The mission of each and every hospital in America is to serve the health care needs of the people in its community 24 hours a day, seven days a week. But, hospitals’ work is made more difficult by our fragmented health care system — a system that leaves millions of people unable to afford the health care services they need.

Hospitals deal with approximately 1,000 insurers¹ and insurers typically have several different plan options. For instance, in the Federally-Facilitated Exchange (FFE) program specifically, there are approximately 150 unique insurers offering over 50,000 discrete health plan options leading to² multiple and often unique requirements for hospital bills. Add to that decades of government regulations, which have made a complex billing system even more complex and frustrating for everyone involved.

Today’s fragmented health care system leaves hospitals with a daily balancing act to maintain their mission to the community while making ends meet. The following is an explanation of key components of hospital billing, including hospital charges, payment and costs.

### Charges vs. Payments

Federal laws and regulations require hospitals to maintain uniform charge structures. Payments, however, do not correspond to those charges. What a hospital actually receives in payment for care is very different. That is because:

- Medicare: 47% of the typical hospital’s volume of patients³
- Medicaid: 24% of the typical hospital’s volume of patients³
- Privately insured patients make up 29% of the typical hospital’s volume of patients
  - For fee-for-service Medicare patients, the U.S. Congress sets hospital payment rates.
  - For fee-for-service Medicaid patients, state governments set hospital payment rates.⁴
  - Private insurance companies negotiate payment rates with hospitals.⁵ Private insurance company payment rates vary widely with larger insurance companies typically better positioned to demand bigger discounts.
  - Tax-exempt hospitals are prohibited from billing gross charges for those eligible for financial assistance. Under the ACA, tax-exempt hospitals are required to have a written financial assistance policy that is widely distributed in the community. Care is either provided for free, or based wholly or partly on Medicare rates under the Internal Revenue Service (IRS) regulations.
  - Insured patients who are seeking care at a hospital outside their insurance company’s network, patients ineligible for financial assistance and patients whose care is paid for by other types of insurance (e.g., worker’s compensation, auto liability insurance, etc.), are the only patients that may be billed full charges.

### Payments vs. Costs

It is important to note that negotiated payments from insurers and public programs do not always reflect the actual cost of providing care. Medicare and Medicaid pay less than cost, the uninsured pay little or nothing, and others must make up the difference.
• Medicare and Medicaid pay less than the cost of caring for program beneficiaries – a shortfall of $76.6 billion in 2018 borne by hospitals.⁶

• Hospitals provided $41.3 billion in uncompensated care, both free care and care for which no payment is made by patients, in 2018.⁷

• Private insurance and others often make up the difference.

Payments relative to costs vary greatly among hospitals depending on the mix of payers.

**Percent of Hospitals Losing Money, 2018**

In 2018, two-thirds of hospitals lost money providing care to Medicare and Medicaid patients and about one-third of hospitals were operating on negative operating margins (see chart).

America’s hospitals are faced with mounting financial challenges. Government programs like Medicare and Medicaid pay hospitals less than the cost of caring for the beneficiaries these programs cover while insurance companies negotiate deep discounts with hospitals. The growing numbers of uninsured and underinsured further complicate this financial picture. While there are government programs such as Medicare and Medicaid disproportionate hospital payments designed to help hospitals with the cost of treating low-income and uninsured patients, it is not enough to cover the cost of care.

These inequities in payment leave hospitals with a challenging 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 keep up with new technologies and treatments, replace or improve old buildings, and otherwise invest in maintaining and improving their services to meet the rising demand for care. It also helps ensure they can attract and retain frontline caregivers and other critical staff and purchase personal protective equipment (PPE), drugs and other necessary supplies. COVID-19 has placed a tremendous strain on hospitals and health systems. A report recent estimates a minimum of $120.5 billion in financial losses, due in large part to lower patient volumes, from July 2020 through December 2020, or an average of $20.1 billion in losses per month. These estimates are in addition to the $202.6 billion in losses the AHA estimated between March 2020 and June 2020 in a report released in May. This brings the total estimated losses for the nation’s hospitals and health systems to at least $323.1 billion in 2020.

**Sources**

1. [https://aha.org/topics/financial_stress](https://aha.org/topics/financial_stress)

2. The data are from issuer submissions of their QHP applications, and were pulled from the Health Insurance Oversight System (HIOS) for Federally-facilitated states and the System for Electronic and Rate Form Filling (SERFF) for State Partnership states and State-Based Exchange states that use HealthCare.gov. The data are current as of October 1, 2019, and are subject to change.

3. Estimated based on the number of patient days by payer from the 2018 AHA Annual Survey Database.

4. Ibid.

5. Ibid.

6. Taken from the 2018 AHA Annual Survey Database

7. Ibid.