Health Care's Financial Forecast — 2005 and beyond

By David Ollier Weber

IN THIS ARTICLE...

Good, bad and ugly may be the best way to describe the financial forecast for health care over the next few years. Take a look at some of the factors affecting the forecast.

Upbeat news: In 2005, health care providers will bask in a spate of salubrious financial weather.

Downbeat news: Salubrious is a relative term. The sunshine is spotty. Slippery patches of ice lurk in the shadows and ominous clouds billow on the horizon.

Start with the positives.

Sunny spots

Medicare, which accounts for about $4 of every $10 in revenue collected by 4,800 U.S. hospitals and 875,000 physician practices, will augment total reimbursements to doctors by 4 percent this year.

That means an additional $2.2 billion to divvy up. Hospitals will share an extra 6.6 percent for outpatient care, or some $1.5 billion.

The increase for physician services works out to a 1.5 percent payment boost across the board. The Balanced Budget Act (BBA) of 1997 had called for a 3.3-percent cut, but Congress intervened. Hospitals meanwhile will get a 3.3 percent inflation update for outpatient services.

Inpatient care at urban hospitals is slated for reimbursement at a 4.7 percent higher rate in fiscal 2005; rural hospitals will see an average increase of 6 percent. Total Medicare payments to approximately 3,900 acute care facilities are projected to be $105 billion, up from a projected $100 billion in fiscal 2004.

Doctors and hospitals will also have a new source of Medicare revenue: "Welcome to Medicare" physical examinations for incoming beneficiaries. Hospitals can collect $78 for each outpatient exam from the government and, along with doctors, can bill for a more extensive visit and follow-up treatments if indicated.

A new emphasis on preventive care for Medicare patients will cover blood glucose and cholesterol tests for those at risk of diabetes or heart disease. The Center for Medicare and Medicaid Services (CMS) will also reimburse physicians 106 percent of the price they pay for drugs they administer in their offices.

Non-profit hospitals and health systems in general are as flush as they've been in years. Those with the highest credit ratings, from AA+ to A-, averaged almost 4 percent profitability, according to Standard & Poor's managing director Martin Arrick. That's the best performance since 1997.

A rebounding investment market has helped bolster cash flow and debt coverage.

Factors that have helped non-profit institutions and systems boost earnings, Arrick says, have included aggressive negotiations with managed care organizations, divestiture of unprofitable and non-core business lines, loosened MCO utilization controls, tighter cost management and heightened attention to work force recruitment and retention.

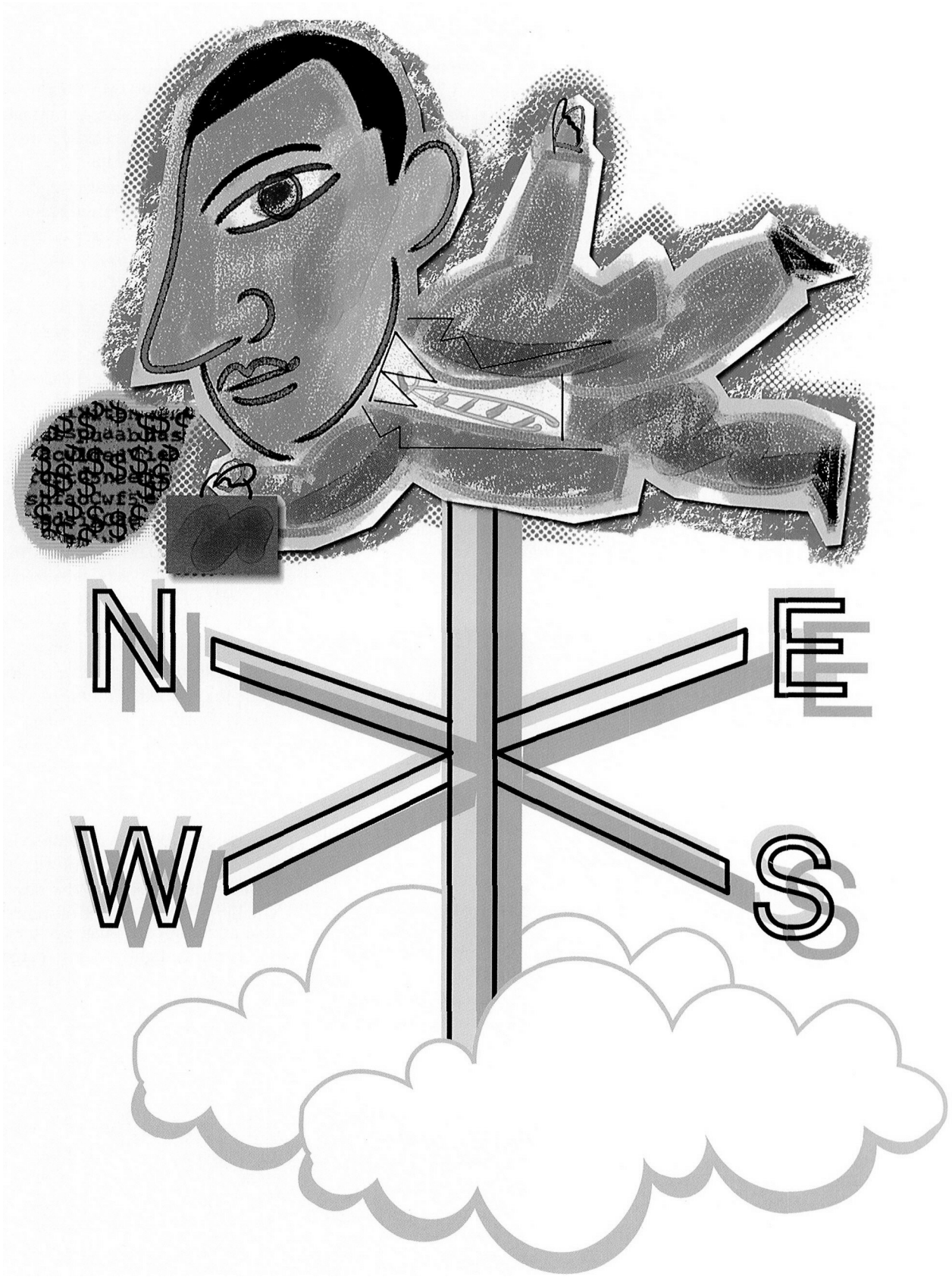
Individual physician compensation on average has handily trumped inflation. Doctors' income rose 11 percent, from $162,000 as a mean for all respondents to *Medical Economics* magazine's 2003 poll, to $180,000 last year.

Practice earnings saw a 6 percent growth, rising to an average of $414,000 from $390,000 the previous year.

The "waning of the gatekeeper model" and add-on services like diagnostic imaging and the opening of ambulatory surgery centers and specialty hospitals have helped specialists prosper, the magazine suggested.

Doctors in group practices—especially single-specialty groups and those with 10 or more but fewer than 24 members—earned the highest paychecks.

Physicians in the fee-for-service South banked $40,000 more than their counterparts in the HMO-saturated East.



In 2005, health care providers will bask in a spate of salubrious financial weather. But the sunshine is spotty. Slippery patches of ice lurk in the shadows and ominous clouds billow on the horizon.

Soaring malpractice liability insurance premiums seem finally to have reached their zenith. Only 15 percent of insurers say they expect "significant" increases in rates over the coming year, according to *Medical Liability Monitor*. Two years ago, eight out of 10 companies projected major premium hikes.

Between 2000 and 2003, direct premiums per doctor ballooned by almost a third, from just over $9,000 to about $12,000. But, says J. Robert Hunter, former insurance commissioner of Texas and a Federal Insurance Administration official under Presidents Ford and Carter, "I expect, if not this quarter, then in another quarter or two, med mal will be down to the rate of inflation or less."

Between 2000 and 2003, inflation-adjusted malpractice payouts per doctor actually dropped—from $7,176 to $6,637 each, a 7.5-percent boon to insurance companies' earnings, Hunter reports.

The "indirect" costs of tort liability are also waning, suggests Tulane University professor Hugh Long, who teaches ACPE courses on financial decision making.

"Better data about outcomes and process mean that fewer and fewer redundant tests and procedures are being performed," he suggests. "There's enough knowledge out there now and they're not very good defenses anyway."

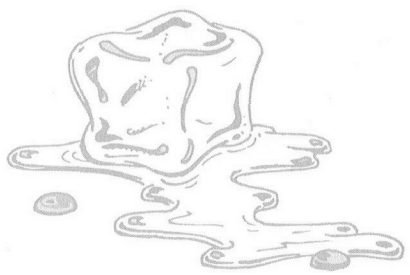
Hunter analyzed the medical liability insurance market for the Consumer Federation of America last October. "I suspect that by this time next year," he concluded, "rates will go flat [and remain] flat for a number of years."

For the first time this century, costs to employers who offer health insurance plans will rise by only a single digit—8 percent—in 2005, according to a recent Towers Perrin survey of the 200 largest U.S. corporations.

The study anticipates that the total tab for covering an employee—including premium, doctor visits, drugs and hospital stays—will average $7,761. The employee's share will rise to $1,610—which is a 14-percent increase and also entails higher copays and a 2 percent reduction in benefit levels.

"While employers have simply shifted some costs to employees through benefit design changes," says Jim Foreman, managing director of global health and welfare for Towers Perrin, "their efforts to control the underlying drivers of health care cost increases are beginning to make a difference."

Foreman says employers and vendors who have implemented disease management programs—a growing number—have shaved two full percentage points off their average annual cost upswings.



Slippery patches

Despite this year's sweetened Medicare payment schedules, physician reimbursements continue to trail inflation by a significant amount.

Health care costs overall will go up 2.7 percent in 2005, the Government Accountability Office (GAO) predicts. Hospitals have been given better-than-offsetting Medicare rate increases but doctors will still see a gap of more than 1 percent between their Medicare income and inflation.

Government spending per Medicare beneficiary has risen by more than 7 percent a year on average since 2000. It's projected to jump another 4.7 percent in 2005, according to the GAO. Meanwhile, annual Medicare payment updates to doctors have increased a mere 1.7 percent on average.

The Congressional Budget Office notes that future updates to the Medicare physician payment formula will have to take into account—and begin to recoup—more than $13 billion of past over-budget spending. The increased reimbursement rates in 2004 and this year—in place of cuts envisioned in the BBA—have postponed and exacerbated that reckoning.

Medicare's new and enhanced benefits create immediate earning opportunities for providers. They will, says AMA executive vice president Michael D. Maves, MD, "trigger physician office visits, which in turn may trigger an array of other medically necessary services, including laboratory tests, to monitor or treat conditions that might have otherwise gone undetected and untreated." The downside is that the surge in claims could lead to even more drastic cuts in future Medicare reimbursement rates—already slated for a hefty reduction in 2006 and beyond.

While well-managed hospitals and health systems are posting their best financial results of the new century, the 46 percent of institutions in the lower credit-rating tiers are faltering, notes Standard & Poor's Arrick. Median profit margins in 2004 for organizations rated BBB+ or below ranged from 1.9 percent to a negative 0.4 percent.

Credit ratings have been downgraded for more hospitals and health systems than have been upgraded over the past year, adds Arrick. The debt of nearly one in 10 organizations is now rated "speculative," versus only 6 percent in 2001.

Stand-alone hospitals have been the most vulnerable. They lack the insulation from local competition, economic vicissitudes and demographic shifts that come

Physician reimbursements continue to trail inflation by a significant amount.

from size, geographic dispersal, service line diversity and market-share clout when negotiating with payers.

In addition:

- Many states have either reduced Medicaid eligibility or limited or delayed Medicaid rate increases.
- Insurance costs—both malpractice and property—have risen, as have labor and supply costs.
- The growing citizens' army of uninsured and underinsured patients is beginning to affect hospital bottom lines by swelling write-offs for charity care and bad debt.

Primary care physicians' incomes are losing ground to inflation. Indeed, the median annual compensation of OB/GYNs and family practitioners fell in the last surveyed year, while that of internists and general practitioners stagnated. Only pediatricians saw a gain, of 8 percent, reports *Medical Economics*.

In a sluggish economy, workers who have lost jobs and health insurance for themselves and their families put off seeing the doctor unless it's unavoidable.

Even commercial payers have been ratcheting down their reimbursement rates. Yet costs to maintain a practice—salaries, benefits, supplies, rent—continue to track the consumer price index: up 3.4 percent in 2004, with another 2.4 percent speed bump anticipated this year.

Medical liability reform was a central plank in George W. Bush's 2004 campaign for election to a second term as president. "We must confront the frivolous lawsuits that are driving up the cost of health care and hurting doctors and patients," he reiterated in his initial post-victory press conference.

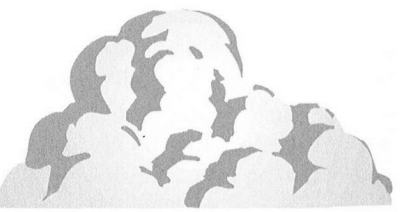
The American Medical Association has been pressing hard for Congress—now with Republican majorities in both chambers—to enact a $250,000 cap on the amount a med mal plaintiff can collect in non-economic damages. But political observers say such a proposal will encounter tough sledding in the Senate.

Tort reform was on the ballot in four states in 2004. Voters, however, sent mixed messages. In Oregon and Wyoming, they defeated initiatives to limit non-economic damages for medical injuries. Nevada's electorate, on the other hand, endorsed a strengthening of existing caps, and Floridians approved limits on plaintiffs' attorney fees.

In fact, it hasn't been the trial bar or greedy litigants who have driven medical malpractice premiums into the stratosphere, finds analyst Hunter. Rather, it has been a combination of falling interest rates (which battered insurers' investment portfolios), a generally crummy economy and the unrealistically low-balled premiums insurers charged to be competitive in the soft market prior to 2000. Med mal underwriters themselves are the culprits in the crisis, he maintains.

Although the double-digit annual spike in health care costs to employers has finally been blunted, "the cumulative effect of soaring costs year over year has created a bigger cost base," Foreman says. That means, "while this year's percentage increase creates an appearance of lower costs, the increase in the actual dollar amount is similar to years past."

Employers are devoting 87 percent more money to work force health care than they did four years ago; employees are out of pocket 71 percent more. Though throttled down, the 2005 increase—an additional $582 per worker—is still "unsustainable" on a yearly basis, Foreman warns.



Ominous clouds

A slipping U.S. economy shows no signs of regaining traction. The University of Maryland's Peter Morici, former chief economist of the U.S. International Trade Commission, forecasts a weak 3.5 percent uptick in gross domestic product in 2005. And that's a dropoff from even last year's anemic 3.8 percent GDP growth.

Drags on recovery, according to Morici, include lethargic consumer spending now that the stimulus

effect of recent tax cuts has ebbed, a soaring trade deficit, the high price of oil coupled with the staggering tab for health care—both feed inflation and the latter is a major damper on job growth—and rising interest rates.

Morici expects the federal funds rate to hit 3 percent by year-end. Since the prime is generally three points higher, medical groups and hospitals will find borrowing significantly more expensive.

High petroleum costs will also have an appreciable impact on health care providers' margins, warns Richard Clarke, president of the Healthcare Financial Management Association. Not only will heating and cooling become more expensive, but so will the myriad of medical products that incorporate plastics.

A massive new Medicare outpatient drug benefit will kick in next year, too. The Congressional Budget Office calculates its cost through 2013 at $770 billion. Premiums paid by Medicare recipients who opt for coverage will underwrite $131 billion of the costs, and reduced federal contributions to Medicaid programs and federal recapture of state Medicaid drug savings will cancel another $230 billion. Most of the remainder, notes the CBO, will simply fatten the federal deficit—already an unprecedented $412 billion and projected to grow to $2.3 trillion over the next decade.

"We have a huge drug benefit with a huge doughnut hole in the middle," declares Arrick. "The question is, 'How are people going to react when they really understand that?'"

Deficit reduction was another key plank in President Bush's election campaign. Since Medicare already consumes a fifth of the federal budget, it will be an inevitable target, analysts agree.

"The big bucket is hospitals," notes Arrick. They will almost certainly bear the brunt of reimbursement hits… that is, he adds, "if anybody really cares about the deficit." In any case, "the Medicare firecracker is going to go off in our hands no matter what."

After a wave of mergers and closures, most surviving U.S. hospitals are operating at or near capacity. Since 1995, the number of beds nationwide has shrunk by more than 50,000, notes Amit Bohora, health care practice industry manager at Frost & Sullivan. And almost half the remaining 820,000 beds, he adds, are occupied by patients with medical conditions (that is, not recovering from surgery or childbirth, for example).

Freeing up space by shortening lengths of inpatient stays is a strategy that has reached its endpoint, he asserts. Drops in LOS leveled off in 2001 and are holding steady. Meanwhile, the number of patients with chronic conditions—who account for the lion's share of medical spending—will balloon to 81 million in the next 15 years as the baby boom ripens. That's 35 percent more than in 2000.

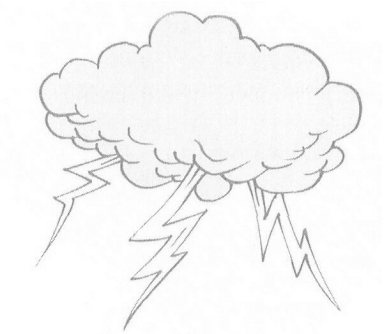
Running at capacity puts a squeeze on lucrative elective procedures, Arrick points out. As providers move to protect their margins—and their access to capital—they're tempted to slough off non-economical business to safety net providers.

Avoidance of care for the poor and uninsured calls into question the tax-exempt status of not-for-profit institutions. And that describes 85 percent of U.S. hospitals.

State and local taxing authorities, strapped for revenues to fund safety net health services, are scrutinizing the charitable care practices of local NFPs. Trial lawyers have zeroed in on hospitals that over-bill or over-aggressively try to collect from uninsured patients and are busily filing suits.

Attacking hospitals for stinting on charity care is "a populist winner," warns Arrick.

"Whether or not you're going to be able to stay non-profit—or at least tax exempt—is probably going to be a more important issue for hospitals over the next four or five years than the rise of interest rates," Long says.



Impending storms

More than 15,000 fledgling doctors are graduated by medical schools in the United States each year. But that may not be enough to meet the nation's population and demographic demand over the next 15 years, worries the Council on Graduate Medical Education. Shortfall projections have ranged from 88,000 to as many as 200,000 physicians by 2020.

Some 205,000 additional registered nurses have been recruited to the U.S. workforce since 2001, mostly by understaffed hospitals. That's the strongest surge in nurse hiring since the advent of Medicare in 1965. But almost two-thirds of these bedside caregivers were over the age of 50 and a third (there is some statistical overlap) were foreign-born.

Despite the RN influx, the nursing shortage has barely been dented, admit the researchers who reported those numbers in *Health Affairs* last November. As many as 1 million nursing positions could be unfilled nationwide by 2008, say forecasters.

"Consumer-driven" is the euphemism du jour for "costlier out of pocket" health insurance coverage. Absent the ability to continue wringing double-digit annual premium increases from their business clientele, says Arrick, private health insurers are trimming benefits, hawking "consumer choice"—and in the process pushing more workers onto the uninsured rolls.

An alternative to traditional health insurance, health savings accounts, or HSAs, have been sanctioned in the Medicare Prescription Drug Improvement and Modernization Act of 2003 and are a cornerstone of President Bush's health care reform agenda.

Individuals can buy a relatively cheap health insurance policy with a high deductible (a minimum of $1,000) to cover catastrophic medical needs, then sock away money tax-free in an HSA (up to $2,600 for individuals or $5,150 for a family, adjusted annually for inflation) to foot routine medical bills. Unspent savings can be rolled over to subsequent years.

HSAs are growing in popularity. Even Kaiser Permanente, the prototypical HMO, unveiled a high deductible plan cum HSA this year in Colorado, Georgia and the Pacific Northwest. Next year, California.

Critics like the HFMA's Clarke worry that these instruments may prove "really inadequate and leave patients exposed and consequently the hospital exposed" for the cost of care provided.

There is also, says Arrick, a serious potential for adverse selection. "If you're a medical frequent flyer, you're going to blow through your deductible anyway, so that won't matter to you," he explains. "But if you're a mother with four kids, and you used to have a $15 copay for each visit to the pediatrician but now it costs you $120, will that push you into the emergency room?"

Finally, there's the elephant at the hors d'oeuvres tray—the one in six Americans without any health insurance whatsoever. Their numbers (now roughly equal to the Medicare population) burgeon year by year—43.6 million in 2002, 45 million in 2003....

Ingenious blueprints abound for erecting a tent under which basic drugs and medical services would be available to every man, woman and child in the United States. Democratic Presidential candidate John Kerry offered one version; the Columbia University School of Nursing recently crafted another (which could be funded, they estimated, for a premium of only $172 a month excluding drug copays and a $1,500 cap on out-of-pocket expenses; the uninsured are by no means invariably indigent). But none of these proposals has even come close to awakening enough interest to overcome political inertia.

In sum: "You don't need to get to 20 or 30 or 40 percent of the population without insurance to see major problems in the system," warns Arrick.

"The problem of the uninsured is such a big issue that it may finally trigger a real debate about the road we're going down," Long agrees.

So there you have it

This has been the unofficial financial weather forecast for the 50 United States for 2005 and beyond. Dab on the sunscreen but keep an eye peeled for ice slicks and carry an umbrella.

And make the best of the moment.

"These," declares Arrick, "are the good old days."

David Ollier Weber *is a freelance health writer and frequent contributor to this journal. He can be reached by e-mail in Mendocino, Calif., at doweber@kilasprings.net*