Hospital Charges Explained

The mission of each and every hospital in America is to serve the health care needs of people in their communities 24 hours a day, 7 days a week. But, hospitals’ work is made more difficult by the fragmented health care system we have in America…a system that leaves millions of people unable to afford the health care services they need…a system in which federal and state governments and some private insurance companies do not meet their responsibilities to cover the costs of care for Medicare, Medicaid, or privately insured enrollees…a system in which payments do not recognize the unreimbursed services provided by hospitals. Today’s fragmented health care system leaves hospitals with a daily balancing act to maintain their mission to the community while making ends meet.

Following is an explanation of hospital charges. It is intended to serve as a resource document for the hospital field.

Lack of Coverage for All

Though many consider the U.S. health care system to be among the best in the world, nearly 44 million Americans are without health insurance (Chart 1). The number of uninsured people has grown by nearly 10 million since the mid-1980s. Most of these people cannot afford to pay for medical care. Hospitals, however, are a guaranteed access point for emergency needs, where care is provided to patients regardless of their ability to pay. While the government protects this access by law through the Emergency Medical Treatment and Labor Act (EMTALA) which guarantees that anyone coming to a hospital emergency department receives a health screening and stabilizing care, the government does not guarantee funding for

![Chart 1: Number of Uninsured Individuals 1985 - 2002](chart1)

![Chart 2: Hospital Uncompensated Care Costs (in billions) 1997-2001](chart2)

Source: American Hospital Association Annual Survey, data for community hospitals
this care when the patient is unable to pay. Instead, America’s hospitals absorb these costs, more than $21 billion in uncompensated care each year, which is a mixture of charity care provided to the poorest uninsured patients and care for which payment is never made (Chart 2).

**Broken Payment System**

In addition to the growing number of uninsured people in America, the hospital payment system itself is broken. Government programs, like Medicare and Medicaid, pay hospitals less than the cost of caring for the people these programs cover; insurance companies negotiate deep discounts with hospitals; and many people who are uninsured pay little or nothing at all.

These inequities in payment leave hospitals with an annual balancing act—hospitals must ensure that the payments they receive for care from all sources exceed the costs of providing that care. A hospital cannot continue to lose money year after year and remain open. Hospitals need a positive bottom line in order to be able to replace or improve old buildings, keep up with new technologies and otherwise invest in maintaining and improving their services to meet the rising demand for care. In 2001, over half of hospitals lost money providing care to Medicare and Medicaid patients and nearly one third lost money overall (Chart 3).

**Charges vs. Payments**

Because of federal laws and regulations, hospitals generally charge the same amount for the same service to all patients, with limited exceptions. While what a hospital charges all patients is the same, what a hospital actually receives in payment for that care is very different.

- For Medicare patients, about 40% of the typical hospital’s volume of patients, the U.S. Congress sets hospital payment rates. Medicare pays, on average, only 43% of hospital charges.

- For Medicaid patients, about 13% of the typical hospital’s volume of patients, state governments set hospital payment rates. Medicaid, on average, pays only 44% of hospital charges and as little as 27% in some states.
Private insurance companies negotiate payment rates with hospitals. Privately insured patients make up 37% of the typical hospital’s volume of patients and pay, on average, only 52% of hospital charges. Private insurance company payment rates vary widely. Larger insurance companies typically are better positioned to demand bigger discounts.

Together, Medicare, Medicaid, and private insurance make up 90 percent of hospital charges (Chart 4). Because nearly all of a hospital’s payments are set either by government or through negotiations with private insurance companies, the vast majority of patients never pay full charges. Charges for people without insurance represent only 5% of total hospital charges. Those without insurance have no one to purchase coverage on their behalf. But for those uninsured patients who qualify for the hospital’s charity care or other financial assistance programs, all or a portion of hospital charges are forgiven. Only a small portion of patients who do not qualify for or who do not seek assistance receive hospital bills that reflect full charges. The charges for these patients are the same as those for insured patients who are seeking care at a hospital outside their insurance company’s network as well as for patients whose care is paid for by other types of insurance (e.g. worker’s compensation, auto liability insurance, etc.).

Payments vs. Costs

How do these government-set and insurance company-negotiated payments compare to the actual cost of providing hospital care to patients? Medicare and Medicaid pay less than cost, the uninsured pay little or nothing, and others must make up the difference.

- The federal Medicare program currently pays only 98 cents on average for each dollar of cost for the care of Medicare patients.

- The Medicaid program (state and federal partnership) pays only 96 cents for each dollar of cost for the care of Medicaid patients.
Hospital uncompensated care, both charity care and care for which no payment is made by patients, makes up about 6% of the average hospital’s costs. For this care, hospitals overall are paid only 12 cents per dollar of cost in the form of tax subsidies from state or local governments to help fund care for poor populations. These tax dollars are generally received only by hospitals that are owned by local governments but not all public hospitals receive tax support. Most hospitals receive no government financial support at all to provide this care.1

Privately insured patients and others often make up the difference.

Payments relative to costs vary among hospitals.

**Setting Hospital Charges**

Each year hospitals must adjust their charges in order to maintain financial viability. Hospitals must raise *charges* to end up with *payments* that cover the costs of providing patient care as well as the costs of maintaining essential public services (e.g. being prepared for disasters and public health emergencies), keeping the buildings and technologies up-to-date, and supporting the health needs of their communities. Setting charges is complex and challenging because a hospital must anticipate both what might happen to their *costs* over the next year as well as what might happen to *payments*.

In predicting *costs*, hospitals face uncertainty about how much they will need to increase wages to attract qualified staff and/or to secure contracts with unionized workers. Hospitals must estimate how much it will cost to purchase pharmaceuticals, medical devices, and other supplies. These products are continually changing, and newly introduced drugs and technologies are often significantly more expensive than those they replace. While the medical benefits are often substantial, these products increase costs in ways that are hard to predict and often are not accounted for in payment rates that are set in advance or fixed by government. Moreover, new regulations (e.g. the Health Insurance Portability and Accountability Act, California’s mandated staffing ratios and seismic standards, etc.) can drive up costs.

In predicting *payments*, hospitals must anticipate many factors including: what future government-set rates might be; what future negotiated rates might be with the private insurance companies in their area; how often managed care plans will deny payment; how many people might be in need of charity care; how many people may not pay amounts owed to the hospital; and other factors.

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1 The Medicare and Medicaid Disproportionate Share Hospital (DSH) programs are supposed to provide funding to hospitals to help serve low-income populations. Even with these payments included in the Medicare and Medicaid categories above, Medicare and Medicaid do not cover the costs of their enrolled populations, let alone the costs of services to uninsured populations.
Each year the U.S. Congress determines how much the government is willing to pay hospitals to provide care to Medicare patients. Medicare rates are determined within the context of all the budgetary needs of the federal government as part of a political process. Medicare payments have historically been set below the costs of providing care to Medicare patients though how far below varies over time and by service. Today, Medicare pays about 84 cents per dollar of costs, on average, for outpatient services. Each year Medicare is supposed to provide hospitals an increase in both inpatient and outpatient payments to account for inflation in the prices of the goods and services hospitals must purchase in order to provide patient care—much like social security beneficiaries and government employees get a cost of living adjustment each year. But inpatient updates have been set below the rate of inflation in all but two of the past 15 years resulting in a shortfall that has grown over time. This shortfall jeopardizes hospitals’ ability to serve their communities.

State Medicaid rates are set in much the same way. Unlike the federal government, however, most states have constitutional requirements for a balanced budget each year. Thus in times of financial stress, like today, the rates that states pay hospitals and other providers can be a prime target for budget cuts, regardless of what is happening to the costs of providing care to Medicaid patients.

Insurance companies will try to negotiate the best rates they can. They too try to hold down their payment rate increases each year. If a large insurance company is not willing to cover the full cost increase of providing care to its beneficiaries, then the shortfall has to be made up elsewhere.

The following example illustrates how this situation leads to hospital charges rising faster than costs and payments.

- If the costs to hospitals of providing care go up by 6%, hospitals must figure out how to set charges such that the payments they receive at least cover costs and at best provide some additional funds to allow hospitals to keep technologies and facilities up-to-date and meet other service needs of the community.

- If 80% of a hospital’s payments are not affected by charges because they are either fixed by government or negotiated with insurance companies in a way that is not tied to charges (per diems, capitation, fee schedules) that leaves only 20% of a hospital’s payments that are affected by charges.

- If government rate setters and insurance companies are only willing to pay a 5% rate increase, even though the cost of providing care has gone up by 6%, hospitals must raise charges for the 20% of their payments that are affected by charges by enough to cover this shortfall—or by 10%.
The Math

80% fixed/negotiated payments \( \times \) 5% increase \( \rightarrow \) 4%

+ 20% charge-based payments \( \times \) 10% increase \( \rightarrow \) + 2%

= 6% overall increase required to cover cost increases

Although the assumptions here are hypothetical, this illustrates how a decision by the government to give hospitals a rate increase that does not even cover inflation can affect other patients—particularly the uninsured.

Because government and other payers pay less than the cost of caring for patients, each year hospital charges have risen at a rate that is a few percentage points higher than the increase in costs. Of note, however, is that the relationship between charges and costs has been consistent over time (Chart 5). As cost growth slowed in the mid-nineties, charge growth slowed as well. Now, as the rate of cost growth is again increasing, the level of charge increases has gone up as well.

The Result

While charges have grown over time at a rate slightly faster than costs, hospitals have not benefited. While charges have grown, payments—what hospitals actually receive—have barely kept pace with costs (Chart 6), and the financial performance of hospitals has declined since 1997 (Chart 7).

As mentioned earlier, hospital payments must be more than the costs of providing care so hospitals can continue to improve their services to meet the ever-changing health needs of their communities.
Conclusion

The payment system for hospitals is broken. Payments for half of the services hospitals provide are set by government and don’t even cover costs. Many of the nearly 44 million uninsured cannot afford to pay anything at all. Insurance companies pay different rates depending on their size and ability to demand discounts. Each year every hospital must do its best to balance costs and payments as it strives to meet the needs of its community.