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Hospitals: The biggest losers in the health care debate

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No matter which health care regulations and statutes are enacted or repealed in 2018, one thing is certain: America's obesity epidemic will pose ongoing and new challenges to the financial viability of hospitals and other health care providers. It is a challenge that is not likely to go away anytime soon.

THE PROBLEM

According to a recent report from the Centers for Disease Control and Prevention, 40 percent of adult Americans over the age of 20 are obese.[1] This is an increase from 30 percent only 15 years ago.[2]

Further fueling this epidemic threatening our nation's health is the 20 percent rate of obesity for children ages 6-19.[3] In addition, 70 percent of Americans are either overweight or obese.[4]

In other words, an unhealthy weight is now the norm and normal weight is becoming the outlier.

OBESITY AND ITS IMPLICATIONS FOR HOSPITALS

Obese patients have an increased risk for a myriad of diseases, including heart disease, certain cancers, liver and kidney disease, gallbladder disease, Type 2 diabetes, mental health issues and more.

Obesity during pregnancy increases the chances of complications and stillbirth. And the longer children are obese or overweight, the more likely they are to remain so as adults.[5]

Obesity also increases the probability that patients will have conditions that may complicate whatever condition(s) they are being treated for in a health care setting and thereby increase treatment risk and potential financial loss.

Those conditions include stroke, cardiac failure, hypertension, diabetes and respiratory problems. In addition to the risks these conditions pose to any patient, they also increase the costs of treating them.

One study compared hospital stay and surgical costs for obese patients with costs for nonobese patients. To control for medical complexity, each obese patient was matched one to one with a nonobese patient using age, sex, race and 28 comorbid defined elements to ensure an accurate side-by-side comparison.[6]

The results showed that total hospital costs incurred for obese patients were about 3.7 percent higher than for nonobese patients undergoing the same procedure.

Looking at the components of hospital costs, length of stay was higher for obese patients as was the cost per day for diagnostic and therapeutic procedures needed after the surgical procedure.

This study estimated that annual hospital expenditures for the largest volume of surgical procedures are about $160 million higher for obese patients compared to their nonobese counterparts.[7]

Overall, studies indicate that obese people have more and longer hospitalizations (one study indicates that obese people have a 3.85 percent greater risk of hospitalization), use more prescription drugs and make more outpatient visits than do normal-weight persons.[8]

Diabetes alone now costs the U.S. health care system more than $322 billion, and obesity is a leading factor in developing this disease as evidenced by the fact that states with lower obesity rates generally have a lower incidence of diabetes.[9]

Some observers have concluded that providing coverage and bringing down the cost of coverage for high-risk patients has increased obesity rates because there is no "penalty" or incentive to change "unhealthy" behaviors.

Some studies use body mass index as an indicator to demonstrate these cost increases. They estimate an increase of 2.3 percent in health care costs for every unit of BMI increase. And these costs may negatively impact a provider's bottom line.[10]

Finally, to the extent the passage of the Affordable Care Act in 2014 prohibited health insurers from denying coverage or increasing premiums for pre-existing conditions such as obesity, obese people can now get coverage at an affordable rate.

Some observers have concluded that providing coverage and reducing the cost of coverage for high-risk patients has increased obesity rates because there is no "penalty" or incentive to change "unhealthy" behaviors. And there is evidence that obesity rates have increased since the enactment of the ACA.[11]

With an increase in the obesity population comes an increase in the high-risk patient population for hospital and other health care providers. In most instances, these providers do not have the option of turning away sick, high-risk or complex patients. Instead, they must render appropriate medical care.

WHO WILL PAY?

The next logical question, then, is who will pay for the increased costs associated with treating an increasingly obese patient population?

Typically, government or private commercial payers bear the cost of health care services. In 2015, for example, only about 11 percent of health care expenditures were paid by individuals with the rest paid by governmental and private health plans.[12]

Of course, both private health and governmental payers make or save money when they delay or deny payment of claims.

When private payers delay payment, they can take advantage of the "float." And when government payers delay payments, they have better control of their budgets. With denials, both payers anticipate that some percentage will not be pursued.

Currently, reimbursement denial rates for all payers generally hover between 5 and 10 percent nationally, while the rate exceeds 10 percent in some parts of the country.[13] These denials cost the health care industry $262 billion annually.[14]

Considering that health care spending in the United States is more than $3.2 trillion, even a fraction of a percent increase in denial rates or uncompensated care levels due to obesity can spell financial disaster for medical providers.

The additional reworking costs associated with appealing denials and delays have always taken a toll on health care providers' financial health. Expense growth has outpaced revenue growth, which is, not surprisingly, hurting the bottom line.

The average operating margin for most hospital providers is currently less than 3 percent. With the increase in the obesity population, this already-low operating margin may decline even further.

Payers will not be able to accurately predict losses associated with treating more obese patients whose hospital stays might be extended by unanticipated events. Commercial health insurers are in the business of making money.

If they have to make large payouts, they will slow-pay or deny with the hope that such denials will not be pursued. And if such claims are pursued legally, payment will be delayed even further by arbitration or litigation. In some cases, settlements may produce payments that are less than the amount owed.

WHAT CAN HOSPITALS DO?

Hospitals and other health care providers can take steps to minimize the impact the growing obesity epidemic may have on their bottom lines. Specifically, they can:

- Review and comply in a timely manner with payer contract or regulatory provisions, which generally give health care providers ways to challenge denied claims. Many hospital personnel ignore these provisions (which sometimes include deadlines for timely pursuing such claims) and ultimately lose the right to be paid for otherwise valid claims. The majority of these denials can be overturned with aggressive appeals and judicial intervention. Remember, payers secretly hope providers will give up after multiple denials and not pursue payment, so don't give in. The downside for providers is that pursuing denied claims adds significant costs.

- For claims that payers refuse to pay despite reasonable efforts, hospitals may identify government payers that may require that the patient be disabled as a prerequisite for payment. These include Social Security and Medicaid programs. Under certain circumstances, obese individuals may qualify as being disabled and eligible for medical coverage. For example, some state laws may protect obesity as a disabling condition. Clinically diagnosed obesity is considered to be a disability under the New York State Human Rights Law, N.Y. Exec. Law § 296, and courts in New Jersey have concluded that actual or perceived morbid obesity is a protected disability under the New Jersey Law against Discrimination, N.J. Stat. Ann. § 10:5-12. The downside here is that hospitals will have to use their own resources to work with the patient to obtain eligibility, which sometimes takes years to obtain.

- Identify instances where third parties, such as employers or tortfeasors, may be liable for causing damage to the obese patient — and take appropriate legal action. Bear in mind that the tortfeasor in many states cannot be the fast-food industry or beverage industry despite their purported role in the nation's obesity epidemic. At least 26 states have enacted statutes that prohibit people from suing food companies for making them fat. Interestingly, there is some evidence in states that removed the right to file obesity lawsuits that overweight residents were motivated to lose weight and eat healthier. Again, the downside is that hospitals will have to use their own resources to pursue these claims and wait a long time to receive payment.

- Use financial forecasting that appropriately accounts for the higher costs associated with the increase in obese patients. Providers should consider negotiating reimbursement rates that will result in more reasonable compensation for medically necessary services for complications that are likely to occur with obese patients. The downside is that despite the objective basis for taking into account the shift in the obesity population, many payers will still challenge hospital pricing on the basis that the charges are not reasonable or customary. As a result, hospitals may need to expend additional resources, including resources that fund litigation, to obtain payment.

- Educate patients and the community about the role that physical activity and good nutrition play in preventing obesity. Lead by example. Substitute healthy foods for junk food in cafeterias and hospital gift shops. Recommend nutritional screening for patients, and make sure they learn how to compensate for the negative effects medications have on their health, including obesity. The downside is these steps may increase hospital costs over the short term. There may also be a reduction in the patient population with chronic illnesses over the longer term. But is reducing the incidence of chronic illnesses really a bad result for health care providers? The answer is no. We are already experiencing a shortage of doctors, nurses and other health care professionals. Reducing the incidence of obesity and its complications will, at a minimum, free up health care resources so providers can address traumas, natural disasters and other emergencies and acute illnesses over which society has less or no control.

CONCLUSION

The obesity epidemic puts hospitals in a classic Catch-22 situation. They cannot choose their patients, and they must provide appropriate and necessary medical treatment to many of those who come through their doors. When they do, payers will look for ways to deny and delay claims.

The downward spiral will continue until the country can figure out how to work with and motivate health care providers like hospitals to reduce the incidence of obesity. But in the current climate, hospitals may be the biggest losers.

NOTES

[1] Craig M. Hales, Margaret D. Carroll, Cheryl D. Fryar & Cynthia L. Ogden, *Prevalence of Obesity Among Adults and Youth: United States, 2015–2016*, NCHS Data Brief No. 288 (U.S. Dep't of Health & Human Servs., Hyattsville, Md.), October 2017, at 6, http://bit.ly/2xJveAZ. Obesity is defined by the National Institutes of Health as having a BMI of 30 and above.

[2] *Id.* at 5.

[3] *Id.* at 3.

[4] *Overweight & Obesity Statistics*, Nat'l Inst. of Diabetes & Digestive & Kidney Diseases, http://bit.ly/2p4qlRN.

[5] Rodney J. Mason, Jolene R. Moroney & Thomas V. Berne, The Cost of Obesity for Non-bariatric Inpatient Operative Procedures in the United States: National Cost Estimates Obese Versus Non-obese Patients, Annals of Surgery (October 2013), 258(4):541-551.

[6] *Id.*

[7] Joanna C. Parks, Julian M. Alston & Abigail M. Okrent, *The Marginal External Cost of Obesity in the United States* (Robert Mondavi Inst., Ctr. for Wine Econs., Working Paper No. 1201, 2012).

[8] Marsha A. Raebel, Daniel C. Malone, Douglas A. Conner, Stanley Yu, Julie A. Porter & Frances A. Lanty, *Health Services Use and Health Care Costs of Obese and Nonobese Individuals*, Archives of Internal Medicine (October 2004), 164(19):2135-2140.

[9] Casey Leins, *10 Least Obese States*, U.S. News & World Report (Aug. 21, 2017, 1:24 PM), http://bit.ly/2zBSPb1.

[10] Raebel et al., *supra* note 9.

[11] Justin Haskins, *Obesity and Health Care Costs Continue to Rise Under Obamacare*, Human Events (Aug. 26, 2015, 12:01 AM), http://bit.ly/1NI0EM2.

[12] Ctrs. for Medicare & Medicaid Studies, National Health Expenditures 2015 Highlights, http://go.cms.gov/2hn3vyt.

[13] Ayla Ellison, *Average Claim Denial Rate for Large Hospitals, by Region*, Becker's Hospital CFO Report (Mar. 13, 2017), http://bit.ly/2zGNZcj.

[14] Change Healthcare, Healthy Hospital Revenue Cycle Index (June 26, 2017), http://bit.ly/2jro5mL.

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