a 4 percent operating margin. For the typical patient mix outlined above, the charges that a noncontracted patient must pay are three times the amount of the institutional cost, or a markup of 300 percent. If the federal and state governments paid their actual costs of the programs they currently operate, the charges would only be 140 percent of costs. This would represent an immediate potential charge reduction of 53 percent to the patient. Cost shifting is real and significantly affects the prices paid by all persons with and without insurance.

As a result of cost shifting, the burden placed on physicians or hospitals to generate surplus income for expansion and technological advances is transferred to non-Medicare or non-Medicaid patients. Because the actual cost for bad debt and indigent care is also not covered by the government, this cost also affects the ultimate cost structure of healthcare providers. Providers with a smaller percentage of patients who fall under Medicare, Medicaid, indigent, and bad debt have an easier time creating a positive bottom line. They are able to get better and lower-cost financing, which influences their overall capital structure and ultimately their pricing.

**Reality No. 6: The charges for care can never be equal for all regions of the country.**

Politicians have pointed to the differences in the cost of care in various areas of the country, citing low-cost situations and questioning why these lower costs cannot be true for all regions of the United States. These data come from the billing system, where the "cost" being discussed is really charges. The premise being made is that somehow better information from the national plan regarding practice patterns will bring huge savings to the entire system. Better information regarding best practices is helpful and can improve average charges, but unfortunately, until the federal government pays the full costs of the current programs it operates, equalization of expense can never happen. For example, a

hospital in Miami with 70 percent Medicare, 10 percent Medicaid, and 10 percent bad debt will have to have charges that are 454 percent greater than its actual costs versus the 300 percent required for the average hospital. The only way to truly level out charges uniformly throughout the United States is to ensure that every city throughout the country has the same percentage of Medicare patients, Medicaid patients, indigent care patients, and undocumented aliens. Because of cost shifting, hospitals with equal efficiency in Miami can never have the same cost per case, or charge per case, as hospitals in Wisconsin.

**Reality No. 7: Individual's personal health care coverage will likely end up in the national health plan.**

A federally operated national health plan will never compete equally on a cost basis and will drive every other insurer out of the market. Even if the national health plan was initially set up on an equal expense basis with private plans, the loss of patients who currently have insurance that migrate to the national plan would force hospitals and physicians to negotiate larger increases from the private plans. Even a small shift of insured patients into the national plan will cause a disproportionate cost shift to private insurance plans. It is critical that a national health plan pay rates that are higher than actual cost and that payment not be reduced below this level by legislators in the future.

One of the proposed payment rates being floated for the national health plan would equal 110 percent of the current Medicare payment rate, which is \$.89 for every dollar of cost incurred. This means that people participating in the program would also underpay at approximately \$.98 for a dollar of cost. If only a small percentage of the businesses opt to discontinue their current insurance plans and transfer their employees into the national plan, the negotiated rates with insurance companies would increase drastically. This huge cost differential between insurance rates and the national plan would then force businesses to transfer their patients into the national plan as well. Over a fairly short period of time, there would be no alternative to the national healthcare plan, and the United States would be operating under a single payer system.

**Reality No. 8: Government underpayment for Medicare and Medicaid assures that any trigger for implementation of a national health plan based on controlling rising healthcare costs is guaranteed to ensure the implementation of the national plan.**

There has been resistance towards initiating a national health plan; therefore, a compromise solution has been floated that would initiate the national health plan only if healthcare costs cannot be contained. Simultaneously, the healthcare industry has been forced to commit to saving \$155 billion in reimbursement over the next 10 years. There is no plan or methodology to bring about

such savings. If Washington follows its normal behavior, these proposed savings will become part of the future budgets proposed for Medicare. This reduction in reimbursement to hospitals, along with inflation and the existing \$88 billion shortfall, will guarantee the additional costs will be shifted to other payers. Thus, costs (charges) will not be contained at an appropriate level. Therefore, the national plan will be activated. Government reimbursement methodology makes this an inevitable outcome.

Is the cost of healthcare important? Absolutely! But let's take into account the differences in the healthcare product to which Americans have access versus the healthcare product offered by other countries. We can change our system drastically, but in so doing could put at risk our ability to choose, our ability to access needed services at will, and the rate of technology advancement in our country.

America is currently the funding mechanism for the majority of the pharmaceutical advances made in the world. The cost of drugs in other countries is a fraction of that paid in the United States. The balance of the difference in payment is used for research and development that benefits the entire world. An inefficient healthcare delivery program operated by the government does not guarantee access to needed treatment. In other countries that have already attempted the same approach, taxes are higher, GDP growth is lower, treatments are routinely denied, and lines of patients waiting for treatment are long.

Do we need change? Yes! But changes to our healthcare system should be thoughtful and carefully chosen and implemented. We do not have a perfect system, but it is not broken enough to completely dismantle. We have a good building platform to begin the process of rational change. Americans should not let fear, misinformation, and unrealistic pressure for speedy change force them into a reformed system that does not work and has not worked in other countries where it has been tried. The government-controlled healthcare system being discussed in Washington cannot be financially sustained without huge tax increases. Our legislators are so certain about the effectiveness of the new plan that they have excluded themselves from participation. Why not ask our leaders to develop a plan and try it on themselves before subjecting the rest of the country to it? We do need reform, but reform can be achieved by utilizing the best parts of our existing system--correcting its problems, such as portability, eliminating denial for pre-existing conditions, allowing the sale of insurance across state lines, and allowing small businesses to form groups to negotiate for lower premiums. These, and other positive changes, could be made to improve the existing system and could be implemented for significantly less money than a radical overhaul.

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