Medical Economics:

THE HEALTH CARE

FINANCIAL ENVIRONMENT

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Medical Economics:
The Health Care Financial Environment

Theme: Hospitals As Businesses

Welcome to a discussion of the financial environment of hospitals.

In the larger group session, the theme of our discussion will be the health care reimbursement system. In our brief time together, we will trace the history of the hospital reimbursement system, focusing on the shift from cost-based reimbursement, to DRG-based reimbursement, to the current environment dominated by managed care and negotiated rates.

In the smaller group sessions, we will look in more detail at management, financial principles, techniques, and tools. We will examine the financial pressures experienced by Boards, CEOs, and CFOs, as well as department chairs, managers, and physicians throughout the hospital and health care delivery system. We will discuss some basic financial language and principles with the goal of helping you communicate with financial (and other) managers, such as: financial viability; for-profits vs. not-for-profits; revenues, expenses, and net income; assets, liabilities, and fund balance; fixed and variable costs; breakeven analysis; and present value and net present value.

My name is David Roe. I have an MBA in Finance and Public Management and I am currently an Associate Vice President in the Health Sciences Division at Columbia University. I was at the New York City Office of Management and Budget for five years and headed up the Finance Division at the Downstate Medical Center for eleven years.
Health care providers as businesses

Hospitals, physicians, other institutions and practitioners

- For profit
- Not for profit
- Government
The flow of the health care dollar

Traditional

Employer (and individuals) to Insurance Company (Blue Cross, etc) to Provider (Hospitals, Physicians)

or

Government (Medicare, Medicaid) to Provider

New

Employer (and individuals) to HMO to Provider

or

Government (Medicare, Medicaid) to HMO to Provider

Note: “HMO” = Health Maintenance Organization, often a for-profit business that functions as a kind of insurance company
Why do health care costs matter?

U.S. health care costs were rising much more rapidly than the general cost of living, taking up a larger and larger share of the Gross Domestic Product.

Why did that matter? If the cost of employee health grows by 15%/year, and all other costs and revenues are rising at 3%:

<table>
<thead>
<tr>
<th>INCOME STATEMENT</th>
<th>XYZ MANUFACTURER</th>
<th>($$ in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Year 1</td>
<td>Year 2</td>
</tr>
<tr>
<td>REVENUES</td>
<td>$100.00</td>
<td>$103.00</td>
</tr>
<tr>
<td>EXPENSES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries &amp; Wages</td>
<td>55.00</td>
<td>56.65</td>
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<tr>
<td>Fringe Benefits</td>
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<td></td>
</tr>
<tr>
<td>Health Insurance</td>
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<td>5.40</td>
</tr>
<tr>
<td>All Other</td>
<td>8.30</td>
<td>8.55</td>
</tr>
<tr>
<td>Supplies and Equipment</td>
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<td>30.90</td>
</tr>
<tr>
<td>Total Expenses</td>
<td>$98.00</td>
<td>$101.50</td>
</tr>
<tr>
<td>NET INCOME</td>
<td>$ 2.00</td>
<td>$ 1.50</td>
</tr>
</tbody>
</table>

The “bottom line” is very sensitive to small changes in expenses or revenues.
Three major phases of health care finance in the U.S.

1. Cost-based reimbursement ("fee-for-service" or "indemnity" system)
   - government very involved in setting reimbursement rates
   - hospital reimbursement is per diem, largely based on costs; physicians are paid for each service provided
   - controlling costs was not the highest priority for the manager of the health care provider organization

2. DRG*-based reimbursement
   - government still very involved in setting reimbursement rates
   - hospital reimbursement is based on fixed rates per case
   - controlling costs became much more important

3. Managed care reimbursement
   - rates are negotiated between HMO and provider
   - providers may still be paid on a DRG basis but may be paid on a capitated or "per month" basis
   - HMOs shop around for lower cost providers
   - rate competition between providers
   - cost control is more important than ever
   - providers have incentive to provide less service if paid on a capitated basis
   - in theory, primary care physicians act as "gatekeepers"

*DRG: Diagnostic-Related Groupings
For profit vs. Not-for-profit

Similarities
Both must maintain financial health in order to maintain viability
Both seek to increase revenues
Both seek to keep expenses lower than revenues - to produce an operating margin, or net income

Differences
For-profits have investors (e.g. individuals, pension funds) who purchase shares in the corporation
Investors expect a return on investment
- dividends on the shares
- growth in value of the shares
Dividends must be paid by the corporations from operating margin
Maintaining Fiscal Health

Methods for a health care provider to reduce costs

Reduce the price paid for resources
  - salaries and benefits
  - supplies and equipment

Reduce the amount of resources required to provide the service
  - reduce length-of-stay
  - reduce intensity of service provided
  - improve efficiency - re-engineering
  - shift inpatient procedures to outpatient

Methods for a health care provider to increase revenues

Increase in patient admissions (if the provider is paid per case. This is counterproductive if provider is paid on a capitated basis)

Negotiate higher rates with the insurance company or HMO

Improve quality of billing and collection process
Mergers, Acquisitions and Networking

- Relative market strength of HMOs vs. health care providers

- Effort by health care providers to regain negotiating strength
Free market health care system?

Traditional approach

To a great extent, governments determined the rate of reimbursement to health care providers, based largely on costs.

Governments had other controls as well, such as “Certificate of Need” applications for capital projects and major equipment purchases.

New approach

Less government involvement, especially for private insurers and HMOs.

Market-driven, negotiated rate-setting.

Results: - some stabilization of costs, especially in the early years of HMOs
- some loss of independence by individuals when choosing their health care provider
- some level of dissatisfaction by individuals and providers with focus on cost-cutting

Consumer choice -- a market force?