
Building a Healthy Future:
Global Trends Affecting Vermont's Health Care Systems

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Executive Summary

- **Health Care Finance: The Basics**
 - ⇒ **Health Care providers must balance revenues and expenditures.** As with any business, those who provide health care must be on solid financial ground in order to work well and plan for the future.
 - ⇒ **Health Care does not respond to traditional market forces.** Cost does not affect consumption. Even if it did, consumers are insulated from the true cost of care.
 - ⇒ **Under-funded care leads to cost shifting.** Cost shifting leads to more cost shifting, which undermines the financial health of the health care sector.

- **Core Challenges Facing Our Health Care System**
 - ⇒ **By 2030, the number of Vermonters over age 65 will double.** These “baby boomers” will place great demands on our health care system, while simultaneous slow growth in the labor market will leave fewer people to foot the bills.
 - ⇒ **Public funding constraints will continue to pressure Vermont’s health care delivery system.** Federal and state governments face both short and long-term challenges to their ability to fund Medicaid and Medicare.
 - ⇒ **Health care costs continue to rise.** Though hospital expenditures have remained essentially flat, other factors such as rising pharmaceutical costs and the nursing shortage are driving up the cost of care.

- **What Does This Mean For Vermont?**
 - ⇒ **Vermont’s health care providers face financial hardship now, due to existing pressures that are projected to get much worse.** It is crucial that stakeholders devise innovative ways to balance the forces affecting the health care system, maintain Vermonters’ access to quality care, and keep our health care providers solvent.

Introduction

Access to affordable, high quality health care services is a critically important quality-of-life issue for Vermonters and their families. To be the system that Vermonters need and deserve, our health care providers – hospitals, clinics, continuing care facilities, and others – must be financially sound and equipped to provide state-of-the-art treatment for injury or illness relatively close to home 24 hours per day, 7 days per week.

The financial health of Vermont's health care system is at risk. We must begin planning now to keep our system healthy. As we plan for the future, health care stakeholders must address several major trends: health care is becoming increasingly expensive, and there is a widening gap between our growing demand for health care service and our limited ability to pay for these services. The fact that health care does not conform to traditional market theory makes it all the more difficult for stakeholders to close this gap and shore up our system. Additionally, our efforts to devise long term solutions are challenged by the fact that current strategies for funding health care do not drive providers and consumers to the most economical paths in health care: toward disease prevention and management and away from chronic and/or emergency treatment. As a result of all these dynamics, many health system providers are searching for new ways simply to make ends meet rather than planning for the future.

This report is an attempt to clarify the nature and urgency of the problem. The trends that this report documents are not new. They will, however, have a powerful impact on our collective ability to meet the health care needs of Vermonters. Because we cannot fundamentally change these trends, we must understand them and prepare for them so that we can build a better health care system: a system that creates incentives for consumers and providers to become partners, empowering patients to become active participants in their health strategies.

This study is the first in a three-part effort, sponsored by the Vermont Department of Health and the Vermont Association of Hospitals and Health Systems, to shed light on the complexities of health care finance. The next installment will provide market-specific information about Vermont's health care service regions. The third installment will be a planning document that projects capacity needs for health care services. Taken together, we hope these documents will serve as planning tools for health care consumers, providers, and policymakers as we develop strategies to put our health care system on sound financial footing.

The stakes are high, and we must act soon. Ensuring the financial viability of our health care system will require collaborative planning, innovative ideas, and cooperation between public and private stakeholders. If we begin working now to address emerging challenges, we will build a future in which health care

providers are able to respond to immediate care needs while preparing for and maintaining their financial capacity to address the long-term future of Vermont's health care system.

Understanding Health System Finance: The Basics

Health care is a complex, multibillion-dollar service industry in the United States. Nonprofit institutions provide most of our health care in Vermont. But whether a physician making a living through private practice or a nonprofit hospital, all providers are businesses that must be on solid financial ground in order to do their work well, plan for the future, and respond to the present and future needs of Vermont's health care consumers.

The financial health of Vermont's health care industry is crucial for a stable health care delivery system that provides needed services 24 hours per day, 7 days a week. A financially weak health care system threatens both to erode the quality of care and to undermine the ability of providers to take the necessary steps to prepare for future challenges. Just like any other business, the financial health of the health care sector is a function of the revenues collected and the expenses paid to provide health care services. In Vermont, revenues include monies collected for providing patient services from a variety of payers.

Health care providers operate much like any other business in that they must generate enough revenue to cover their expenses of operating over a given time period. Expenses that providers pay include typical items such as salaries and fringe benefits, taxes and interest, and operating expenses such as electricity for lighting, fuel costs for climate control, and payments for water service. Providers expense their buildings and the machinery and equipment over more than one operating year in a manner very similar to the way other businesses depreciate their buildings and equipment. Health system providers have an expense category called "free-care and bad debt," equivalent to "uncollected accounts receivable" that is a part of the income statement of nearly every other business in the State.

Capital-intensive service providers such as hospitals must also collect enough revenue from their business operations to meet the financial requirements of renewing themselves to serve future needs. Equipment and facilities wear out, become obsolete over time and must be replaced. As more sophisticated treatment, prevention, and disease management regimens evolve, they often require more technologically advanced equipment and facilities. Because hospitals have historically been the main drivers of innovation in the health care system, it is crucial that they be able to dedicate funds to renewal. They are the only providers in the health care system with enough financial capacity to invest in new technologies or bear the lead-time costs associated with improving the delivery of care before the demand is actually present.

Why doesn't health care respond to market forces?

Health care is not a typical product or service. Unlike other goods and services, the marketplace for health care is not self-regulating; that is, consumers don't "purchase" only what they can afford. In health care, therefore, higher prices do not reduce demand. Consumers neither defer purchases nor substitute less costly goods and services to economize. Health care is typically not a deferrable expenditure. If you need emergency heart surgery, you can't wait five years to save for it. When a person needs expensive health care, it is often due to a catastrophic event.

Many people seek to finance their health care through insurance, and this third party payment system almost completely insulates consumers from the true cost of their care. This insulating effect, in turn, short-circuits the consumer impulse to economize on the use of care by adjusting their health spending to their ability to pay. Even if consumers wanted to economize, there is no "economy model" in health care that can be substituted to provide the same service at a lower price.

Another reason that health care doesn't respond to market forces is that a significant number of people won't ever be able to afford health care, and as a society we find it unacceptable to deny care to people who can't pay for it. Health care is paid for in three ways. Public payers include the Medicare and Medicaid programs, which are funded through state and federal income tax and through direct beneficiary contributions and co-pays. Private payers are primarily insurance plans funded by individuals and employers. In theory, uninsured people pay for all of their care out-of-pocket; in reality, they rarely have the resources to do so. By some estimates, there are 40 million Americans who lack insurance and 44 million who are underinsured.

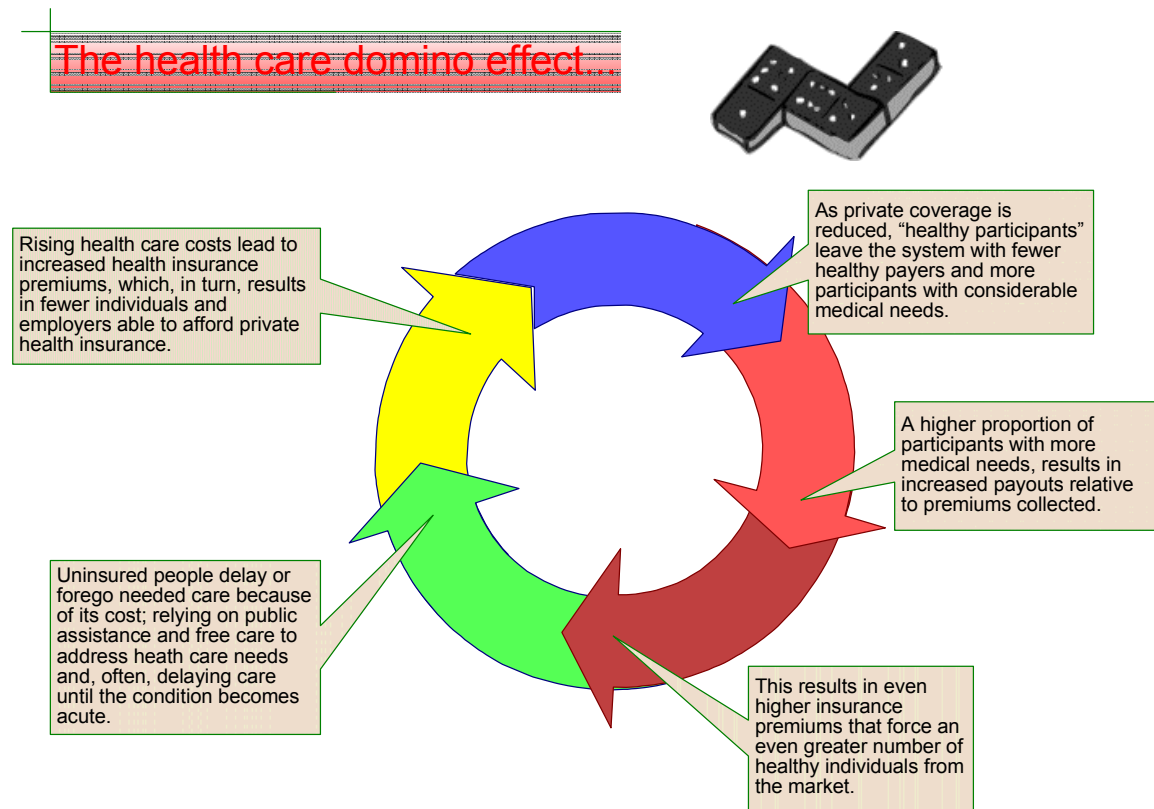
Whether in the public or private payer systems, few consumers pay for the true cost of care. This reality contributes to the complexity of the system.

Why can't everyone just pay for his or her own health care?

Decades ago, we recognized that the true cost of health care was beyond the reach of most Americans. The insurance system evolved to address this fact. Health insurance works because many healthy participants pay premiums to cover the health care costs of a few unhealthy participants. As private coverage is reduced, the number of "healthy participants" in the system declines, leaving fewer healthy participants and more with considerable medical needs. In turn, this unfavorable shift results in higher costs and insurance premiums that force more individuals into the ranks of uninsured. As more participants leave the insurance system, even fewer healthy individuals remain and insurance premiums continue to climb. As the ranks of the uninsured swell further, more and more people delay or forego needed care because of its cost. As a result,

many of the uninsured must seek care in the least efficient and most costly settings —such as in hospital emergency rooms.

On the public program side, rising health care costs in the Medicare and Medicaid programs place acute fiscal pressures on federal and state budgets. These pressures create a financial domino effect for all providers. Inadequate government reimbursement for services leads to payment shortfalls that must be passed on in the form of higher charges to private payers. This is called “cost shifting.” As health care costs rise in the private sector and public funding for health care shrinks, more people lose benefits and join the ranks of the uninsured. As more people become uninsured, health care costs continue to rise. The cost shift grows, and the financial domino effect worsens.



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Cost shifting occurs in three ways. Inadequate federal and state reimbursements for services provided under the Medicare and Medicaid programs result in higher rates charged to private payers to recoup those uncompensated costs.¹ For example, in 2001 private payers in Vermont were charged a total of \$36.0 million more for services than the actual cost of providing those services.

The second way cost shifting can occur relates to the uninsured population. Because providers do not turn away those in need of care, care provided to

those who cannot afford to pay results in an uncompensated or free care burden for providers. These providers, in turn, are left with no other recourse than to pass on the cost of that care to private payers—mostly the privately insured—in the form of higher charges. In 2001, the free care cost shift totaled \$11.3 million or 16.6% of the total estimated cost shift in Vermont that year.²

The third way cost shifting occurs is when insured individuals do not pay the deductibles or co-insurance amounts charged by providers for care. When these amounts are not collected, providers must absorb the loss, creating bad debt expenses. In 2001, it was estimated that bad debt expenses totaled \$20.9 million or 30.7% of the total estimated cost shift in Vermont.³

Cost shifting has a significant impact on health care charges in Vermont. Private payers are paying roughly 22% more for their health services in comparison to the costs of providing those services. That level is significantly higher than both the 103% and 112% comparative ratios for New England and U.S. as a whole, respectively.

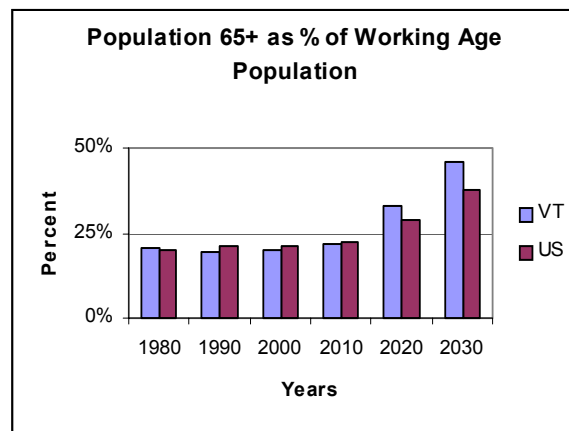
Core Challenges Facing Our Health Care System

All health care stakeholders in Vermont must address three trends -- three core challenges -- whose origins lie far beyond the borders of our state. The stage has been set, and we will have little or no control to alter the course of these trends. Because they will have such far-reaching effects on the quality, cost, and structure of the health care delivery system available to Vermonters, we must take them into account in planning for the future of our health care system.

1. Shifting demographics will mean more people needing more service.

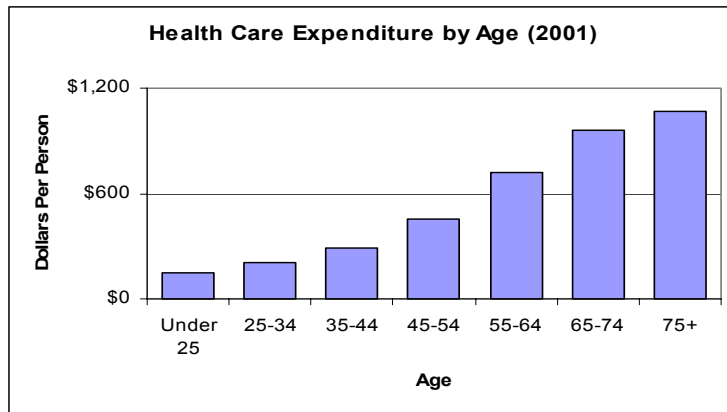
The demographics of the nation and Vermont are changing as the “baby-boom” generation ages. As more and more Americans and Vermonters reach their forties, fifties, and sixties, they will use more services and place increasing demands on private, national, and state resources.

- In the next three decades, nearly 100,000 Vermonters will reach the age of 65. By 2030, there will be twice as many Vermonters over 65 as there were in 2000.



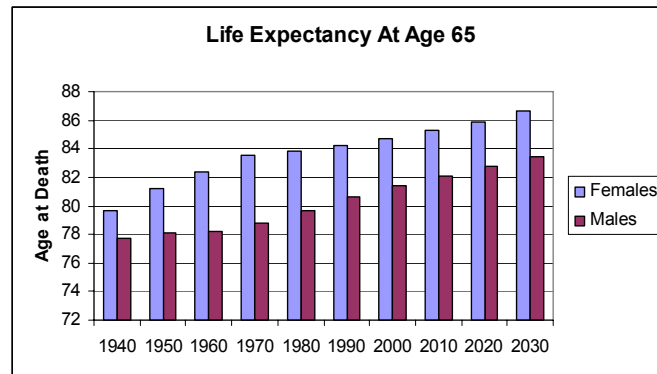
Note: Working age population defined as 20-64 years of age.
Source: US Bureau of the Census, Economic & Policy Resources, Inc.

- Since persons aged 65 years and older tend to spend more than younger counterparts of the population on health care services, the total amount of resources expended on health care in Vermont will rise dramatically as well.



Source: US Bureau of Labor Statistics Consumer Expenditure Survey 2001

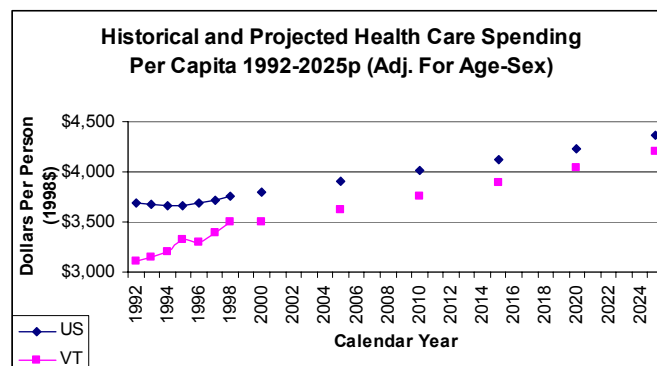
- As they age, baby boomers will demand the ready access to services and prescription drugs that they have come to expect. They will demand more technologically advanced care than did their predecessors.



Source: Social Security Administration (2002 Annual Report of the Trustees)

- Life expectancy will continue to increase, meaning that more people will be using more health care services for longer periods of time.

- While baby boomers age and leave the workforce, growth in the labor force is expected to slow dramatically, leaving fewer working people to generate the income that will be needed to pay everyone's health care bills.



Source: The Vermont Agency of Human Services, *Expansion of Health Insurance Coverage to Uninsured Vermonters*. Interim Final Report (October 2001)

- A 2001 study commissioned by the Vermont Agency of

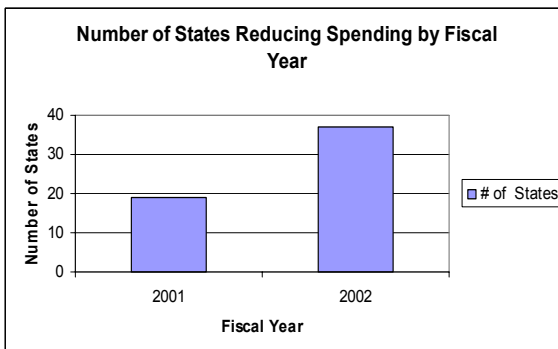
Human Services estimates that demographic change alone will increase per person expenditures in Vermont 22% by 2025 -- and that doesn't account for medical inflation and medical technology growth. This is more than the projected 15.8% increase for the nation as a whole and a 12.7% projected increase for the New England region.

- The increased incidence of chronic diseases such as diabetes, asthma, and cardiovascular disease place additional and growing demands on our health care system. Diabetes, for example, is now the seventh leading cause of death for Vermonters. The rate of hospitalization related to uncontrolled diabetes is currently 7.1 cases per 10,000 people (1999), 33% higher than Vermont's rate in 1985 and well above the national rate of 5.4 cases per 10,000 people.⁴ Between 1983 and 1996 hospitalization charges related to diabetes increased by 600%.⁵
- Growth in demand can be expected to put a significant burden on the ability of the state's economy to support those expenditures, especially as growth in the labor force declines and program cost pressures mount.

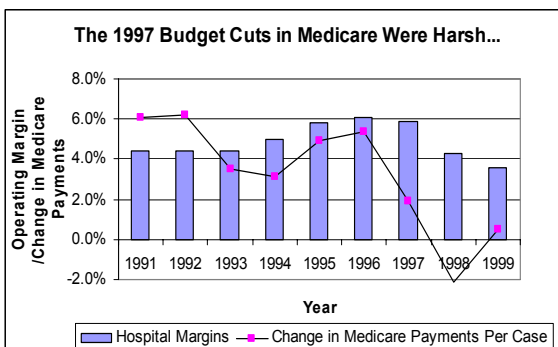
2. Constrained public financial resources will continue to pressure Vermont's health care delivery system.

Cyclical and structural fiscal constraints on federal and state budgets take a heavy toll on the health care provider network. In the short run the cyclical aspects create fiscal pressures that lead to lower reimbursement rates for services covered by Medicare and Medicaid. In the long run, structural pressures such as the growing federal deficit and infrastructure needs in both the national and state economies create additional competition for limited public funding. Taken together, both short and long-term pressures ensure that public funding constraints are going to get worse in coming years, not better.

- The November 2002 Fiscal Survey of the States, shows that nearly every state in the nation is in fiscal crisis as tax revenues have shrunk and spending pressures have



Source: National Governors Association
November 2002 *Fiscal Survey of the States*



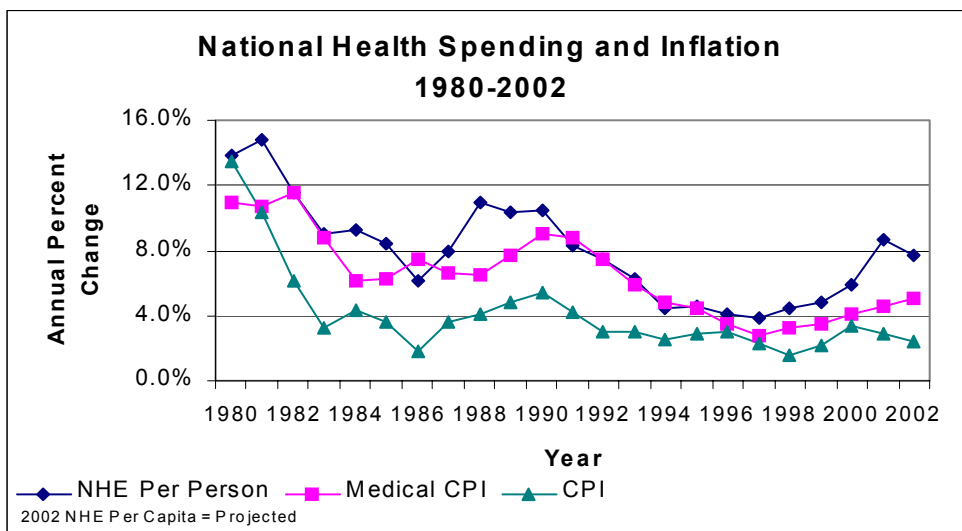
Source: MedPAC, *Data Book on Hospital Performance* (2001)

increased—due mostly to the Medicaid program and other health spending.

- Fiscal pressure to reduce governmental support of health care spending comes at a time when the financial health of providers is already at risk due to significant cuts to the Medicare program since 1997.

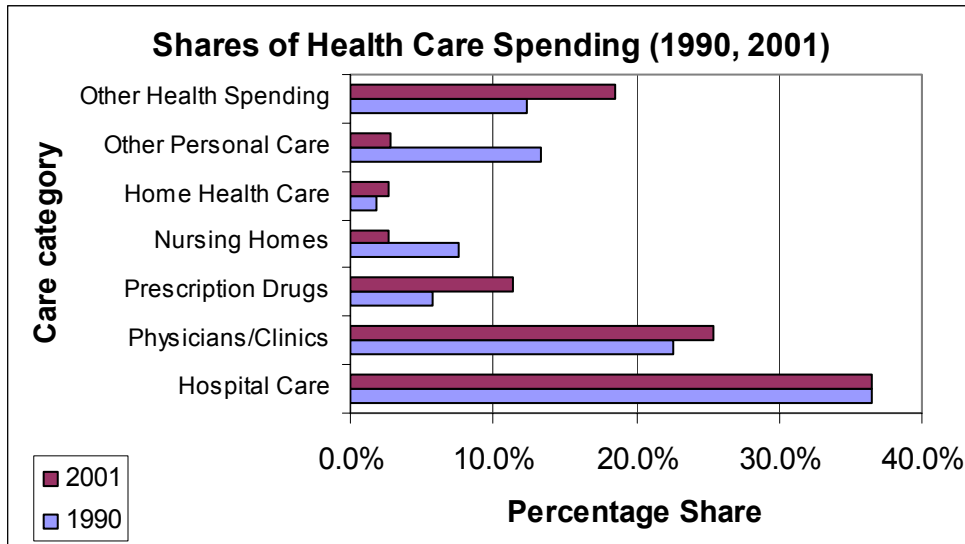
3. Hospital operating and program charges continue to grow faster than the rate of inflation.

Because of the central role hospitals play in the delivery of health services, they experience price increases across the entire spectrum—pharmaceuticals, labor, insurance, utilities, and the like. Hospital labor costs have risen in particular due to workforce issues such as the nursing shortage. Hospitals have attempted to substitute technology to increase labor productivity and help stabilize labor cost pressures. At the very same time, Vermont’s current regulatory structure is not adequate to meet the changing needs of the population; and broad concerns about rising health care costs place constraints on the adoption of new technology.



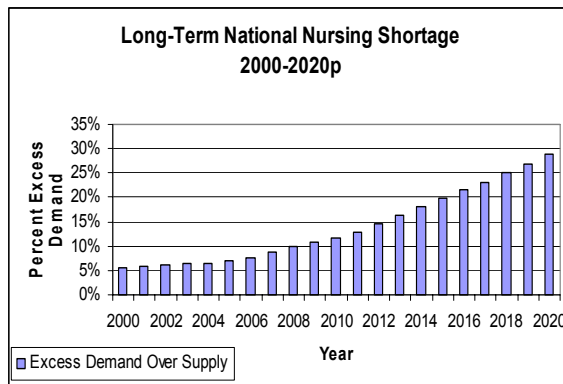
Source: U.S. Department of Labor, Bureau of Labor Statistics (CPI and MCPI); Centers for Medicaid and Medicare Services (NHE)

- U.S. per capita health spending grew at a comparatively restrained rate of under 5% from 1994-1999. Although it grew at a rate that was somewhat higher than the general inflation rate, health-spending growth tracked more closely to the general rate of inflation during the period than it did during the 1980s and early 1990s when it grew much faster. Health spending growth appears to be re-accelerating again—growing nationally at a rate of almost 6% in calendar year 2000.



Source: Center for Medicaid and Medicare Services; Kaiser Family Foundation (Share Calculations)

- Expenditures devoted to hospital care have remained unchanged between 1990 and 2001. Over the same period, spending on prescription drugs rose sharply from 5.8% in 1990 to 9.4% of total health spending in 2001 and Physicians and Clinics rose from 22.6% in 1990 to 25.4% in 2001.



Source: U.S. Department of Health and Human Services

- During this time period the provider network has faced declining levels of government reimbursement, increasing operating costs (particularly for labor), and increasing demand for services using the latest technology. Cost pressures are particularly acute in the area of nursing with more than 100,000 open nursing positions across the country. The current 5% nursing shortage is expected to rise to 12% by 2010 and to 30% by 2020.

What Does All This Mean For Vermont?

As the state enters a new millennium, the service provider network is facing considerable financial hardship. Inadequate reimbursement, particularly from the Medicare and Medicaid programs, has seriously eroded the financial performance of the health service sector dating from the late-1990s.

The Health Care Industry in Vermont.....

- Health Care is Vermont's second industrial sector in terms of employment.
- 16 Hospitals
- 281,493 days of inpatient care and 1,303,956 outpatient visits
- 1,750 Physicians, 4,350 Registered Nurses and 1,400 Licensed Practical Nurses
- Personal Health Care Expenditure in 2001: \$1.9 billion
 - 37% was paid to hospitals
 - 20% to physician services
 - 16% for drugs and supplies
 - 7% to nursing homes
 - 7% for dental care
 - 4% for home health care

Source: *Vermont Health Care Expenditure Analysis*. 2001. BISHCA.

This erosion is now becoming more and more serious as public fiscal positions are weakened by poor economic conditions. On the expenditure side, the provider network has had to contend with mounting cost pressures associated with needed advancements in medical technology, pharmacy costs, and escalating costs associated with attracting and retaining the requisite professional staff needed to assure a high standard of care.

This revenue-expenditure squeeze is occurring at the very same time health care providers are challenged to plan for a dramatically different future that includes the aging of the "baby-boom" population, an increased incidence of chronic disease, and the need to meet changing patient demands at the lowest possible cost. These

pressures threaten to undermine the capacity of Vermont health service providers to continue to provide broad access to services, improve the quality of the care they provide, and meet the implicit financial and technological challenges associated with the inevitable – and desirable – evolution of the services delivery environment.

Vermonters depend on a strong health services provider network. That network must be capable of planning ahead thoughtfully, with a long-range view of the problems and challenges that affect Vermont's health care system. The continued financial health of Vermont's system of providers is currently at risk. This threatens the stability of the health care delivery system—being available 24 hours a day, seven days a week—and undermines the ability of the system to prepare adequately for future challenges.

This is a watershed moment for Vermont's health care system. We must take steps now to shore up our health care network, before the stressors on our system become greater than they already are. Addressing long-term challenges will require a great meeting of minds, the creative collaboration of all stakeholders: consumers, providers, and policymakers. The dynamics of our health care system are complex, but these complexities cannot themselves become the barrier to visionary problem solving. We must work together to

strengthen and maintain a financially viable health care system that will serve Vermonters well for years to come.

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Endnotes

¹ Relative to the cost of providing those services to patients.

² *Expansion of Health Insurance Coverage to Uninsured Vermonters*, p. 55. The Vermont Agency of Human Services. October 2001.

³ *Ibid*, Page 55.

⁴ *Health Status Report 2002*. Vermont Department of Health. June 2002.

⁵ *Diabetes in Vermont: A review of the data*. Vermont Department of Health. 1999.