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Stresses to the Safety Net: The Public Hospital Perspective

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Introduction

Every year, more than 10 million people receive care from public hospitals and health systems – a complex and diverse set of providers that share a mission to deliver health services to individuals, regardless of insurance coverage or ability to pay. Together with federally funded health centers, free clinics, public health departments and scores of individual physicians and other health practitioners, public hospitals provide critical access points for the nation's uninsured population and form a vast patchwork of providers that is commonly referred to as the health care safety net.

Despite their importance, there is no single or stable source of financial support for public hospitals' service to their communities. Safety net financing is fragmented; consequently, providers must knit together resources from many different funding sources to create a stream of revenue to cover the costs of providing a very broad range of services. Part 1 of this report describes those sources of revenue, demonstrating the significant role Medicaid plays in supporting the current public hospital safety net, documenting that nearly 40% of all safety net revenues are from Medicaid. It also highlights trends affecting the health of the safety net over the past decade. Part 2 describes particular challenges that safety net hospitals and health systems are experiencing as they attempt to rebound from the economic downturn of the early 2000s.

Part 1 – A Profile of Public Hospitals and Health Systems

Public hospitals have a long history of service to the community.[1] The first public hospital, Philadelphia General, opened originally as an almshouse in 1731 and continued operating until 1977. Early public hospitals combined traditional almshouse activities on behalf of the poor with efforts to provide health services to patients and medical education for the nation's health care workforce.

Today, there are over 1,100 public, non-federal acute care hospitals in the country, most of which are owned by county governments.[2] Nearly three-quarters (73 percent) of these hospitals are located in rural settings and most are relatively small – 69 percent of acute care public hospitals have fewer than 100 beds and 85 percent have fewer than 200 beds.

The term "safety net hospital" refers to a subset of public and not-for-profit hospitals that provides disproportionate amounts of care to low-income and uninsured patients.[3] Many of these hospitals belong to the National Association of Public Hospitals and Health Systems (NAPH), and NAPH's membership has collectively come to represent the majority of traditional safety net hospitals in the country. Currently, 61 hospital systems are included in NAPH's membership, representing approximately 120 individual hospitals and more than 700 affiliated community clinics. Most of the hospital systems are located in metropolitan areas although, in many cities, their service areas extend well beyond urban boundaries.

Safety Net Hospital Financing: Who Pays for the Care?

Increasingly, researchers and policymakers have underscored the role that Medicaid plays in financing care for low-income individuals. In a 2003 *Health Affairs* article, Alan Weil, then director of the Urban Institute's Assessing the New Federalism program, dubbed Medicaid "the workhorse of the U.S. healthcare system."[19] Clearly, without Medicaid, the current public hospital safety net could not exist.

Medicaid has become the engine that fuels access to health services for individuals who rely on the safety net for their care. Medicaid funding is the single largest source of support for both public hospitals and community health centers.[20] It provides this funding through a combination of payment mechanisms for direct patient services and institutional supports.

The Medicaid program is a federal-state partnership that provides health coverage to certain low-income and disabled individuals. All states opt to participate in the Medicaid program and must conform to federal regulations concerning mandatory populations, benefits and policies.[21] States have considerable discretion, however, in terms of shaping their Medicaid programs and can create more or less generous programs that still meet federal requirements and restrictions. Patients qualifying for Medicaid in one state may be uninsured in another state with different eligibility requirements for Medicaid. Thus, large safety net hospitals and health systems are extremely sensitive to changes in both federal and state Medicaid policy.

Current Financing of Safety Net Hospitals

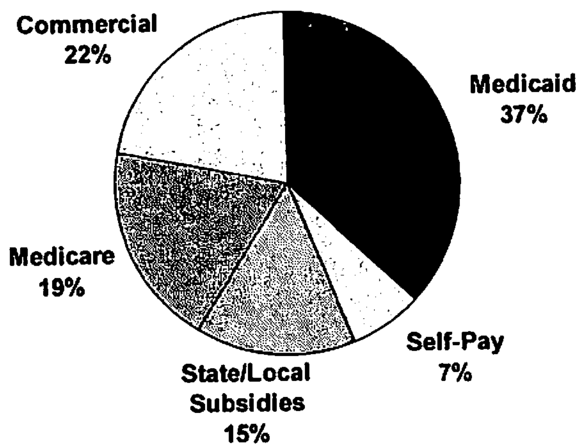
In national studies, the safety net has been described as being "intact but endangered"[22] and "fragile yet resilient"[23] – terms that recognize the precarious state of safety net financing in this country. In 2002, while acute care hospitals had margins on average in the 4.5 percent range, more than half of NAPH members had negative margins and the average margin for all hospitals in the membership was -0.3 percent.[24] This is dangerously low for an industry that considers margins below the 2 percent level to be inadequate for financing working capital or reinvesting in infrastructure and technology.[25] Unfortunately, low margins are not unique to 2002; average margins at NAPH hospitals have been below the 2 percent point since 1998.[26] These low margins are evidence that safety net hospitals and health systems are incapable of shifting costs onto other payers, underscoring the importance of adequate reimbursement through Medicaid.

The Medicaid program constitutes a very large proportion of revenues for safety net hospitals and health systems. In 2002, the Medicaid program was responsible for over one-third (37 percent) of the nearly $23 billion in net revenues collected by

NAPH hospitals (see Figure 4). This includes state and local subsidies to cover losses. When excluding state and local subsidies, the proportion covered by Medicaid is even greater – 49 percent of patient care revenues. Only 7 percent of revenues came from uninsured patients, most of whom are very low-income and therefore not required to cover the full costs of care out-of-pocket.[27]

Figure 4

NAPH Hospital Net Revenues by Payer Source, 2002



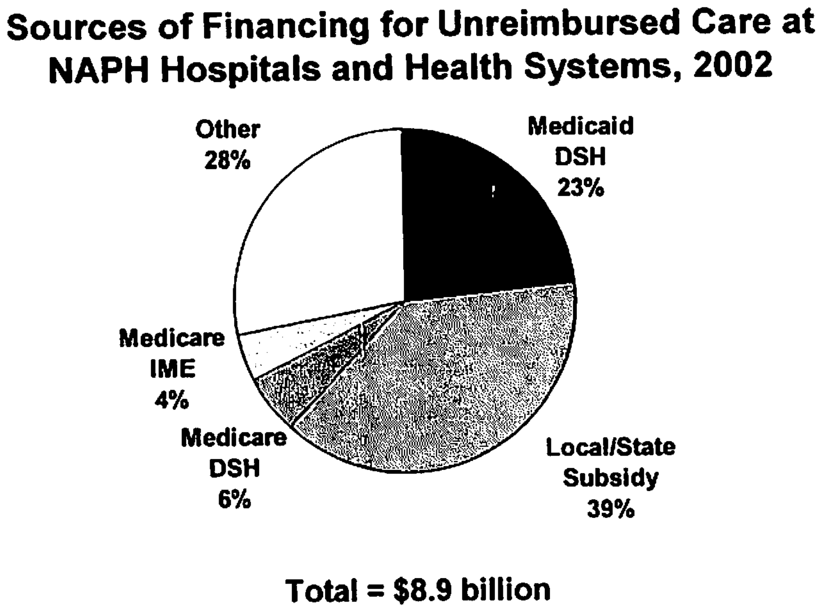
Total = $23 billion

Source: NAPH Annual Survey of Members, 2004.

As part of their mission to serve large numbers of uninsured and low-income patients, safety net hospitals provide significant amounts of uncompensated care. While these hospitals provide only about 4.3 percent of admissions nationwide, they are responsible for 24 percent of uncompensated care provided by the hospital industry.[28]

While uncompensated care represents 21 percent of the costs at NAPH member hospitals, an even greater percentage is *unreimbursed*, meaning the payments received for services provided do not cover the full costs of providing these services. Safety net hospitals often lose money on Medicare and Medicaid patients. These hospitals and health systems rely on a number of sources to support this unreimbursed care. As Figure 5 illustrates, state and local subsidies are important to safety net financing, providing 39 percent of the unreimbursed care. Despite the importance of this funding, state and local financing varies quite a bit across NAPH hospitals and is considerable in some communities and minimal in others. On average, state and local subsidies represent about 15 percent of net revenues at NAPH hospitals.[29] Still, over 15 percent of NAPH hospitals receive no state or local support and an additional third indicate that these subsidies represent less than 10 percent of net revenues.

Figure 5



Source: NAPH Annual Survey of Members, 2004.

State and local subsidies take many different forms and reflect the political, economic, cultural and historical realities of the community in which the hospital operates. Local support can provide direct payment for general health care services, or it can provide targeted subsidies, for example for specific services such as trauma services or capital expenditures.[30] Often, when local monies finance direct patient care, communities define populations who are eligible for free- or reduced cost services in terms of county or city residency requirements, income eligibility, or other criteria.

Another 28 percent of funding for unreimbursed care comes from revenues not associated with direct patient care, such as interest and investment income, cafeteria and parking revenues, medical record fees, rental fees, and sales taxes. Funding from tobacco settlements is included in this category.

Medicaid disproportionate share hospital (DSH) payments are also a significant source of funding for unreimbursed care, financing 23 percent of this care, while Medicare DSH finances about 6 percent of unreimbursed care. Medicaid DSH payments are determined by individual state Medicaid programs and are given to hospitals the state designates as serving a disproportionate share of low-income or uninsured patients.[31] These payments are in addition to payments made to hospitals for direct patient services and are intended to offset losses hospitals experience treating Medicaid and uninsured patients. The payments are capped at the state level so that state contributions cannot exceed federally determined limits.

The Medicaid disproportionate share hospital payment was enacted as part of the Omnibus Budget Reconciliation Act of 1981. OBRA '81 severed the link between Medicare and Medicaid payment practices for hospitals. As states moved from cost-based reimbursement to a prospective payment methodology, they were required to "take into account" the situation of hospitals serving a disproportionate number of low-income patients with special needs.[32,33] Although states were slow during the 1980s to set up DSH programs, changes in the program's financing mechanisms during the 1990s facilitated rapid growth of the program, which by 2003 provided approximately $8.6 billion in federal Medicaid funding to nearly all of the states and the District of Columbia.[34]