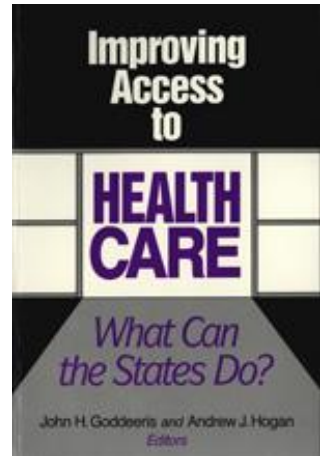

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5.5

Uncompensated Care

What States Are Doing

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Since the early 1980s, the problem of providing access to health care for those who cannot afford it has received considerable attention. Nonuniform Medicaid eligibility policies across states have resulted in less than 40 percent of those below the federal poverty line being eligible for Medicaid (Bautista 1986; Burwell and Rymer 1987; Jones 1989). A population estimated to number as many as 37 million is without health insurance (Bashshur and Webb, chapter 2 in this volume). The absence of inclusive federal policies and programs to provide health care access for at-risk populations has left the states with the responsibility of addressing the problems of access to care for those who cannot pay.

Hospitals have traditionally provided uncompensated care, defined as charity care and bad debt losses, and shifted the costs of such care to patients who had private insurance or Medicare (Saywell et al. 1989; Hadley and Feder 1985). It has been estimated that because of cost-shifting, private payers paid an average of 10.6 percent more for hospital-based care in 1982 (Hadley and Feder 1985; King 1989). Today, cost-shifting has become more difficult since payers have instituted various cost-containment procedures. But uncompensated care has continued to be provided by many hospitals, and its costs have escalated.

Measuring the volume of uncompensated care is problematic because of ambiguities in defining what is uncompensated and difficulties in determining the actual costs of care. Estimates of dollar amounts of uncompensated care have often not distinguished between provider *charges* for care and the actual *costs* of that care, resulting in nonuniform estimates. Nonetheless, one estimate of the cost of care for which hospitals were

not compensated directly and which was not covered by government appropriations indicates that it climbed from \$2.8 billion to \$7.2 billion between 1980 and 1987 (King 1989). In 1988, the American Hospital Association (1990) estimated that 6,438 nonprofit and state and local government hospitals provided a total of \$14.6 billion of uncompensated care.

Hospitals, in a competitive environment, adopt cost-containment strategies which may include limiting or eliminating uncompensated care to those without financial access. The American Hospital Association found in 1981 and 1982 that nearly 15 percent of hospitals surveyed limited the amount of charity care they provided. That included 26 percent of public hospitals that were members of the Council of Teaching Hospitals (Glenn 1985; Jones 1989). Financially stressed hospitals, in order to control costs, may engage in "patient dumping," leaving public hospitals and those with historic commitments to serve the poor with the challenge of trying to provide quality care to those who are unable to fully pay for services received. The net result is increased risk for those who are uninsured or underinsured.

State Responses

State responses to the issue of uncompensated care vary. The following examples demonstrate some of the differences in state initiatives.

Florida

Florida attempted to deal with uncompensated care in its Health Care Access Act of 1984 (HCAA). The Act established a medically indigent pool funded by an assessment on hospital net operating revenue and a state contribution. This pool would provide the nonfederal match for expanding Medicaid. Hospitals were not targeted directly for uncompensated care reimbursement, since it was felt that in reporting amounts of uncompensated care they could include bad debt, charity care, contractual allowances, professional "courtesy" care and third-party discounts, making estimates of revenues lost because of care for the un-

insured or underinsured unreliable. The unreliability of such data contributed to the political decision to focus on consumers by expanding Medicaid and medically needy programs, and by committing funds to primary health care programs (Jones 1989; Lewin 1985). Hospitals that chose to serve patients covered under these expanded programs could attempt to recoup revenues lost through the assessment. Evaluations of the Health Care Access Act reveal it did not solve the problem of provision of uncompensated care. Certain hospitals admitted more Medicaid patients but continued their practices of denying access to those who were uninsured (Jones 1989).

In 1987, Florida passed the Indigent Care Bill to provide financial support to hospitals providing disproportionate amounts of care to the poor. It attempted to establish an equitable method for distributing the burden of indigent care among providers. It also provided higher rates of reimbursement to physicians for certain procedures, such as obstetrical services, in an attempt to improve access to care for the poor using some of the funds collected by the assessment on hospital net revenues. Florida has seen an increase in the demand for uncompensated care, resulting in heavier burdens for financing and delivering uncompensated care for a decreasing number of providers as alternative medical care delivery modalities increase. Jones (1989) suggests the need for better long-term public and private insurance solutions to the uncompensated care problem, as well as a physician "tax" raised by a surcharge on licensing fees as a means of providing funds to support indigent care programs.

Florida's efforts are attempts to equitably distribute financing of indigent care without the regulatory approach of an all-payer system. It employs hospital assessments, Medicaid expansions, use of medically needy and medically indigent programs, and an experimental effort to make health insurance accessible to small employers (Jones 1989).

In contrast to Florida's mixed-approach, other states have addressed uncompensated care through "all-payer" and other approaches. A brief overview of actions taken by these states to deal with uncompensated care follows. A basic assumption of all-payer systems is that the state assumes control of hospital costs by instituting rate-setting, and that all purchasers of care at a particular hospital are to pay the same rates.

Maryland

Since the early 1970s, hospital reimbursement rates have been regulated in Maryland. In 1977, the state requested and was granted all-payer waiver status by the federal government. This was part of a state strategy to improve access to health care while at the same time attempting to control health care costs. The Maryland Health Services Cost Review Commission was charged with establishing prospective rates for specific services and procedures. Hospitals were to be reimbursed for provision of uncompensated care after review of their requests. If the request was approved, the costs of uncompensated care became part of the rates that all payers were required to pay for services at that hospital. This process assures that all payers for hospital services share the reasonable costs of uncompensated care (Salkever, Steinwachs and Rupp 1986). In effect, this approach spread the costs of uncompensated care among all payers, thereby increasing its political feasibility. Davidson (1985) admits Maryland's approach has its critics, but argues that it does seem to provide access to health care for Maryland's residents, including those whose care had previously been uncompensated. He found that in 1983, nearly all Maryland inner-city hospitals providing relatively large amounts of uncompensated care were profit making. Medicaid patients may also have gained access to more providers than previously, thereby offering greater freedom of choice. Thus, Maryland's all-payer system, despite problems, may have gone far towards finding a workable method for dealing with the problem of uncompensated care for the poor and uninsured.

New Jersey

New Jersey's all-payer rate-setting system began in the 1980s. In order to provide access to health care for those without insurance, the state allowed hospitals to include charity care and bad debt losses as reimbursable costs, thereby providing incentives for hospitals to treat the uninsured. Rosko (1990) found that New Jersey's all-payer system has increased access to inpatient and outpatient hospital care to the uninsured. It has also provided needed financial support to inner-city and

teaching hospitals, which have historically provided considerable amounts of uncompensated care (Halpern 1985). There are many questions regarding the financial impact of all-payer systems on hospitals that can be addressed but that are beyond the scope of this brief overview.¹

New Jersey's hospitals share in the total cost of uncompensated care. Insurance premiums, paid by employees and private-pay patients, include payment for uncompensated care. In 1988, it was estimated that New Jersey's uncompensated care costs were nearly \$400 million. Under New Jersey's all-payer system, most third-party payers cover the costs of uncompensated care in the rates they pay for hospital care. In effect, a surcharge is added to hospital bills. Excess revenue goes to the state's Uncompensated Care Trust Fund, administered by the New Jersey Department of Health, which then pays hospitals that provide above average amounts of uncompensated care. Medicaid also assists in funding uncompensated care, since federal law requires state Medicaid agencies to provide additional amounts to hospitals with relatively large amounts of uncompensated care (New Jersey 1989; Rosko 1989).

New Jersey has found that total uncompensated care expenses have risen recently (Rosko 1990). It has been suggested that this may be because of hospitals opting not to aggressively collect on bad debts, since they can seek reimbursement from the uncompensated care fund. If New Jersey's approach to dealing with uncompensated care is to continue, it must maintain political viability, which could be weakened if uncompensated care costs became viewed as unmanageable. New Jersey's system has improved access to hospital care, but it does not guarantee that all uninsured persons will in fact receive such care. Individuals may still be unable or unwilling to attempt to gain access to hospitals because they may seem inaccessible and forbidding. The acceptability of medical services to potential patients is another important factor in determining access to services.

Massachusetts

Massachusetts also developed an all-payer system which attempted to reimburse hospitals for uncompensated care in the early 1980s. When Massachusetts initiated its all-payer program, it hoped that medical costs could be controlled and that hospitals that were at risk financially and that may have been providing large amounts of uncompensated care would benefit by plans to reimburse a portion of the costs of that care. Rosenbloom (1985), in assessing the Massachusetts all-payer system, concluded that its main purpose was to benefit at-risk hospitals, not necessarily to create a program of guaranteed access to health care for the uninsured. Consequently, he cautioned that the system could be used to shield inefficient hospitals, such as those with excess bed capacities.

Many controversial issues arose in Massachusetts in the mid-1980s as the debate over how best to finance uncompensated care intensified. Hospitals providing uncompensated care for the uninsured felt they were competitively disadvantaged, compared to free-standing clinics or surgery centers. In 1985, the Massachusetts Hospital Association argued against continuing the federal waiver which allowed Medicare participation in the all-payer system. Hospitals feared federal limitation on payments, which would increase their financial problems. Eventually, the all-payer approach was discarded. A bad-debt free-care pool was established to reimburse hospitals for uncompensated care. As special interests clamored for or against regulation of health care, the Massachusetts legislature and Governor Dukakis passed the Massachusetts Health Care Security Act in 1988. It intended to provide access to health care for all residents through health insurance. A health insurance trust fund was to be established to provide coverage for the uninsured. The Massachusetts plan will be financed by requiring most employers to pay a surcharge on employees' wages, which will go into a state health insurance trust fund. A new state department will provide health insurance for many uninsured residents. Since 1988, the financial problems of Massachusetts have worsened, leaving uncertain its ability to finance a universal access plan (Goldberger 1990).

New York

New York's approach to the provision of uncompensated care is complex. Like Massachusetts, New Jersey, and Maryland, it utilized an all-payer rate-setting program aimed at controlling hospital costs, financing uncompensated care, and reducing cost-shifting. Eventually, New York developed an insurance-pool approach to promote health care access. Uncompensated care pools, financed through hospital rate-setting, were created to provide access for the uninsured (Berman 1985). Hospitals seeking reimbursement for uncompensated care must demonstrate reasonable efforts to collect bad debts (Meyer 1986). Provider reimbursement for uncompensated care has sometimes proven to be a complex and cumbersome process. Thorpe (1988) analyzed New York's experience and found a "leaky basket effect" in which money earmarked for reimbursement of uncompensated care was used for other purposes. Nevertheless, New York's approach has provided improved access to health care (Rosko 1990).

Summary

Early evaluations of the Maryland and New Jersey all-payer systems suggest they are able to control overall provider costs at least as well as partial-payer systems. Funding mechanisms for uncompensated care reimbursement also promote access to health care for the uninsured. Rosko (1989) found these all-payer systems provide important financial relief to hospitals that provided disproportionate amounts of uncompensated care. Cost-shifting was also reduced. New York's complex system appears to have produced similar results (Thorpe 1987).

All-payer systems are not without potential problems.² Service utilization, unless carefully scrutinized, might escalate under such plans, thereby driving overall health care costs upward. All-payer systems should not inadvertently discourage efficient financial management by providers (Wilensky 1986; Meyer 1986). Maryland and New Jersey require hospitals to vigorously attempt to collect on bad debts.

As Feingold (1988) has argued, both quality of care and cost efficiency should be goals of any reimbursement system established to deal with uncompensated care. All-payer systems are attractive, since all insurers or payers would pay identical rates for services offered at

specific hospitals. Payment rates can be determined by the state working with providers, consumers and other interested parties. Reimbursement rates can foster payment for the amount of uncompensated care done by a specific hospital.

Among the all-payer systems implemented, there have really been two different strategies used to pay for uncompensated care. One approach builds the costs of such care provided by a particular hospital into the rates that hospital charges and requires all payers using that hospital to pay those rates. This strategy has the apparent disadvantage that hospitals providing a great deal of uncompensated care will need to charge high rates and may have difficulty attracting paying patients in a competitive environment.

The other approach includes a uniform surcharge on rates at all hospitals, with the revenue pooled and redistributed to hospitals providing uncompensated care. It is important to note that, while this strategy has been associated with all-payer systems, it does not, in principle, require such a system. All-payers might pay a uniform surcharge without necessarily paying the same rates for hospital care.

Concluding Remarks

In the absence of a federal program to guarantee access to health care for the uninsured, it is clear that it will be a state and local government responsibility to deal with the problem. Short of establishing a state program of universal coverage, it is also clear that the provision of reimbursement for uncompensated care will be a necessary component of those solutions.

Whereas the foregoing has addressed uncompensated care provided by hospitals, another important aspect is that of uncompensated care provided by physicians. Issues related to uncompensated care by physicians have received relatively little attention in state initiatives. A review of available knowledge about the provision of uncompensated care by physicians showed that there is very little useful data. Available national estimates are limited. However, if these crude estimates are applied at the state level, the contribution of uncompensated care by

physicians could be substantial. In contrast to hospitals, which have received some support from insurers to cover the costs of uncompensated care, it appears that such support is not explicitly reflected in payments to physicians.

The lack of useful information may be one of the reasons why uncompensated care by physicians is minimally recognized in state strategies, where the main attention is upon uncompensated care provided by hospitals. Information systems that collect hospital-based data are available, and these sources can be used to derive estimates of the magnitude of uncompensated care. In contrast, there appear to be no information systems for the collection of physician-related data on which to make such estimates.

Our experience in a small preliminary survey indicated that there is great variability in the way physicians report uncompensated care in terms of both "charity care" and "bad debts." Since most physician offices do not appear to have computerized records, the tendency to make rough estimates contributes to the variability and unreliability of such reports. Methods that provide improved information are needed in order to understand uncompensated care provided by physicians.

NOTES

1. See Hsiao and Dunn (1987) for discussion of the impact of New Jersey's all-payer DRG system on hospital costs.
2. Indeed, Massachusetts, New Jersey, and New York have all allowed the Medicare waivers for their all-payer systems to expire.

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