Hospital Financial Management

Payer Types

- Non-governmental or private (commercial) health plans pay rates that are negotiated between the payer and the hospital through contracts, thus creating a network of providers that offer health services to patients who are insured by a particular health plan.

- Government payers usually pay the lowest rates and often do not cover the cost of the service. Types of government payers include Medicare, Medicaid, the U.S. Department of Veterans Affairs, and state and local correctional agencies.

- Patients who have no insurance coverage (i.e., the uninsured) are considered self-pay. Patients who have insurance that does not cover the entire cost of their care (e.g., deductibles or copayments) or that does not cover a particular service may also be considered self-pay. These types of patients are often referred to as "underinsured."

    - Hospitals may work out payment plans with self-pay patients to receive some payment for the cost of care that was provided. A self-pay patient may qualify for the hospital's indigent and charity care policy based on family income. In these cases, the hospital may cover the entire amount of the patient's bill or will subsidize the cost of the bill and require the patient to pay some amount based on his or her income and a pre-established sliding scale.

    - Hospitals may also provide financial assistance on a case-by-case basis to patients who have exhausted their insurance benefits, who are underinsured and/or whose income or assets exceed financial eligibility criteria but face extraordinary medical costs.

- Hospitals may also receive payments from other sources, such as automobile insurance policies for patients who were injured in an accident.

Inside the H

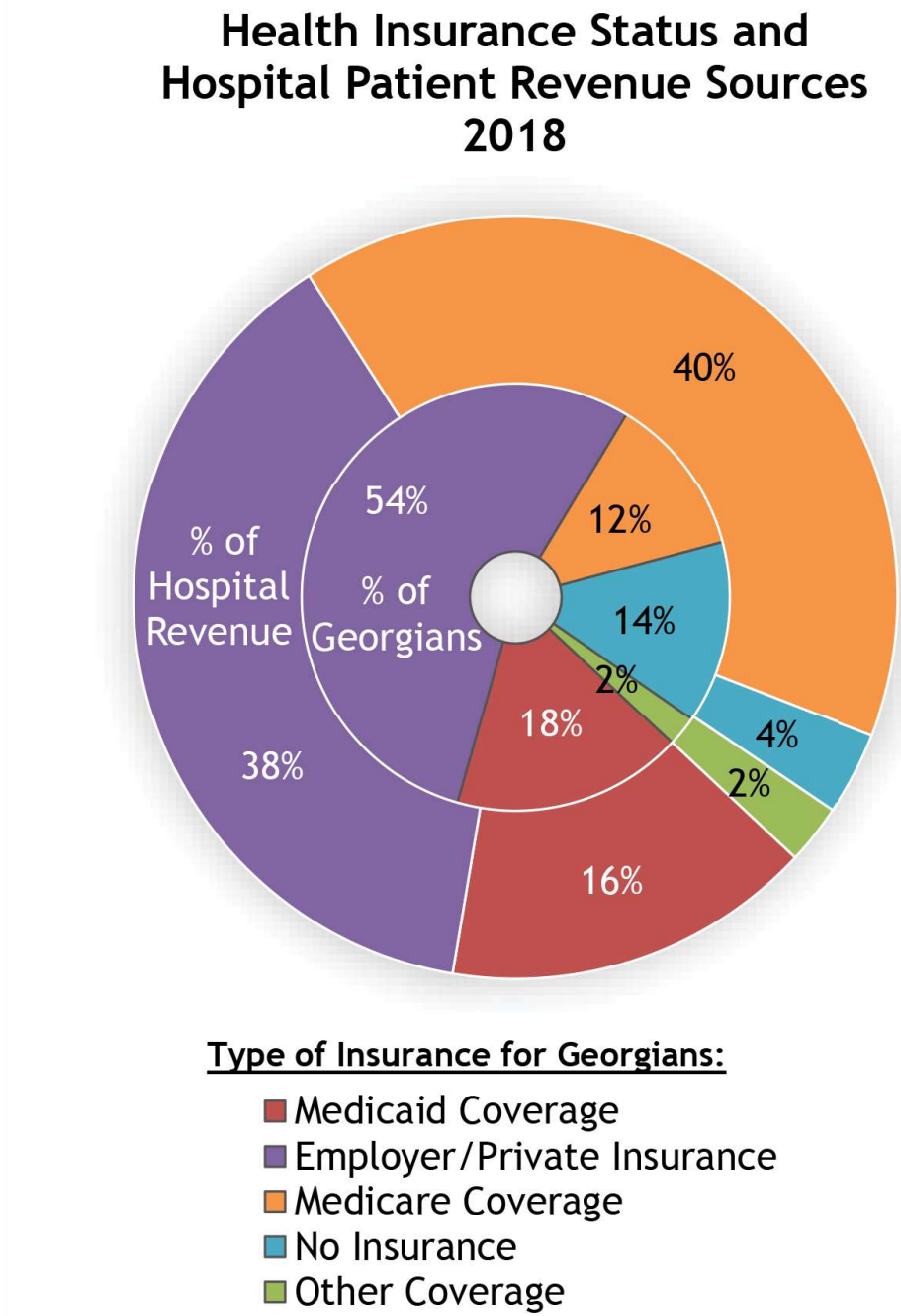
Hospitals charge the same prices to all patients as a requirement of Medicare participation.

While charges are the same regardless of the patient being served, the hospital receives different payment amounts depending on the payer source.

Hospitals negotiate actual payments with some payers and receive predetermined amounts from programs like Medicare and Medicaid.

Figure 2 on page 12 reflects the distribution of patients by payer types and the amounts received by hospitals.

Figure 2



Patient Billing

The format of a hospital bill may vary by hospital; however, the elements of the bill are universal. A hospital bill will begin with the amounts the hospital charges for the services that were rendered. Hospitals are required to charge the same amount for any service regardless of the patient's payment source. Patients with insurance that has made a payment on the claim will likely see an adjustment reflecting the difference in the hospital's charges and the amount the insurance company has negotiated for the services rendered. This is known as a contractual adjustment and is the base amount used to determine the patient's cost sharing. Patients who qualify for the hospital's indigent or charity care programs would see similar adjustments showing the value of the financial aid being provided. Any residual amount left after considering these adjustments would typically be the amount owed by the patient. These amounts may comprise a combination of deductible, coinsurance, copayments and non-covered charges due as determined by the insurance plan.

Bad Debt

Hospitals incur bad debt, which occurs when a patient does not pay his or her bill and does not qualify for the hospital's indigent or charity care programs. Hospitals must cover bad debt losses from positive margins gained from other payers. According to the 2017 Georgia Department of Community Health's Hospital Financial Survey, Georgia hospitals reported $733 million in bad debt cost, or about 3.1 percent of their total expenditures. In recent years, hospitals have seen escalating increases in bad debt due to higher patient cost sharing under most private insurance plans. Average bad debt decreased 4 percent from 2017 to 2018.

Subsidizing Uncompensated Care

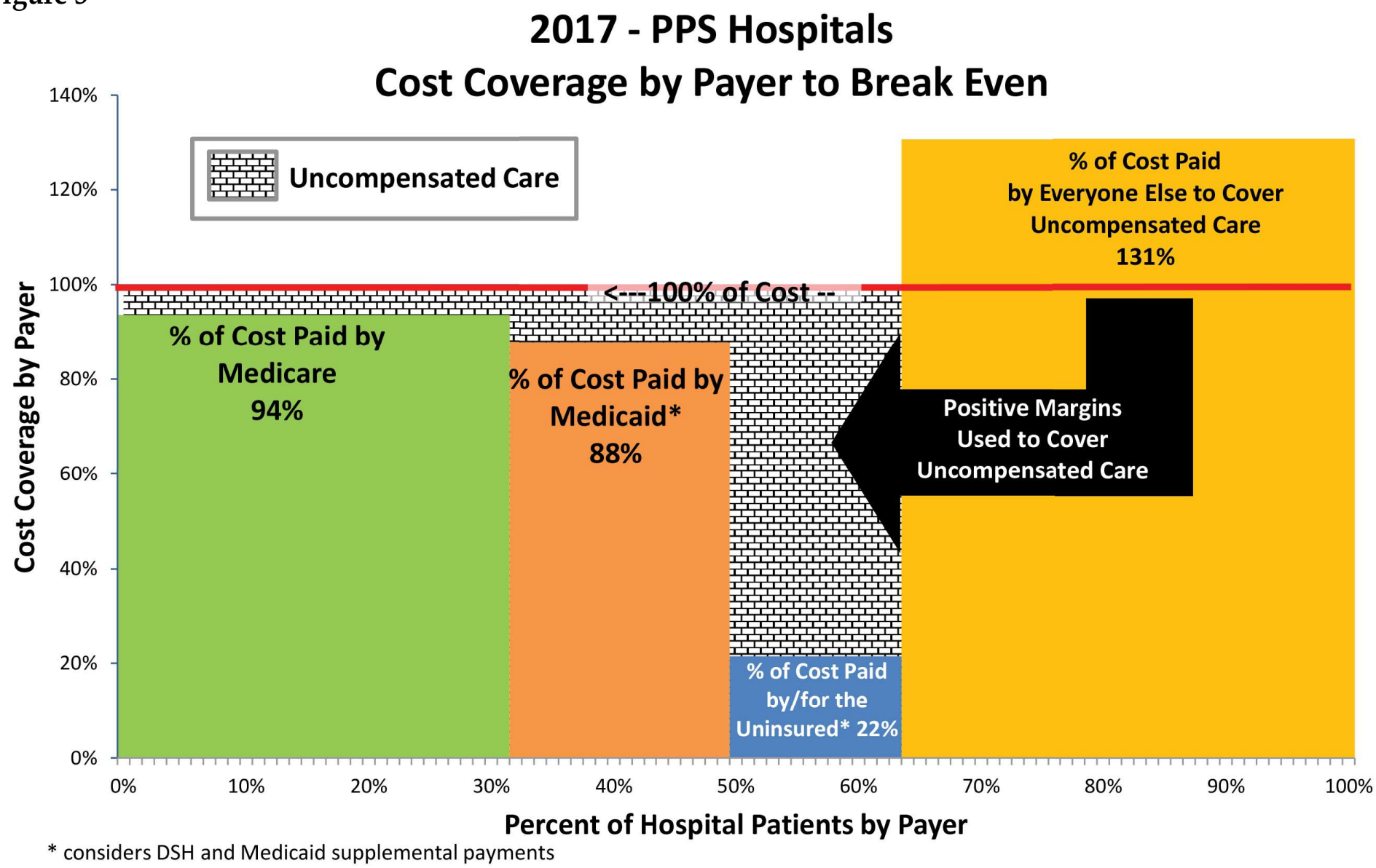
To make up for deficits from Medicare, Medicaid and the uninsured, hospitals must make positive margins from other payers. Together, Medicare, Medicaid and uninsured patients account for 64 percent of all Georgia's hospital encounters.[21]
As shown in Figure 3 on page 14, PPS hospitals need to make a 31 percent profit on the remaining encounters from other payers to offset their uncompensated care.[22]

One way the state helps protect hospitals from the financial burdens of uncompensated care is through the Certificate of Need (CON) program. GHA supports CON as an important component of Georgia's health planning process because it discourages unfair competition from facilities that serve few, if any, patients with payer sources that don't cover cost. Discussed in more detail on page 65 of this publication, CON helps control costs by requiring all applicants wanting to build new health care facilities to demonstrate the need for additional health care capacity, thus preventing overutilization and unnecessary duplication of services.

Hospital Expense

In 2017, 48 percent of Georgia hospitals' expenses covered payroll and employee benefit payments for 150,000 full-time employees.[23] The average cost of a 2018 hospital admission in Georgia was around $11,700; however, costs varied widely depending on the services provided during the admission.[24]

Figure 3



* considers DSH and Medicaid supplemental payments

Hospital Fiscal Health

As discussed in other sections of Hospitals 101, hospitals incur costs in providing some health care services but don't get paid as a result. This can occur for various reasons; some are out of the hospital's control (e.g., fixed reimbursement by governmental payers that is less than cost, emergency care for the uninsured). Regardless of the cause, these situations can present a challenge to a hospital's fiscal health.

At the most fundamental level, hospitals measure their fiscal health by their ability to remain in business to provide services to patients in their communities. A more accounting-based measure is the use of the operating margin, which is the difference between net operating revenue divided by total operating revenue. The goal is for a facility to have a positive operating margin.

Hospitals with positive operating margins are able to enhance their community benefit and charitable care programs as well as invest in technology upgrades and capital improvements. Positive margins also allow them to weather future economic downturns through the use of reserve funds, much like the state does with its Shortfall Reserve Fund.

While Georgia's hospital industry is, on average, achieving modest margins, 40 percent of Georgia's hospitals still lost money in 2018.[26] This situation is significantly worse for rural hospitals, as 69 percent had negative total margins. Hospitals can cope with negative operating margins in the short term by carefully controlling cash flow, utilizing revenue from other lines of business the hospital may own (e.g., a nursing home), delaying capital improvements and, of course, reducing expenses. These are only short-term solutions, and hospitals that are unable to realize and maintain positive operating margins will likely face closure sooner or later. Unfortunately, this was the case for 11 Georgia hospitals since 2013.

(See Figure 4 on page 16 for more details on trends in hospital margins.)
Hospitals must rely on other sources of revenue to achieve modest margins.

Inside the H

GHA annually calculates operating margins for patient care (i.e., revenue and expenses only from patient care) as well as total margins (i.e., revenue and expenses from all sources of the hospital's operations.)

In 2018, the patient care margin for all hospitals in Georgia was 4.5 percent, with half of Georgia's hospitals losing money based on the payments they received for taking care of patients. Revenue from supplemental governmental payments, investment income and other non-patient sources added 4.6 percent to the average margin in 2018.[25]

GHA predicts margins will continue to be negatively impacted, primarily due to accelerating reductions in payments from governmental programs like Medicare and the Medicaid Disproportionate Share Hospital (DSH) Program.

Figure 4