



# Health Policy Reports

The Center for Health Services Research  
The University of Tennessee

## Health Policy Reports

summarize important issues in health policy. They are written by Associates of

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## HEALTH CARE ON A TIGHTROPE: IS THERE A SAFETY NET?

### Part I: Uncompensated Care

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Over 40 million people in the United States do not have health insurance and even more have insurance that does not meet their health care needs (1). These citizens do, however, require and receive considerable health care resources. Data suggest that the adult uninsured utilize approximately 60% of the outpatient and inpatient services as do the insured (2).

The vast majority of the uninsured as well as the underinsured poor cannot afford to pay for this health care out-of-pocket (1). But someone does pay. The health care delivery systems these people rely upon and the costs to the these systems will be the subject of this and the next Health Policy Report. In this report, we will take a brief look at the costs of this uncompensated care, assess who does pay the bills, and take a peek into the future to forecast what may happen to this important source of health care financing. In the next report, we will examine the structure of the delivery system that is specifically intended to serve this growing group – the health care safety net.

### What is Uncompensated Care and Who Receives It?

What do we mean by “uncompensated care”. The term generally includes two elements that are generally combined and presented as one figure. The first component is true “charity care” – costs of care for patients without insurance or with inadequate insurance relative to their income, that is, care for which no insurance or other payment is expected. The second is “bad debt”, that is, care usually assumed to be provided to the nonpoor who, for some reason, do not pay their bills. Of the total

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amount of uncompensated care provided by hospitals, approximately one-third to one-half represents charity care (3).

This distinction between charity care and bad debt may not be accurate. A recent study of recipients of uncompensated care in Massachusetts suggests that both forms of uncompensated care are, in reality, generated by care provided to patients unable to pay. Weissman et al (3) found that 84% of designated charity care was given to patients with incomes under the federal poverty level (approximately \$10,360 per year for a family of two and \$15,600 for a family of four), while 76% of bad debt for emergency care and 64% of bad debt for nonemergency care were for patients under the federal poverty level. Of those with incomes of under \$20,000, 68% report “not making it” or “just making it” (1), so that the added burden of hospital or significant outpatient health care costs would be, for most, unmanageable. Thus, most bad debt is for patients who could not reasonably be expected to pay for care and should be included as charity care rather than as “free loading” by those able to pay.

### **Who Provides Uncompensated Care and How Much Does it Cost?**

Uncompensated care is usually considered to be a hospital problem. In 1994, hospitals provided \$16.8 billion in uncompensated care (4,5). This represents approximately 6.1% of total operating expenditures.

These figures, however large, underestimate the true impact of the lack of insurance and poverty on hospital finances. From the hospital side, they do not include discounts for hospital care required by public payers. For example, hospitals in Tennessee reported receiving only 61% to 72% of their costs under TennCare (6). When these shortfalls are included, uncompensated care rises to almost 13% of overall hospital revenue (7). From the patient’s side, the amount of uncompensated care substantially underestimates the impact of not having insurance and low income on health care; 33% of working-age persons with incomes under \$20,000 reported having medical conditions for which they did not seek care and 31% did not fill a prescription because of the costs (1). If they would have sought and received necessary care but could not pay, the level of uncompensated care would have been markedly higher.

The burden of uncompensated care is not evenly distributed across hospitals. Private hospitals provide most uncompensated care; in 1994, not-for profit private hospitals provided 55.8% of all hospital based uncompensated care and for-profit facilities contributed an additional 5.3% (4). Public facilities provided the remainder (38.9%). Thus, mainstream facilities – not public facilities commonly thought to represent the safety net – bear the majority of the load.

However, public facilities and major teaching hospitals carry a disproportionately large share of the obligation. Urban public hospitals incur 14.9% of overall hospital expenses but 35.2% of uncompensated expenses, that is, they assume 236% of their “fair share”, with uncompensated care accounting for 15.4% of their total expenses. Major public teaching hospitals carry 290% of their “fair share”; uncompensated care accounts for 18.9% of overall expenses. And hospitals with high Medicaid volumes carry 145% of their “fair share”. In contrast, for profit and not-for-profit private hospitals each bear only 76% of their share (4).

Although hospitals have been the spotlight of most discussions, they provide less than half of total uncompensated care. It is, in reality, physicians who bear the majority of the burden. In 1994, physicians provided \$21.14 billion in uncompensated care, 26% more than the \$16.8 billion provided by hospitals (5). Perhaps more important than the actual amount is the rapid rise in the physician component; the 1994 level represents a 65% increase (after inflation) from the 1990 level of only \$12.76 billion. This rapid rise may reflect attempts by hospitals to reduce their costs by shifting care to ambulatory settings as well as by rises in the number of uninsured, underinsured

and poor patients. Smaller amounts of uncompensated care (approximately \$1 billion per year) are also provided by community health centers.

### **Who Really Pays the Bills?**

How do providers pay for this care? For hospitals, paying for uncompensated care is a balance between internal and external cost shifting. Hospitals have been required to provide uncompensated care by two mechanisms (3). First, those which received federal funds for capital improvement under the Hill Burton Act are required to provide a defined amount of uncompensated care for 20 years. Second, maintaining not-for-profit status requires hospitals to provide community benefit, of which uncompensated care is a major element.

The funds to meet these demands are derived from several sources. Direct funding may come from governmental programs. Public hospitals receive direct subsidies from state or local governments. Those with teaching programs receive indirect (as well as direct) medical education (IME) funding to cover the extra costs of educational activities; since these hospitals have an excess burden of uncompensated care, these funds do in reality support charity care. Finally, hospitals with a high volume of poor Medicare and Medicaid patients receive additional Medicare and, often Medicaid, payments as disproportionate share (DSH) funds. These federal funds are substantial; approximately 6% of all Medicare funding and 13% of all Medicaid funding to hospitals are for DSH payments (7). Additional monies to compensate for care may be derived from state uncompensated care pools (8) in states with such programs or from private philanthropy.

A major source of funding for uncompensated care is cost shifting (9). This mechanism relies upon receiving reimbursement from paying patients (that is, their insurance companies) that exceeds the cost of their care. The excess payments are then used to subsidize the care of the uninsured, etc. As the level of uncompensated care rises, hospitals increase their charges (and presumably payments on behalf of insured patients) to cover the rise in charitable care. This form of payment is increasing as indicated by the rise in the ratio of charges to costs from 112% in 1980 to over 124% in 1994 (3).

Various states have attempted – with limited success — to reduce the burden of uncompensated care to hospitals. The most rational approach is to extend health insurance coverage to the uninsured. Expansion of Medicaid to cover more pregnant women and infants with family incomes under 133% of the federal poverty level reduced uncompensated care by 5.4%; for hospitals with a special commitment to maternity and infant care, uncompensated care fell by 28.5% (10). This approach, while logical, has problems. Expansion efforts tend to be limited. TennCare expansion has, for example, left 6% to 14% of Tennesseans without insurance (6) and recent expansion of employer-based insurance has been associated with a fall – not the expected rise – in the percent of employees enrolling in coverage plans (11). These programs, as noted above for TennCare, extract significant discounts so that “unreimbursed” care may fall less than does charity care; in Tennessee, uncompensated care after five years of TennCare (\$354.2 million in 1997) is approximately the same as before TennCare (6). Finally, if insurance is provided by government programs such as Medicaid or its replacement managed care alternatives, the costs are transferred from providers to the government and thereby to taxpayers. This results in a leveling of the playing field so those that provide previously uncompensated care are reimbursed, but whether or not there is a net reduction in total costs is uncertain.

Other state approaches include establishing uncompensated care pools that reimburse hospitals for care to the uninsured (8), restructuring the delivery system to emphasize outpatient care and establishing set rates for care from a centralized payment source that assures payments, at some rate, for all care (12).

## WHAT DOES THE FUTURE BRING?

Several trends suggest that providing uncompensated care will become more difficult in the future even as the need continues to grow. The first is the rapid growth of managed care plans. These plans put greater price discipline on the market through negotiated discounts that reduce operating margins and reduce the ability of hospitals (and other providers) to cost shift. Uncompensated care by both hospitals and physicians is indeed lower in regions with high penetration rates of managed care (13,14).

Second, public funding of otherwise uncompensated care is diminishing or, at a minimum, not keeping up with growth. Direct public subsidies, and disproportionate share and indirect medical education funding are all shrinking. Medicaid and possibly Medicare payment rates may also fall as states and the federal government struggle to maintain balanced budgets. The number of hospitals with remaining Hill-Burton obligations is declining (from approximately 4000 in 1980 to under 500 in 2000) while the number converting to for-profit status without statutory obligations for community benefit (and with no guarantee that the taxes they pay will go to health care) rises (15). All of this occurs at a time when the number of uninsured is rising.

Evidence from the recent past has suggested these forces have already impacted the level and sources of uncompensated care. The amount of uncompensated hospital care provided to the uninsured has fallen from \$482 per person per year in 1987 to \$431 per person per year in 1995, and the amount of uncompensated care provided per dollar of compensated care has fallen from \$0.42 in 1984 to \$0.36 in 1994, a 14% fall. (4).

What do these trends suggest for the future? The ability of all hospitals and providers to provide uncompensated care will become progressively more constrained as the forces described above continue to develop and interact. Mainstream providers who provide most of the uncompensated care – private hospitals and individual physicians whose major commitment is to the population as a whole rather than to the poor or uninsured and who expect to generate adequate incomes and revenues if not profits – have the greatest ability to control or reduce the care they provide in response to fiscal pressures.

This, in turn, results in a progressive shift of responsibility toward public safety net programs. This is already occurring; between 1990 and 1994, the percent of all hospitals with uncompensated care costs exceeding 10% of total costs that were public increased while the percent that were private fell (5).

The consequences of a continued fall in the provision of uncompensated care are clear. Although uncompensated care is not as efficacious as insured care (16), it is all that a growing proportion of people in our nation have. The shift away from mainstream providers will also put greater stress on safety net programs. This pressure especially when combined with other detrimental influences they face has placed their survival at risk. These forces and their consequences will be the topic of the next Health Policy Report.

## REFERENCES

1. Budetti J, Duchon L, Schoen C, Shikles J: Can't Afford to Get Sick: A Reality for Millions of Working Americans. New York: The Commonwealth Fund, 1999.
2. Long SH, Marquis MS: The uninsured 'access gap' and the cost of universal coverage. *Health Aff* 1994; 13(2):211-220.
3. Weissman JS, Dryfoos P, London K: Income levels of bad-debt and free-care patients in Massachusetts hospitals. *Health Aff* 1999; 18(4):156-166.
4. Mann JM, Melnick GA, Bamezi A, Zwanziger J: A profile of uncompensated hospital care,

- 1983-1995. *Health Aff* 1997; 16 (4):223-232.
5. Cunningham PJ, Tu HT: A changing picture of uncompensated care. *Health Aff* 1997; 16: (4):187-175.
  6. Mirvis DM, Bailey JE, Chang CF: TennCare – five years of Medicaid managed care for Tennessee. Submitted.
  7. Weissman JS: Uncompensated hospital care. Will it be there if we need it? *JAMA* 1196;276:823-828.
  8. Spencer CS: Do uncompensated care pools change the distribution of hospital care to the uninsured? *J Health Polit Pol Law* 1998; 23:53-73.
  9. Morrisey MA: *Cost Shifting in Health Care*. Washington, DC: American Enterprise Institute, 1994.
  10. Dubay LC, Norton SA, Moon M: Medicaid expansions for pregnant women and infants: easing hospitals' uncompensated care burdens? *Inquiry* 1995; 32:332-344.
  11. Cooper PF, Schone BS: More offers, fewer takers for employment-based health insurance: 1987 and 1996. *Health Aff* 1997; 16(6):142-149.
  12. Thorpe KE: Does all-payer rate setting work? The case of the New York Prospective Hospital Reimbursement Methodology. *J Health Polit Pol Law* 1987; 12:391-408.
  13. Cunningham PJ, Grossman JM, St. Peter RF, Lesser CS: Managed care and physicians' provision of charity care. *JAMA* 1999;281:1087-1092.
  14. Mann J, Melnick G, Bamezai A, Zwanziger J: Uncompensated care: hospital's responses to fiscal pressure. *Health Aff* 1995; 14(1):263-270.
  15. Needleman J, Lamphere J, Chollet D: Uncompensated care and hospital conversions in Florida. *Health Aff* 1999; 18(4):125-133.
  16. Blendon RJ, Aiken LH, Freeman HE, Kirkman-Liff BL, Murphy JW: Uncompensated care by hospitals or public insurance for the poor. Does it make a difference? *N Engl J Med*. 1986 May 1;314(18):1160-3.