

## Rates, Continued from page 2

rate based on a patient's diagnosis and treatment, with additional payments available for very expensive "outlier" cases. During the recession, Oregon set Medicaid reimbursement rates for urban hospitals at 72% of Medicare rates. Since 2001, Oregon has taken steps to improve reimbursement rates to these hospitals. A hospital provider tax was enacted in 2003 to leverage federal dollars and use them to raise hospital reimbursement rates to 100% for DRG hospitals in a portion of the Medicaid program.<sup>19</sup>

## Hospital Profits

While all but two of the state's hospitals are considered non-profit, that doesn't mean that they don't make a profit, it means that they don't pay taxes.

Profit is defined as the amount by which income exceeds expenses. Operating profit (or "operating margin") is the difference between operating revenue and operating expenses. Total profit (total margin) is the difference between all hospital revenue (including investment income, donations, and taxes) and all expenses. Profit rates are expressed as a percentage: the amount by which revenue exceeds expenses divided by revenue.

Oregon hospital operating and total profits have exceeded national profit rates every year since 1997. In 2005, the median Oregon hospital had a total profit of 5.3%. As the chart on page one shows, Oregon hospitals have been significantly more profitable than their national counterparts since at least 1997.<sup>20</sup>

## Citations:

1. CMS – news release Jan. 10, 2006
2. Center for the Study of Health System Change, Paul B. Ginsburg, et al, "Tracking Health Care Costs: Spending Growth Remains Stable at High Rate in 2005"
3. Kaiser Family Foundation, State Health Facts 2006.
4. Employment numbers from Oregon Employment Department; Inpatient visits from the OHPR discharge database; Outpatients visits from the Hospital Database 2005
5. Oregon Health News 2006 Hospital Report
6. Ibid.
7. Ibid.
8. 2005 AHA Annual Survey
9. Kaiser Family Foundation, State Health Facts based on CMS data.
10. Prime Target: Hospitals?, Modern Healthcare, 1/15/07
11. Kaiser Family Foundation, State Health Facts based on CMS data.
12. Behind Oregon's Health Care Crisis, Oregonians for Health Security, 2/05
13. CMS Office of the Actuary, 2004 State Estimates – all payers – personal health care.
14. Kaiser Family Foundation, State Health Facts based on CMS data
15. Behind Oregon's Health Care Crisis, Oregonians for Health Security, 2/05
16. Oregon Health News 2006 Hospital Report
17. Medicare Cost Reports; actual percentage markup was 103.7% for Oregon hospitals in 2003. For a fuller discussion of this issue see "The Price of Motherhood," Oregonians for Health Security, August 2005, p. 2.
18. Office of Health Policy and Research, Audited Financial Statements.
19. Oregon Office of Rural Health, Oregon Health & Science University, November 2004
20. Medicare Cost Reports; actual percentage markup was 103.7% for Oregon hospitals in 2003. For a fuller discussion of this issue see "The Price of Motherhood," Oregonians for Health Security, August 2005, p. 2.

## Policy Primer



# Hospitals: Reducing Costs and Increasing Accountability

Hospital spending makes up the greatest portion of our health care dollar. It is also the fastest rising component of health care costs. For the private market, hospital costs (outpatient and inpatient) are the largest single drivers of health spending growth, accounting for 38% of the total increase in health care spending in 2005.<sup>1</sup>

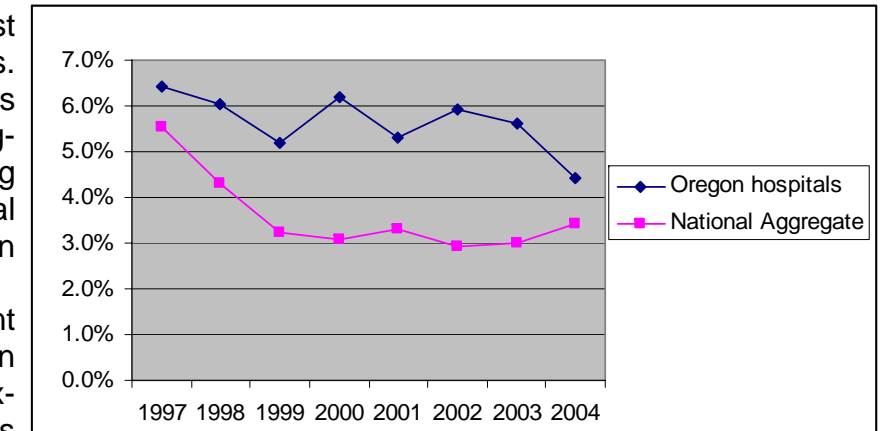
Spending for hospital outpatient services has grown more quickly than any other slice of the health care expense pie for privately insured patients every year since 2002.<sup>2</sup> In Oregon, we spent \$1,673 per capita just on hospital care in 2005.<sup>3</sup>

In 2005, Oregon's 58 acute care hospitals employed more than 51,000 people and accounted for more than 367,000 inpatient discharges and more than 8.3 million outpatient visits.<sup>4</sup>

Operating profits rose by 15% in 2005, following a 28% increase in 2004.<sup>5</sup> Net income for Oregon hospitals (and Southwest Washington Medical Center) was \$406.9 million, up \$30 million from 2004.<sup>6</sup> Operating income, which rose about a half a percentage point each of the past five years, rose \$10.8 million in 2005.<sup>7</sup>

Oregonians spend less time in the hospital than most of the country. In 2004, Oregon ranked third lowest in the nation for inpatient days per 1,000 residents, with only 407 days.<sup>8</sup> However, on the flip side, Oregon hospitals charge some of the highest prices in the nation. In 2004, Oregon was the second most expensive state to spend a day in the hospital, with an average daily rate of \$1,977.<sup>9</sup>

## Oregon hospital margins compared to national aggregate




The growth in hospital spending has a huge impact on the state budget, since Medicare, Medicaid, and other government programs are responsible for 57% of all hospital spending.<sup>10</sup>

## Oregon Hospital Landscape

*Oregon is the second most expensive state in the nation to spend a day in the hospital<sup>11</sup>*

Currently, there are 58 hospitals in Oregon, with all but two operating as non-profit or public institutions. Oregon does not regulate hospital prices, and hospitals have no competition in most parts of the state. In many areas, especially the Portland metropolitan area, the market has consolidated over the past decade. In the Portland tri-county area, two health systems together control about four-fifths of the market.<sup>12</sup> Changes in hospital ownership and consolidations have moved many decisions from community halls to out-of-state corporate board rooms.

Hospitals collected more than \$6 billion in Oregon in 2004 — more than the state government general fund.<sup>13</sup> Hospital expenses per adjusted inpatient day grew 44% from 1999 to 2004, much faster than the national rate of 32%.<sup>14</sup>



**Oregonians for Health Security** seeks to unite health care professionals, consumer organizations, caregivers and concerned citizens to advocate for improved access to quality, affordable and secure health care.

9813 SE Hwy 212  
Clackamas, OR 97305  
503-655-2793 503-655-2879 fax 888-654-2273  
[www.oregoniansforhealthsecurity.org](http://www.oregoniansforhealthsecurity.org)

# SOLUTIONS

## Hospital Construction

Four of every 10 staffed hospital beds in Oregon sat empty in 2004, yet Oregon's hospital systems are spending record sums to build new hospitals.<sup>15</sup>

PeaceHealth's Sacred Heart is building a new hospital in the backyard of Springfield's community hospital which in turn is building in Eugene; Legacy recently built a new hospital in Vancouver; Providence has expanded in Portland and Newberg and is looking to build new facilities in Portland's east and west suburbs; and Kaiser is building in Washington county.

Hundreds of millions of our health care dollars are spent on this expansion, but, for the most part, they are not building the primary care facilities we need, especially in underserved communities.

The public is paying for this building boom in the form of higher hospital charges, increased taxes when non-profit hospitals remove property from the tax rolls, and increased insurance premiums. Yet, we have little input on how our money is spent.

## Uncompensated Care

Hospitals have reported increasing costs for uncompensated care, including charity care, since Oregon and the nation plunged into recession and thousands lost public and private insurance coverage.

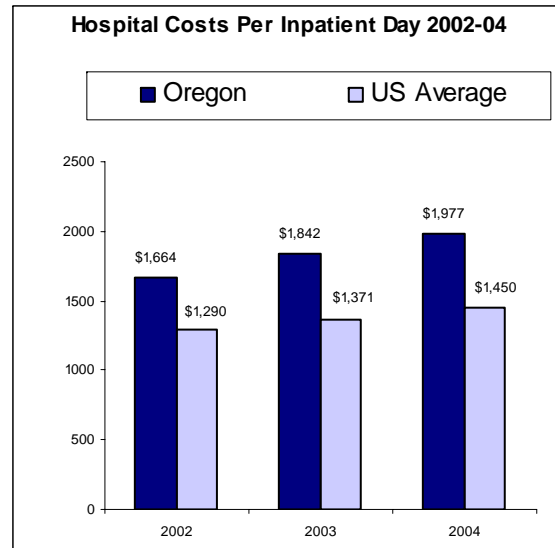
The cost of hospital uncompensated care has remained essentially flat as a percentage of expenses, however. Total uncompensated care provided by all community hospitals nationwide was 5.1% of total expenses in 1980 and 5.6% in 2005, peaking at 6.4% in 1986 and dropping below 6.0% during all years after 2000.<sup>16</sup>

In Oregon, data about the cost to hospitals of uncompensated care is not readily available, however, hospitals report a major increase in the billed amounts forgiven as charity care or written off as bad debt. Fitch Ratings reports that bad debt continues to be driven primarily by the growing uninsured population.

## Hospital Pricing

The price a hospital charges a patient (the "list price," or what hospitals call a master charge) includes the cost of providing the service, plus a markup. List prices in Oregon are, on average, more than double what it costs to provide the service.<sup>17</sup>

Some hospitals and some services have higher markups than others, though it is almost impossible for the average consumer to access this information.



Hospitals discount the list price for large, influential health purchasers and the government (e.g. for Medicare), yet most hospitals do not discount for uninsured patients. This means that the one in six Oregonians without health insurance—those often with the least ability to pay—are generally charged the highest amount.

Because hospitals make more money from some types of patients and some types of services, hospitals have incentives to avoid certain patients while competing for others and to avoid providing certain services while increasing

the demand and their market share of others.

## Hospital Reimbursement Rates

Reimbursement rates are the after-discount prices paid by Medicare, Medicaid, and commercial insurers. Studies show that reimbursement rates paid by commercial insurers are highest, Medicare lower and Medicaid lowest.

Both the federal and state governments have established programs to ensure that rural hospitals—which tend to see a higher percentage of Medicare and Medicaid patients than do urban hospitals—are adequately reimbursed. Medicare and Medicaid both pay Type A & B rural hospitals 100% of their actual costs for providing services. Of Oregon's 58 acute care hospitals, 30 are Type A or B hospitals, meaning that they have 50 or fewer beds and are classified as "rural" or "remote."

Both Medicare and Medicaid reimburse DRG (Diagnosis-Related Group) hospitals a flat

**Continued to back page**

## Fair Hospital Pricing

Oregon spent \$6 billion on hospital care in 2005 and the amount is growing faster than the cost of living. A major contributing factor to these rising costs is unchecked hospital prices.

Hospitals have little incentive to provide the best patient care at the best price.

Fair Hospital Pricing legislation would:

- Set fair prices for those who can least afford care by requiring hospitals to bill uninsured patients no more than they bill for patients covered by Medicare or their largest-volume commercial insurers.
- Create incentives for hospitals to lower their prices and increase efficiency by setting a ceiling on profits of 5%. Hospitals that meet targets for efficient operations and good patient outcomes would have a ceiling of 6%.
- Increase access to affordable health care by investing excessive hospital profits in the Oregon Health Plan.

## Hospital Financing Accountability

Taxpayers are subsidizing an unprecedented hospital building boom and allowing hospitals to finance this expansion cheaply through the use of tax-exempt revenue bonds.

These bonds were designed to encourage development in the best interest of the community. Yet in many cases, these tax breaks are used to build facilities that aren't in the best interest of the community and, in fact, may actually increase the cost of health care without improving health care access at all.

Legislation to make hospital financing account-

able would:

- Ensure tax dollars are being invested wisely by requiring hospitals to demonstrate the proposed capital expenditure meets community health care needs.
- Require hospitals seeking tax-exempt bond financing to show financial need.
- Promote accountable hospital financing by requiring hospital facility bonding authority members to disclose conflicts of interest and recuse themselves from considering applications of hospitals with which they are connected.

## Community Voice in Planning

When the Certificate of Need (CON) process was created to address the reality that overbuilding drives up health care costs, the process applied to most hospital development and was influenced by community-based planning.

Over the years, public input has been stripped away and a CON is no longer required for many types of hospital investments. The process needs to ensure health care needs are being met and that the community has a voice in how health care dollars are being spent.

Strengthening CON legislation would:

- Provide the community a voice in health care planning by requiring the state to consider recommendations from community-based groups.
- Plug the loopholes in the CON law that permit health systems to do some development, such as closing hospitals or building new facilities near existing ones, without any public oversight.
- Hold hospitals accountable to the promises they make when seeking a CON.



*"I never dreamt after 24 years, my husband would lose his job and all this would happen. I owe thousands of dollars now. I can't go to the hospital anymore, once you've already lost one house you fear the whole process." Sue Krieger, Forest Grove*

Nine years ago, the Kriegers lost their health care coverage, when Charlie lost his job of 24 years. One night, Sue went to the emergency room fearing a heart attack. The hospital told her she could get on the Oregon Health Plan. She spent four days in the hospital undergoing tests to find the problem. The Kriegers ended up with a \$20,000 bill because Sue didn't qualify for OHP- Charlie made \$28 too much. Uninsured and unable to pay the bill, the hospital put a lien on their home. Sue and Charlie ended up selling their home to a broker and paying the hospital, to escape the lien. They were never offered assistance from the hospital. The whole process leaves Sue with more fear. She was going to a clinic at OHSU, but the costs went up and she started receiving more bills and worries about another lien.