

THE EFFECT OF UNCOMPENSATED MEDICAL CARE ON SAFETY-NET  
HOSPITALS IN THE UNITED STATES

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## **Abstract**

Uncompensated hospital care presents a significant problem in the United States health care system, and it is most prevalent in non-profit, “safety-net” hospitals, which make up the 10% of hospitals that provide the most uncompensated care. The incidence of uncompensated medical care stems from the inherent relationship between poverty and health in that poorer people (who tend to experience a lower health status) receive care from hospitals and are unable to pay for it, which results in these hospitals providing this care for a fraction of the charge or even free of charge. This study looks at the specific impact that uncompensated medical care has on hospitals, specifically these safety-net hospitals that provide the most uncompensated care. This study first looks into the existing literature to explain the incidence of poverty in America and the correlation it has with health status. It then looks into the policies currently in place that force hospitals to provide medical care without adequate compensation. The portion of original research looks at the views of two employees at a large safety net health system in the eastern United States; one works in the financial services department and the other works in the budget-planning department. With their insight, the remainder of the study involves a discussion of the specific effects of uncompensated care along with the accompanying policy implications.

## **Preface**

Chapter 1 of this study is the review of the existing literature relevant to the research question. This literature consists of studies and statistics on both poverty and health care, with an overall emphasis on policies relating to uncompensated medical care. Chapter 2 outlines the methods by which I conducted my research. It illustrates the process I went through to get approval for and ultimately conduct interviews with safety-net hospital finance employees. Chapter 3 looks at both the results of the interviews and the discussion of how these results fit into my overall study. It is in this section of the study that I could compare the views of my interviewees to the existing literature from Chapter 1. Chapter 4 features the various conclusions that I was able to draw from my study. It is in this section that I was finally able to truly find the significance of my research. I was able to then make my own conclusions on what the most advantageous policies would be to maximize hospital reimbursement, while lowering the amount of uncompensated medical care. This chapter also includes all of the limitations of my study and it also suggests potential future research and studies based upon my findings.

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## **Chapter 1 – Literature Review**

### **Introduction**

Of all the social problems that exist in the United States, a few that are consistently highlighted include the many ineffective aspects of the American health care system. While the lack of access to health care and the potential drawbacks of not having a universal health care system are discussed a great deal, one issue that does not seem to be as widely publicized is the financial burden placed on hospitals that serve the uninsured and underinsured population. While it is certainly imperative for the indigent populations of the United States to receive medical care when needed, hospitals provide such a great deal of uncompensated medical care that a unique financial burden is created with very few possible solutions. Of the different types of hospitals in the United States, non-profit hospitals tend to provide the most uncompensated care and are therefore the most financially burdened. It is because of this that is most important to explore the financial implications of non-profit hospitals' provision of uncompensated care and their general treatment of the indigent population.

However, it is impossible to discuss the uncompensated care provided by non-profit hospitals before first looking into the strong connection between poverty and health status along with the accompanying causes of poor health status in the United States. After determining the causes of low health status, it is beneficial to note the policies that are put in place to reduce the prevalence. It is only after this is discussed that it becomes possible to delve into poverty's impact on hospitals, starting with the policies that mandate the treatment of all patients no matter their ability to pay for care. It is then

possible to differentiate the main types of hospitals in the United States and determine the impact that uncompensated care has on all of them. In doing this, it is beneficial to compare the several types of insurance and reimbursement methods that hospitals come across when being paid for services rendered. It is only after exploring all of these aspects and looking at the information that is already known that one can properly look at the significant financial burden that uncompensated care puts on non-profit hospitals.

### **Poverty and health: a significant correlation**

There has always been a correlation between poverty and health; both are strong indicators of life expectancy and overall quality of life. Those who experience financial success are more likely to achieve better health outcomes throughout their lives. However, the inverse is true as well; those who lead impoverished lives financially are more likely to experience significant health problems over the course of their lives. Unfortunately, there is a high prevalence of poverty all over the world, and therefore also a high prevalence of health problems as well. This is no different in the United States, where many people live under the federally determined poverty line. Many of these American citizens experience health problems for which a main cause is lack of resources.

The United States Department of Health and Human Services (DHHS) is responsible for setting the poverty guidelines for the country. In 2010, DHHS set the poverty guidelines for the 48 contiguous states and Washington, D.C. at an annual income of \$10,830 for a family of one and adding \$3,740 for each additional family member (DHHS 2010). According to the United States Census Bureau, in 2009, there

were approximately 43.6 million Americans living at or under these poverty guidelines, which accounts for about 14.3% of the population of the United States (U.S. Census Bureau 2010:14). It is unfortunate that as the population of the United States increases each year, so will the number of Americans living in poverty. This is indeed the projected trend, which also does not bode well for the health status of these people (U.S. Census Bureau 2010:14).

DHHS launched a new initiative in 2010, “Healthy People 2010,” with several goals, including the elimination of health disparities. Under this goal, DHHS listed several reasons behind health disparities in the United States and it determined that the largest health disparity in the United States is between people with high household incomes and those with low household incomes (Healthy People 2010). Higher incomes can lead to improved access to medical care, access to better housing and safer neighborhoods, and exposure and ability to practice healthier behaviors (Healthy People 2010). On the other hand, Americans who are living closer to the poverty line are more likely to experience health issues associated with substandard access to medical care such as diabetes, obesity, and heart disease. This can be attributed to many factors, most of which stem from the difficulty of affording or obtaining health insurance.

#### *Poverty and health by the numbers*

Unfortunately, as there are currently 43.6 million people living in poverty in the United States, it is becoming increasingly difficult to afford health insurance of any kind (U.S. Census Bureau 2010:14). According to the Kaiser Commission on Medicaid and the Uninsured, the number of uninsured American citizens reached approximately 50

million in 2009, with 41.7 million being non-elderly adults and 8.3 million being children (Kaiser Family Foundation 2010). This number does not include the many “underinsured” Americans who the Kaiser Commission on Medicaid and the Uninsured define as those who “have health insurance but face significant cost sharing or limits on benefits that may affect its usefulness in accessing or paying for needed health services” (Kaiser Family Foundation 2002 <<http://www.kff.org/uninsured/upload/Underinsured-in-America-Is-Health-Coverage-Adequate-Fact-Sheet.pdf>>). The number of uninsured Americans rose to 50 million, which is a significant increase from the previous two years, with there being 45 million uninsured Americans in 2007 and 45.7 million in 2008, and there is no end to the increase in sight (Kaiser Family Foundation 2010). With the incidence of United States citizens without a form of health insurance on the rise, it is important to understand the reasons behind the significant lack in coverage.

The United States health insurance system is primarily employment-based, so it is critical to begin the exploration with employment or the lack thereof. According to DHHS and its Agency for Healthcare Research and Quality (AHRQ), nearly two-thirds of the United States population under 65 receives employment-based private health insurance, making it easily the most utilized type of health insurance in the country (AHRQ 2004). In this manner of health insurance coverage, the employer will usually subsidize the majority of the monthly premium so that it becomes relatively affordable for the employees and the other beneficiaries. In most cases, this format works well, but there are those who slip through the cracks in that they have jobs but do not have any form of health insurance. On the other hand, there are the people who have jobs that offer



benefits, but who are simply too poor for whatever reason to afford even the discounted health insurance rates offered by their employers (U.S. Department of Labor 2010).

### **Causes of low health status**

#### *Education*

On the other hand, there are also millions of Americans who have jobs that do not offer benefit packages, including health insurance coverage. Many of these jobs are with small firms that do not produce enough revenue to afford the high cost of providing health insurance for its employees. These jobs mostly do not pay well enough to support the purchase of private health insurance at full price. This problem mainly seems to stem from lack of education, another contributing factor toward health disparities that “Healthy People 2010” highlights in its initiative (Healthy People 2010). If a person is able to continue his or her education to achieve a bachelor’s degree or even a graduate degree, he or she is far more likely in the long run to attain a higher paying job, which much of the time would also come with a benefit package including health insurance coverage. However, the lack of education that could result in working a job not offering health insurance could be partly as a result of the economy of the United States experiencing a recession. People are more likely to go straight into the labor force after completing high school or their undergraduate education because finances are becoming too tight to put off a salary and they often have to settle for jobs that do not offer health insurance.

#### *Current Economic Climate*

In addition to being partly responsible for Americans settling for employment without benefit packages, the current recessionary climate of the economy of the United States is responsible for the loss of over 8 million jobs since the recession began in December 2007 (Bivens 2010:1). In fact, according to the United States Bureau of Labor Statistics (BLS), the current unemployment rate is at 9.6%. This figure can be achieved by dividing the number of unemployed workers by the entire labor force and multiplying the resulting answer by 100 so the total can be expressed as a percent (BLS 2010). This translates into there being roughly 14.5 million unemployed workers in the United States today. Although some of these people are beneficiaries of their spouse's health insurance policy, the unfortunate truth is that many of these unemployed workers go without any health insurance coverage at all.

*COBRA and Medicaid: Policies fighting against low health status*

However, there have been some policies put into place in order to protect (with respect to health insurance coverage) workers who lose their jobs. The Consolidated Omnibus Budget Reconciliation Act (COBRA) was passed in 1986, enabling a person to continue his or her health insurance coverage after job loss or any sudden event that would otherwise cause a break in health insurance coverage (U.S. Department of Labor 2010). COBRA is certainly an improvement over the alternative of a lack of health insurance coverage, but it comes with some very significant negative aspects. For one, COBRA, for the most part, is only effective for 18 months. In passing COBRA, the United States government felt that 18 months would be an appropriate length of time to look for and find a job to replace the one which administered the recently lost health

insurance coverage. Although it is certainly enough time for certain people to attain new employment and new health insurance coverage, it is not the case for all people, and those people simply end up in a terrible situation: with no job and no health insurance coverage. Perhaps the characteristic of COBRA with the most significant negative impact is that the beneficiary is required to pay the policy's full premiums. These premiums are extremely expensive, especially without an employer subsidizing the majority of their cost. Paying for these full-price premiums become even more difficult when the lack of any new income is factored into the mix. To make matters worse, the beneficiary is locked into the exact policy that he or she had while employed. This may not seem like a significant restriction, but in many situations, employers offer very complex benefits packages with comprehensive, expensive health insurance policies. Even if they wanted to, newly unemployed workers on COBRA could not reduce their current policy in order to save money. Therefore, many Americans who have recently lost their jobs elect not to take advantage of COBRA even if they are eligible. To these people, the money they would save by not using COBRA outweighs the inevitable lapse in health insurance coverage.

In addition to COBRA, the United States government began administering insurance to the impoverished population. In 1965, as part of the larger "Social Security Act," congress created Medicaid, a health insurance meant to cover the poorest citizens, as well as disadvantaged pregnant woman and the elderly. Although it is also funded by the federal government, Medicaid is partially funded and administered completely at the state level. Bodenheimer and Grumbach (2009) state, "The federal government [pays] between 50% and 76% of total Medicaid costs; the federal contribution is greater for

states with lower per capita incomes” (p. 12). Eligibility for Medicaid is based on a variety of factors with the most important being financial status, which in most cases should hover around the federal poverty level to be eligible. In some special cases such as pregnant women and the elderly, eligibility levels rise above the poverty line (Centers for Medicare and Medicaid Services 2010). According to the Kaiser Commission on Medicaid and the Uninsured, as of December 2009, the number of people enrolled in Medicaid had risen to 48.57 million Americans, and the number has increased by about 6 million since the beginning of the recession two years earlier (Kaiser Family Foundation 2010). With about one third of Americans either uninsured or on Medicaid, it is becoming more difficult every year to ensure them adequate access to primary health care. Many traditional primary care providers—general practitioners—will not accept patients who are on Medicaid or uninsured because of the poor reimbursement rates. Therefore, many of these people are forced to seek alternative means of primary care to the usual private general practitioner’s office such as from free clinics and federally qualified (Medicaid accepting) community health centers. In fact, in many cases, uninsured and underinsured Americans are utilizing hospital emergency departments as a means of primary care. This continuously causes a significant strain on hospitals’ with respect to their finances and with their efficiency, and there is very little they can do to counteract these burdens due to certain policies that the United States government has put into place.

**Hospitals provide access to health care when other providers do not**

## *EMTALA*

Because of the way that the United States health care system is set up, one of the most significant problems with the system always seem to stem from impoverished Americans' lack of access to health care. However, as hospitals in American society are seen as a cornerstone of the health care system, the United States government has implemented policies that force them to provide care to those who might not be able to afford it otherwise, while health care providers can simply turn these patients away. These policies are significant enough where they unquestionably impact society on all its levels: individually, organizationally, and societally. The policy that has the most significant impact on all three levels is the Emergency Medical Treatment and Active Labor Act (EMTALA). The United States congress passed EMTALA in 1986 along with the Consolidated Omnibus Budget Reconciliation Act (COBRA), which, among other matters, made it possible for people to continue their health insurance coverage after cutting ties with their employer for whatever reason (U.S. Department of Labor 2010). Unlike COBRA, which focuses on health insurance coverage, EMTALA focuses directly on benefiting people in dire need of medical treatment. EMTALA, as laid out in United States code Title 42, 1395dd. (a) and (b), states that not only are hospitals with emergency departments required to provide medical screenings for patients without taking into account their health insurance coverage, they are also obligated to provide patients with stabilizing treatment should they require it. The policy states:

(a) In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary

services routinely available to the emergency department, to determine whether or not an emergency medical condition exists.

(b) If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either—

1. within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or
2. for transfer of the individual to another medical facility (U.S. House of Representatives 2010 <<http://uscode.house.gov>>).

This law essentially enables people without any health insurance coverage to use any hospital with an emergency department as a primary care provider, which in turn has several significant consequences (U.S. House of Representatives 2010 <<http://uscode.house.gov>>). First, using an emergency room as a primary care provider slows down the overall productivity of the entire emergency department. The emergency department suffers due to the backup caused by patients who might otherwise be at a general practitioner's office. Also, the clinical staff in the emergency room is forced to manage situations outside its main focus in that they are specially trained to practice emergency medicine, but they are forced to practice general medicine, which is a waste of their ability and training. Second, even though being treated in a hospital emergency department is certainly better than not being treated at all, it is not as advantageous as one might think for patients to receive primary care in a hospital emergency department. Unless, of course, an uninsured patient has an emergency medical condition, he or she will in all likelihood receive his or her other treatment last. Not only does this patient have to put up with the stigma that accompanies a lack of health insurance, which might bump him or her to the back of the line to begin with, but without actually needing urgent

care, he or she would already have to wait in line behind those with pressing medical conditions.

Above all else in significance, perhaps, is the consequence of the financial burden that EMTALA puts on hospitals, most notably as a result of uncompensated hospital care. Fifty-five percent of emergency room visits are not paid for, which forces hospitals to set aside billions of dollars each year in “bad debt,” money that they will certainly lose due to lack of compensation (American College of Emergency Physicians 2010). In fact, according to the Kaiser Commission on Medicaid and the Uninsured (2004), in 2004, uninsured patients received approximately \$40.7 billion in uncompensated care, a figure that is growing larger each year due to the harsh economic climate (p. 2). Another frightening statistic is that this \$40.7 billion was about 2.7 percent of all health care spending in 2004, highlighting a noticeable drawback to the current setup of the United States health care system (Kaiser Commission on Medicaid and the Uninsured 2004:2).

In addition, as laid out in the text of EMTALA, hospitals treating uncompensated emergency room visits are required to continue providing care to the patients until they have reached an adequate level of physical stability (U.S. House of Representatives 2009 <<http://uscode.house.gov>>). Within this statute, it obviously neither matters how long a patient needs to remain hospitalized nor how medically serious his or her condition is. Perhaps the easiest example of this statute’s financial impact on hospitals can be explained using different types of emergency surgery (all of which are relatively costly). For instance, if an uninsured patient is taken to a hospital’s emergency room with appendicitis (infection of the appendix) and needs an emergency appendectomy (removal of the appendix), s/he might be hospitalized for a day or two. While surgery of any kind

surely carries fixed costs such as medical equipment and personnel, the fact that an uninsured patient that needed to be hospitalized would be able to be discharged the next day can certainly be considered a medical victory and almost even a financial victory as well. This is because the alternative situation could not be quite so lucky for the hospital. In this situation, an uninsured patient can come into the emergency room with something as simple as chest pain. The patient's mandated emergency room screening could then reveal an irregular heartbeat or some other heart condition. This would then lead to more costly tests and then ultimately to extremely costly open-heart surgery and its accompanying extended inpatient stay. Every service provided in this scenario is uncompensated from the patient or a third party. A scenario such as this one could total up to hundreds of thousands of dollars. This scenario is only one case, and one that is not uncommon. Quickly, hundreds of thousands of dollars of bad debt can turn into millions per year for hospitals that see many uninsured patients. While EMTALA certainly provides a necessary solution to lack of access to health care, it places an overwhelming burden on hospitals in the United States.

Physicians and hospital administrators always have the second type of scenario in the back of their minds as they attempt to find the balance between what is best for the patient and what is best for the hospital. Because of this, interactions between the doctors and these patients, whom they know are not paying anything for services rendered, can be different than they would be if they involved insured patients (Emanuel 1995:323). Even if a physician is very competent at what he or she does, it may be difficult for his or her judgment not to be clouded by the fact that the hospital at which he or she is attending is pressuring him or her to have an uninsured patient discharged as quickly as possible. In



fact, according to Hasan et. al. (2010), privately insured inpatients had the shortest lengths of stay, most likely due to a higher overall health status, while Medicaid patients had the longest lengths of stay, longer in every studied medical condition than their uninsured counterparts (p. 456). This is most likely due to the fact that although physicians are hesitant to order extra tests and perform extended observation that would keep Medicaid patients in the hospital, they are even more hesitant when it comes to patients without insurance. Because Hasan et. al. (2010) compared patients with similar medical conditions and the uninsured patients had shorter lengths of stay than those with Medicaid, it seems clear that hospital and physician cost consideration had to have had an effect on the outcome.

With programs like Medicaid, the United States government has made an effort, specifically on the state level, over the years to not only improve Americans' access to health care, but also to aid hospitals in their battle with uncompensated care and bad debt (CMS 2010 <<https://www.cms.gov/History>>). Government insurances and subsidies provide the balance in society along with acts such as EMTALA. While EMTALA is very effective in helping the uninsured patient, government insurance programs help both patients and providers. However, in some situations, depending on factors such as the type of hospital, the location of the hospital, and the resources the hospital has, Medicaid is truly unable to make up for the devastating impact that EMTALA has financially on the hospital.

*Three types of hospitals in the United States*

First, before analyzing the effect that EMTALA has on hospitals, it is important to explore the differences between the various classifications of hospitals in the United States. There are essentially three types of hospitals found in the United States: public hospitals, private hospitals, and non-profit hospitals (Walker 2005:4). In some situations, however, non-profit organizations do indeed own private hospitals. It is very common for stockholders to buy and sell shares of private hospitals like they would for any large corporation, and the hospital's profits are spread around to these stockholders. Because these private hospitals do indeed exist to make a profit, they are responsible for paying income and property tax to the government. Non-profit hospitals, on the other hand, are exempt from paying income and property tax, as they are not owned privately and any profits that they might see go toward the overall improvement of the institution, not into the pockets of investors. Public hospitals operate like non-profit hospitals in that they are not owned by stockholders, but are different in that they are actually owned by various government agencies. A testimony from David M. Walker, the United States Comptroller General to the United States House of Representatives states: "In 2003, of the roughly 3,900 nonfederal, short-term, acute care general hospitals in the United States, the majority—about 62 percent—were non-profit. The rest included government [public] hospitals (20 percent) and for-profit [private] hospitals (18 percent)" (Walker 2005:4).

It is also important to note that the three types of hospitals in the United States are not spread out evenly across the country. Later in Walker's testimony, he explains that his study found that the distribution of non-profit hospitals varied significantly by state. He found that the vast majority of non-profit hospitals could be found in the northern half of the United States, with the most being in the northeast and Midwest regions of the

country and the least being in the southern states (Walker 2005:4-5). In fact, though there are several states that are almost entirely made up of non-profit hospitals (with a few public hospitals and zero for-profit hospitals), there are also states such as Florida that have a higher percentage of for-profit hospitals than non-profit hospitals (Walker 2005:4-6). According to University of Michigan law professor Jill R. Horwitz (2005), approximately two-thirds of all urban hospitals in the United States fall under the non-profit classification, while the remaining one-third is split between for-profit and government hospitals. This statistic would suggest that non-profit hospitals are larger, on the whole, than the other two types of hospitals because hospitals in urban areas, for the most part need to have more beds, as there are more potential patients that live in the most populated (urban) areas of the country. Walker's testimony confirms this information when his study found that non-profit hospitals are generally about twice as large as for-profit hospitals in terms of patient operating expenses (Walker 2005:6). The location and size of public hospitals in the United States, on the other hand, are not as easy to predict.

Although, as stated before, there are certainly significantly fewer public hospitals than non-profit hospitals, they are much more spread out throughout the country than both for-profit and non-profit hospitals. This is due to the fact that the placement of these hospitals is solely dependent on the discretion of a government agency, such as the Veterans Health Administration (VHA), which is responsible for the regulation of the United States Department of Veterans Affairs Medical Centers across the country. Walker's data also revealed that along with public hospitals being spread out relatively proportionally across the country, they also varied significantly in size and number. In

terms of patient operating expenses, the size of these government-run hospitals fluctuates drastically by state relative to the other two types of hospitals. For instance, in 2003, public hospitals in the state of California had virtually the same average patient operating expenses as non-profit hospitals in the state, which made up almost exactly double the average patient operating expenses for the state's for-profit hospitals (Walker 2005:6). Public hospitals in Florida actually experienced \$30 million more in patient operating expenses than their non-profit counterparts, which (like California) had approximately twice the patient operating expenses as Florida's for-profit hospitals (Walker 2005:6). To contrast with this, Walker points out that the average patient operating expenses for public hospitals in Georgia sit right in between the amounts for the state's for-profit and non-profit hospitals, while the figures for public hospitals in both Indiana and Texas sit significantly below the figures for the other two types of hospitals in both states (Walker 2005:6). However, even with the distinct differences between the three basic types of hospitals, as Horwitz (2005) states: "there is reason to expect all [types of] hospitals to provide a similar array of medical services: General hospitals all treat patients with a mix of needs, contract with the same insurers and government payers, operate under the same health regulations, and employ staff with the same training and ethical obligations" (p. 790). It is because this is the case and the fact that EMTALA was passed that a significant financial burden has been created that affects certain hospitals more severely than others.

### **Inadequate reimbursement: a unique financial burden on hospitals**

#### *Private health insurance*

With financial implications in mind, perhaps the most important phrase of Horwitz's (2005) statement was "contract with the same insurers and government payers," because when it comes to hospitals' survival, reimbursement for services rendered is the key. Physicians and hospitals, no matter what the type, determine the prices of individual services (i.e., procedures, diagnostic tests, etc.). For these providers to be paid, there are essentially two methods of reimbursement in the United States: third-party payment and self-payment. Third-party payment, more specifically payment using a private or government-based insurance to pay for medical expenses, is by far the most common method of hospital reimbursement in the United States, as approximately 64% of Americans carry some form of private health insurance (United States Census Bureau 2010). Most private insurance in the United States reimburses on (or on a variation of) a "fee-for-service" basis, which essentially means that if the private third party payer (insurance company) approves a service, it will pay the provider most of the previously determined full value of the service (Bodenheimer and Grumbach 2009:32). For hospitals, this is the most preferable form of reimbursement other than paying directly out-of-pocket, which is very rare. Many of these private insurance companies that reimburse in this manner do so within managed care organizations such as Preferred Provider Organizations (PPOs) and Health Maintenance Organizations (HMOs). PPOs are made up of a group of physicians who have made an agreement with an insurance company; they effectively create a network in which patients can choose among the limited number of physicians in order to remain covered at a lower cost (Bodenheimer and Grumbach 2009:32). In exchange for the presumably higher number of patients the physicians treat, the insurance company would get to reimburse at a discounted rate.

HMOs are similar to PPOs, but they actually require patients to receive care from providers that are only in network. If a patient receives care from an “out-of-network” provider, then he or she will forgo coverage (except in emergency situations), and will be responsible for the payment for services rendered (Bodenheimer and Grumbach 2009:32). It is also important to note that there have been many instances in which private insurance companies have switched from traditional fee-for-service to more aggregate forms of reimbursement such as diagnosis-related groups (like Medicare) in hospital care and capitation (fixed payment for each patient served) in primary care (Bodenheimer and Grumbach 2009:32).

#### *Government issued insurance*

However, unlike private health insurance, United States government issued health insurance is not nearly as desirable a reimbursement option for hospitals. The United States government issues two basic forms of health insurance to the general public: Medicare and Medicaid. Medicare, which is funded and administered completely at the federal level, covers all American citizens who are 65 years of age or older and even some who are younger in certain situations, such as those with End Stage Renal Disease (ESRD) and other disabilities (CMS 2010). Hospitals experience their Medicare reimbursement from its “Part A” hospital insurance, which reimburses through diagnosis-related groups (DRGs). As the Centers for Medicare and Medicaid Services (CMS) state: “Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG” (CMS 2010 <<http://www.cms.gov/AcuteInpatientPPS>>). These DRGs are multiplied by a fixed rate

that is based on the geographical location of the hospital, also factoring in if the hospital treats a sizeable low-income population (CMS 2010). Today, Medicare Part A makes up the majority of most hospitals' overall reimbursement, and its DRG system is perhaps the most lucrative reimbursement option after private health insurance.

However, the financial problems for hospitals truly begin with the inadequate Medicaid reimbursement. Medicaid has several fundamental differences from Medicare. For one, while Medicare is an entitlement for all American citizens once they reach a certain age, Medicaid requires an application and has strict eligibility guidelines, with only the poorest of the poor gaining access. Also, Medicaid is administered and funded on the state level, with only a portion of its funding coming from the federal level. Medicaid, unlike Medicare, reimburses hospitals using low fixed per diem rates varied by state instead of a DRG system and rather than reimbursing per service (CMS 2010). Although this is certainly a more cost effective method of payment in the eyes of the state and federal governments, reimbursing in this fashion becomes very detrimental financially to the individual hospitals. For instance, Medicaid will reimburse the same dollar amount whether the beneficiary has a broken arm or a brain tumor, not taking into account the amount of tests and diagnostics needed (Bodenheimer and Grumbach 2009:39). Additionally, Medicaid does not take a patient's length of hospital stay into account. The hospital will receive the same fixed per diem rate whether the patient is staying for three days or fifty-three days. A Medicaid case could easily reach the point at which it would not be so different to the hospital had the patient had no health insurance coverage whatsoever (Zuckerman 1987:71).

Although Medicaid reimbursement is truly substandard from a hospital perspective, it does indeed cover a wide range of care, and offers some payment to the provider. Therefore it is not the worst-case scenario financially for hospitals. The worst reimbursement situation for hospitals certainly comes with treating patients without insurance, who are diplomatically referred to as self-payers, which is obviously deceptive, as they pay nothing most of the time. Again, there are the rare situations in which self-payment is the most desirable. For whatever reason, if a wealthy individual has no insurance and decides to pay for a procedure or test with his or her own money, then the hospital would receive 100% reimbursement, which is a relatively rare occurrence. However, when situations like this arise, hospitals are certainly prepared. According to a study by health economist Gerard F. Anderson of Johns Hopkins' Bloomberg School of Public Health, hospitals charge self-paying patients and patients without health insurance approximately 2.5 times the amount that they charge patients with private or government issued health insurance (Anderson 2007:780). This is made possible by the fact that self-pay patients do not benefit from private insurance companies or the federal government negotiating discounted service rates with the hospitals.

Anderson (2007) states:

Five categories of patients were routinely presented a bill based on the prices in the hospital's chargemaster file: (1) the uninsured; (2) international visitors; (3) people insured by health plans lacking contracts with hospitals (most commonly health savings accounts, or HSAs); (4) people covered by automobile insurers; and (5) people covered by workers' compensation plans. These patients are often categorized as "self-pay" because they or their insurer does not have a contract with the hospital. Of these five categories, the forty-five million uninsured Americans [in 2007] represent the preponderance of self-pay patients in most hospitals (p. 781).



In fact, in 2004, hospitals, on average, charged self-pay patients three times the amount allowed by Medicare (Anderson 2007:780). This is simply a method that hospitals use to attempt to balance out the financial burdens caused by policies such as EMTALA that force most of them to treat all patients, no matter what their ultimate compensation will be. As the vast majority of self-pay patients are indeed without any form of health insurance, hospitals' ultimate compensation is commonly nothing at all.

### *Safety-net hospitals*

Hospitals that administer the most charity care are commonly referred to as “safety-net” hospitals. In a 2003 executive summary, AHRQ states: “The 10 percent of hospitals with the highest proportion of hospital stays for the uninsured are termed ‘safety-net hospitals.’ In these hospitals, between 9 and 50 percent of the hospital stays are for the uninsured” (AHRQ 2003 <<http://www.ahrq.gov/data/hcup/factbk8/factbk8a.htm#intro>>). The executive summary continues to explain that the majority of these hospitals are in urban areas and the largest number of them (45%) falls under the non-profit classification with public hospitals (43%) at a close second (ARHQ 2003). AHRQ does, however, make the distinction that safety net hospitals in rural areas have a 58% chance of being publicly owned, while in urban areas they only have a 31% chance (AHRQ 2003).

As can be seen by the above statistics, policies such as EMTALA and inadequate reimbursement rates of Medicaid negatively affect hospitals in both urban and rural areas of the United States. The vast majority of hospitals that are significantly affected are either non-profit or public hospitals. Although for-profit hospitals do indeed ultimately

administer some care that is uncompensated, they are not required under EMTALA to serve all patients unless they receive federal funding (Kaiser Family Foundation 2007:11). This is due to the fact that these hospitals are privately owned enterprises and are not exempt from paying income and property taxes. On the other hand, the reason that both public and non-profit hospitals are exempt from paying income and property taxes stems from the fact that they are required to provide a certain amount of charity care each year. Like the service charge inflation, the tax exemptions act as a method of attempting to balance out the financial burden that comes with being required to treat all patients and accept substandard payment methods such as Medicaid. There is truly not a lot that safety-net hospitals can do to counteract the difficult financial positions in which they commonly find themselves.

There are of course the few policies that favorably impact safety-net hospitals such as tax exemptions. The most significant of these is the United States government's payments to "disproportionate share hospitals (DSH)," which are hospitals that treat the highest percentage of indigent patients. According to DHHS, the United States government allocated approximately \$11.34 billion in funds to DSH hospitals (DHHS 2010). Although this might seem like a significant sum of money, it is spread over hundreds of hospitals, which might each lose several million dollars per year. The DSH government funding is, therefore, unfortunately not a completely effective solution. Other policies include emergency Medicaid, which can be granted retroactively (by a state's Department of Social Services) in certain intense acute care situations to patients not previously approved for Medicaid (Kaiser Family Foundation 2008). A hospital also commonly has financial experts on its staff that can predict and allocate a certain section

of its operating budget towards charity and uncompensated care. Otherwise, there is not much more safety-net hospitals can do to balance out their uncompensated care losses than to rely on philanthropy and fundraising.

Because of safety-net hospitals' lack of ability to counteract their uncompensated care losses, there have been many cases of hospitals filing for bankruptcy, closing, and merging due to these irrevocable losses. One prime example of a safety-net hospital not being able to remain sustainable due to losses from serving the uninsured and underinsured populations is the recent takeover of St. Clare's Hospital by Ellis Hospital in Schenectady, New York. As a small non-profit Catholic hospital, St. Clare's was burdened significantly by EMTALA in that it was obligated by law to serve the estimated 15,000 – 18,000 uninsured people living in Schenectady County, as well as the sizable underinsured population. Although it had managed to continue operating since its establishment in 1949, St. Clare's was finally truly unable to sustain itself any longer in 2008, when it was forced to surrender its operating license, and Ellis Hospital (the larger non-profit hospital in Schenectady) absorbed all of its services. In the announcement of the impending takeover, outgoing St. Clare's President and CEO Robert P. Perry stated, "We're at the end of an era. The sad reality is that St. Clare's could not continue to care for the poor and uninsured of Schenectady without quickly running out of money to pay our employees and our bills" (as quoted in Wechsler 2008). Unfortunately, situations like that of St. Clare's are not few and far between, and as the uninsured population in the United States continues to increase each year, they will likely become more common, which is detrimental for everyone. Insured patients have fewer places to receive acute care and uninsured patients have fewer places to receive both acute and primary care,

while remaining facilities become more crowded. What ultimately happened to St. Clare's was not the worst case scenario because its facility was ultimately salvaged due to Ellis Hospital's agreeing to accept responsibility for its operation. In many situations, the closing hospital's facility is simply abandoned. Overall, it is clear that the positives of EMTALA and Medicaid solidly outweigh their negatives, in that the wellbeing of the patient should be held above all else. The financial burdens that safety-net hospitals experience are simply an unfortunate, but necessary byproduct of the current American health care system. If there could somehow be a feasible method guaranteeing significantly more lucrative reimbursement for hospitals without cutting back on patients' medical care, then the United States health care system would truly be greatly improved. Until then, the United States has a lot to work towards in terms of its health care system and safety-net hospitals will continue to be at risk.

**More to learn...**

Although there is much written on the correlation between poverty and health status and there is an abundance of literature emphasizing the approximately 50 million uninsured American citizens, much less is written about the financial consequences that take place when hospitals treat these patients and are subsequently not compensated adequately. There are published statistics documenting how much uncompensated care is provided every year and where these hospitals are geographically, but there is very little written about the specific impact that the financial burden has on the hospitals that provide the most uncompensated care. Because of this, it is important to further explore

the unfortunate effects that the mandated provision of uncompensated care has on non-profit safety-net hospitals.

## **Chapter 2 – Methods**

### **Overview**

Looking to bring together the plethora of data on both poverty and health care, I wished to study the effects that the impoverished community's lack of payment ability has had on non-profit safety-net hospitals. Again, there is much written on the problem of overall poverty in the United States, as well as the abundant literature on general health policies and their implications. However, there is surprisingly little written about the direct financial impact of uncompensated and charity care on hospitals themselves. Therefore, I set out to look at the impact of uncompensated care at safety-net hospitals, as they (by definition) provide the highest rate of care without compensation in the country.

### **Method and Sample**

I decided it would be most appropriate to collect this information by way of interviewing safety-net hospital employees, with my sampling population coming from employees in the fields of financial services and budget planning, and documenting their opinions on the issue as well as getting concrete financial statistics. With this plan in mind, I interviewed two employees of a safety-net hospital consortium in the eastern United States. One employee worked in corporate financial services and one worked in budget planning. The corporate financial services employee's answers were especially relevant, as much of his job is overseeing the payor reimbursement of all the hospitals in the consortium. The budget-planning employee's answers were also relevant because safety-net hospitals presumably have to account for very high amounts of annual

uncompensated care when they propose their budgets. All of the hospitals in the consortium for which the two participants work are classified as non-profit, so the participants' answers would truly be both comprehensive and relevant.

After I had received approval to conduct the interviews from the Human Subjects Review Committee (HSRC), both participants signed informed consent forms (see Appendix B) and willingly agreed to participate in my interviews. Per the informed consent form, each participant knew that the interviews were voluntary, and that they could choose to participate or not. They also were given the right to withdraw from the interview without penalty at any point if they did not, for whatever reason, wish to answer a question. Also, I promised to ensure their confidentiality as well as the confidentiality of their employer. In order to achieve this level of confidentiality, I was the only person except for Professor Melinda Goldner, under whom I performed this research, to see the answers to the interview questions. I also kept the participants' names confidential, and their employer confidential.

### **Interviews and Data Analysis**

After securing the two interview participants, I first sat down with the corporate financial services employee and I asked him an array of questions ranging from statistics-based questions about his hospital consortium specifically to more general questions on the overall impact of uncompensated care. Having already received answers to the statistics-based questions from the corporate financial services employee, when I interviewed the employee in budget planning, I was more curious about his opinions about the prospect of reducing potential uncompensated care by the use of effective

budget planning. However, I also asked him about the general impact of uncompensated care as well. See Appendix A for an interview guide.

After the two participants answered all of my questions, I combined their answers and broke them down into relevant categories. After I broke these data down by looking for patterns, I returned to all of the studies I used in Chapter 1, and I determined whether my findings confirmed, contradicted, or extended the conclusions of these studies.



## **Chapter 3 – Results and Discussion**

### **Overview of results**

Although the two employees I interviewed are from two different departments within their safety-net hospital, they both shared similar insights regarding the various effects of uncompensated care. As they both answered my questions with a financially based point of view, they both remarked that the only positive aspect of charity care is the fact that patients are not turned away because of their inability to pay. They both felt that it is important for everyone in need to receive proper and adequate medical treatment. However, they both were very candid about the devastating impact that charity care has on non-profit hospitals, especially those categorized in the safety net. Both participants noted that these consequences affect many aspects of a hospital, and that they go much deeper than financial losses. In fact, they seemed to agree that the effects of uncompensated care reach beyond the finance and budget planning departments into the various clinical divisions of a hospital.

### **Importance of the payor mix**

According to the financial services employee, one must first take into account the breakdown of the hospital's (or hospital consortium's) payor mix when thinking about the overall financial implications of uncompensated and undercompensated care. As a point of reference, this employee gave me the breakdown of the general payor mix of his hospital consortium's flagship hospital. Essentially, the payor mix enables the budget planning team to know exactly what sort of patients the hospital serves. According to this

financial services employee, approximately half of this particular hospital's patients are covered by a form of government issued health insurance. This is significant for several reasons. For one, it is important to note that this figure exceeds the national average by almost 20 percent according a 2010 United States Census Bureau Study (US Census Bureau 2010). However, the issue that this employee especially wanted me to take away from the interview was that Medicaid, for instance, only reimburses approximately 70 percent of the actual costs of procedures, tests, etc. As he stated, "The government covers everyone, which in turn lowers the case by case reimbursement." When he said this, he was referring to the fact that as the state and federal governments have a set (relatively low) Medicaid budget, they can only afford to reimburse providers at a low case by case rate. His statement also highlights the fact that there are many poor Americans who qualify for Medicaid coverage, therefore obligating the government to provide this coverage. With the number of people qualifying for Medicaid growing, its reimbursement rate looks to be more and more dismal each year, unless the Medicaid budget increases, which is an unlikely scenario. This statement parallels the Kaiser Commission on Medicaid and the Uninsured's data, which finds that over 48.57 million people receive Medicaid coverage with that number increasing everyday (Kaiser Family Foundation 2010). Also, Medicare, which is this particular hospital's largest payor, does not reimburse at a significantly higher rate than Medicaid. Additionally, the financial services employee said over a tenth of this hospital's patient base is uninsured, which falls right into the "safety-net" range, according to the Agency for Healthcare Research and Quality (AHRQ) (AHRQ 2003).

**Budget planning is impacted**

In addition, one aspect that both of my interviewees said was significantly impacted by the high prevalence of uncompensated care is the hospital budgeting process. As one might imagine, there are many intricacies that go into determining a hospital's annual budget, and the incidence of uncompensated care simply makes the budgeting process of a safety-net hospital significantly more difficult. There is no concrete method of determining how much uncompensated (and undercompensated) care a hospital will provide in a given year, but both participants shed light on the factors that go into the planning process. Both participants clarified that although the budget planning process of their hospital consortium was not actuarial in nature, there is indeed a large team that takes extensive measures to attempt to accurately predict the amount of bad debt and uncompensated care for a particular fiscal year. In addition, they both stressed the importance of trends in the market, managed care, and deductibles (the parts of an insurance claim that the beneficiary must pay out of pocket before he or she can receive medical care). By this they meant they attempt to predict the amount of bad debt caused by uncompensated care by looking at data from the past several years, which determine trends in managed care and deductibles as well as the market. This first part involves looking at the recent changes in the ratio of premiums to deductibles over the past several years. As a rule of thumb, the higher the deductible is for a policy, the lower the premium is for the policy (and vice versa). If an employer or an insurance company raises either the deductible or the premium for certain insurance policies, it can have a negative effect on the beneficiary, in that s/he could determine that s/he cannot afford that change, effectively creating another uninsured person. This scenario can be especially common

when an employee receives his or her health insurance through his or her employer, which much of the time takes away the element of choosing from many coverage options. If scenarios such as this have been becoming more common, the budget-planning department can use this to account for a likely increase in uncompensated care.

The financial services employee then brought up an interesting insight about predicting the amount of uncompensated care by looking at recent market trends; he explained that the budget planning team also looks at what he called “catastrophes.” The catastrophes he was referring to are those that result in local employers having to lay off massive amounts of workers. This is significant because most if not all of these employees would have had private health insurance before their lay off. Because COBRA is so expensive, there is a good chance that many of these people would elect to risk going without any form of health insurance until they are able to find a new job with benefits. This confirms the statements made by the United States Department of Labor, in which it says, “Group health coverage for COBRA participants is usually more expensive than health coverage for active employees, since usually the employer pays a part of the premium for active employees while COBRA participants generally pay the entire premium themselves” (U.S. Department of Labor 2010). Therefore, if any of these people had to use the hospital’s services in this period between jobs, there is a good chance that the hospital would lose significant reimbursement that it would have had previously. It is because of this, the financial services employee argued, that this type of event should be factored into a hospital’s budget planning process. In addition to confirming everything that the financial services employee had said, the budget-planning employee, not surprisingly, talked about attempting to predict the amount of bad debt like an

accountant. He explained that in the budget-planning department of his hospital consortium its employees looked at “the free care umbrella,” which encompassed charity care, bad debt and other free care programs (e.g., emergency Medicaid). In addition to trends and changes in federal regulations, the budget-planning department predicts this amount of free care by looking at the consortium’s hospitals’ gross revenue, net revenue, and patient volume. In other words, the budget-planning department would look at the total amount of cash the hospitals receive, the total amount of cash remaining after the hospitals’ many expenses, and the total amount of patients that use the hospitals’ services each year.

### **Impact on range of services**

Though my two interview participants shared their insights on how the high prevalence of uncompensated care makes it difficult to plan their hospital consortium’s annual budget, they both agreed that its most significant impact is the fact that it limits the range of services that each hospital within the consortium can provide. As the financial services employee said, “uncompensated care limits the ability of health systems to provide new services and it limits what they are generally able to do.” He was quick to point out the unfortunate reality that hospitals may be forced to neglect certain services and sections when they allocate these reduced resources. He used the example of deciding between new medical equipment and renovations to existing units. For instance, a safety-net hospital’s administration might have to choose whether to allocate certain funds to purchase a new MRI machine or to upgrade the birthing unit. He illustrated the fact that the administration is repeatedly faced with decisions like this one, and that

weighing the pros and cons of each scenario is very difficult. He added that in this hypothetical situation, the hospital would likely receive more referrals from general practitioners if it purchases a state-of-the-art imaging machine, which would, in turn, likely increase the hospital's net revenue. However, with a new birthing unit, the obstetrics staff would be happier, and the hospital would likely be able to attract the best OB-GYN physicians, and then perhaps bring in new patients as well, which would be very lucrative for the hospital. Both services have distinct positive aspects, but due to the high rate of uncompensated care, the hospital's administration would only be able to choose one of the two, or at worst, none at all.

Both employees also alluded to the fact that there was no concrete form of revenue sharing among the hospitals in their consortium. Because of this, as the financial services employee pointed out, each hospital within the consortium has its own priorities with regards to how it wants to market itself to the community and its patient base. In figuring out these priorities, each hospital is forced to continually run cost-benefit analyses and create business plans so that each can maximize its net revenue. This particular hospital consortium is made up of hospitals that fall into the safety net and some that do not, so each hospital within the consortium seems to have a distinct role in a distinct community. Both participants agreed that one hospital within their consortium is having the most difficult time coping with the various detrimental effects of uncompensated care. This hospital falls within the safety-net range for amount of uncompensated care provided. Both employees mentioned that this hospital has the oldest facility, and that its various departments are renovated infrequently relative to the other hospitals in the consortium because it is not as financially sound. In fact, the budget

planning employee stated, “This hospital’s overall financial structure is permanently weakened because of inadequate Medicaid reimbursement and the high provision of free care.” He was also sure to point out that although this hospital does not provide the gross amount of uncompensated care that the flagship hospital does, it is proportionally hit much harder than its much larger sister hospital. On the other hand, the lack of a revenue sharing system seems to benefit the hospitals in the consortium that fall outside of the safety net. For instance, a smaller hospital in this consortium located in a more affluent community is able to provide more community-based programming, focusing on disease prevention rather than solely treating existing conditions. In its particular market, it has higher proportionate outpatient utilization than the other hospitals in the consortium. This is due to the fact that this hospital’s patient base is more affluent and generally healthier. Its patients also very rarely are covered by Medicaid or are uninsured. Therefore, its administration is less burdened with having to choose one service over another due to lack of funds. This section of the interview truly opened my eyes to the reality that the prevalence (or lack thereof) of uncompensated care affects all types of hospitals in distinct ways.

### **Very little can be done...**

#### *Policies (both beneficial and detrimental to the cause)*

Another common viewpoint between the two interviews was that they felt there is very little that can be done to reverse the impacts of uncompensated care provided by safety-net hospitals. According to figures given to me by the financial services employee, his health system provides an amount of uncompensated care that makes up a “very large

component” of its budget each year, which can be crippling for the various reasons already discussed. However, interestingly enough, the two participants seemed to hold different attitudes toward this unfortunate reality. The financial services employee was noticeably more negative. When I asked him what measures the health system could take to reduce the high incidence of uncompensated care, he immediately answered by stating how little can be done. He went on to say that as someone who works in the financial services field, it is his job to help maximize the net revenue, but “with policies such as EMTALA in place, you cannot even begin to think about dollars.” Again, the Emergency Medical Treatment and Active Labor Act (EMTALA) dictates that all hospitals with emergency departments in the United States must provide care (at least until they are stable) to all patients without taking into account their ability to pay for the care provided (U.S. House of Representatives 2010 <<http://uscode.house.gov>>). The financial services employee did, however, state that policies such as this one are indeed necessary to ensure maximum access to the uninsured and underinsured community. He then went on to talk about how there is a concerted effort to get uninsured patients enrolled in Medicaid, whether it is basic Medicaid or emergency Medicaid, which is Medicaid coverage that can be granted retroactively after an eligible patient suffers acute symptoms without having been previously approved for Medicaid coverage (Kaiser Family Foundation 2008). The budget-planning employee, on the other hand, was more noticeably positive regarding the issue. Rather than immediately pointing out the financial impact of EMTALA and other safety-net policies, he pointed out his health system’s policies and procedures that helped reduce the negative effects. Above all, he made sure to highlight the health system’s extended access policies. He explained that when a patient is admitted



to one of the hospitals as an inpatient, he or she is assigned a “patient account representative (PAR).” The PAR is in charge of managing everything related to the patient’s account, be it about insurance, bills, or whatever it may be. It is the job of the PAR to exhaust all possible benefits (e.g., emergency Medicaid, etc.) before the hospital must turn to providing the medical care without compensation. The budget-planning employee also talked about how his health system is proud of the fact that it will find full coverage for patients who live at up to and including double the federal poverty line, but who are otherwise uninsured. He talked about how his health system is able to do this by setting aside funds in its annual budget as well as having the PARs enroll patients who qualify in Supplemental Security Income (SSI). Although my two interviewees seemed to hold different attitudes toward the issue of providing a great deal of uncompensated care, they both offered a consistent message: they are both part of a team whose job it is to maximize revenue for the health system as best they can. While they both believe that policies such as EMTALA are necessary, they also realize that it can possibly be financially crippling to their health system. Therefore, they have to come up with numerous ways to supply their health system’s hospitals with compensation.

The various policies that the two employees laid out for me both confirm and extend the literature I used for my research. The studies I examined mentioned EMTALA, and this particular health system certainly experiences the abysmal Medicaid reimbursement rates illustrated by the Agency for Healthcare Research and Quality (AHRQ) data on safety-net hospitals. However, while some literature describes some supplemental safety-net policies such as emergency Medicaid, my interviews extended the information on these policies and shed light on some hospital-specific programs. The

hospital-specific program that comes to mind is the fact that this particular health system will ensure coverage to all patients who live at up to and including double the federal poverty line. Policies like this are extremely important because Medicaid really only covers the poorest of the poor American citizens, leaving the rest of the “poor” community without any means of health insurance much of the time. In addition to elaborating on these policies, the interviews also illustrated the importance of having hospital employees such as the PARs who are skilled at not only answering patients’ financial questions, but who are also knowledgeable about all different coverage options. It is the responsibility of these employees to communicate effectively with all sorts of patients and exhaust all possible options before resorting to the provision of uncompensated care.

*Are all patients charged the same prices for the same services?*

As my interview participants have made clear, hospitals around the United States can do very little to reduce the amount of uncompensated care they provide. It is because of this that reports and studies have surfaced, such as Gerard F. Anderson’s 2007 report, that claim patients are charged for services differently depending on how they are able to pay. Because this concept is integral in understanding the overall efforts to reduce uncompensated care, I was sure to ask my participants whether their hospital consortium charged patients differently on the basis of payment method. One was very quick to say that his health system charges every patient the same prices for the same services. He did, however, clarify that when patients carry private insurance, the health system is allowed to negotiate contracts with these private payors. He continued to explain that, on the other

hand, when patients are covered by government-issued insurance such as Medicare and Medicaid, the state and federal governments dictate what the nonnegotiable reimbursement rates will be.

This practice seems to contradict Anderson's (2007) study. Besides the allegation that hospitals charge patients different rates depending on their method of payment, the most glaring contradiction between the information I received from my interviews and Anderson's article is the fact that his article suggests that not only do hospitals charge "self-pay" patients more for services provided, but they also attempt to justify doing so in six main ways (Anderson 2007:784). In fact, interestingly enough, one of the six methods of justification that Anderson points out has to do with the "role of charity-care policies" (Anderson 2007:784). He says that hospitals seem to feel justified in charging self-pay patients an average of 2.5 times more than health insurers actually pay out because they only collect about 10% of the charges for uninsured patients (Anderson 2007:784). Using data from 2004, Anderson found that on average hospitals are charging self-pay and uninsured patients 307% of what Medicare reimburses (Anderson 2007:781). In other words, as Anderson (2007) puts it, "for every \$100 in Medicare-allowable costs, the average hospital charged \$307" (781). This statement is in stark contrast from the statements I received about charging all patients the same unless they negotiated with a private payor.

Overall, from my interviews I gathered plenty of information, but several main themes were visited over and over again: uncompensated care has a far-reaching negative impact on safety-net hospitals, and although policies are put into place that attempt to reduce the amount of uncompensated care provided, there is very little that can be done to

lessen the significant negative effects. This includes the fact that this particular safety-net health system does not charge its patients differently depending on their ability to pay, and therefore it cannot reduce the various negative effects of uncompensated care in this way.

## **Chapter 4 – Conclusions**

### **High incidence of uncompensated care**

After conducting thorough research on the issue of uncompensated care provided by non-profit safety-net hospitals in the United States, there are a few notable conclusions that have to be drawn. The first is the fact that the provision of uncompensated care is pervasive across the United States as it totaled \$40.7 billion in 2004, which encompassed approximately 2.7% of total health care spending that year (Kaiser Commission on Medicaid and the Uninsured 2004:2). This implies several things: for one, the United States spends over \$1.5 trillion on health care, which most people would agree is too much spending. However, the second implication seems to be more significant; if hospitals are providing over \$40.7 billion in charity care, it means that there are far too many people who are uninsured or underinsured. This simply confirms the long-believed idea that there is a direct and distinct relationship between poverty and health.

### **Uncompensated care has many negative effects**

It was easy, after conducting my interviews, to draw the conclusion that uncompensated care negatively affects safety-net hospitals in significant ways. Although there is a great deal of literature that says just this, my interviewees were able to delve into some of the specific ways in which their hospital consortium has suffered over the years because of their high provision of uncompensated and charity care. A specific impact that was discussed throughout both of my interviews was the fact that the high prevalence of uncompensated care “limits the ability of health systems to provide new

services and limits what they are able to do,” as the financial services employee stated so well. It effectively forces the hospital administrators make difficult choices. This could entail only being able to afford a single new service rather than several that could potentially attract new patients, new clinical staff, and more revenue to the health system. It could also entail choosing one service to keep over another because the high provision of uncompensated care is causing the health system to cut its budget and, therefore, cut an essential service. As the budget-planning employee stated, “one of our hospitals’ financial structures is permanently weakened due to poor Medicaid reimbursement and the provision of free care.”

### **Again, very little can be done...**

#### *Ineffective budget planning*

Perhaps the most troubling conclusion from my research is the fact that it seems that very little can be done to reduce the high incidence of uncompensated care. A significant contributing factor to this seems to be the difficulty for a safety-net health system to predict the amount of uncompensated care for the coming year’s budget. The problem is that there is no perfect method to predict this amount. My interviewees discussed how their respective departments go about attempting to budget uncompensated care, going into detail about the various variables that could potentially affect the upcoming year’s charity care provision total. However, it became clear to me after conducting the two interviews that there was indeed no perfect gauge for determining the potential amount of uncompensated care, which therefore inevitably

leaves safety-net hospitals and their budget-planning and finance departments guessing, which is not beneficial for any party involved.

### *Detrimental policies*

In addition to the conclusions about the difficulties in planning financially, I can safely say now that the policies in place today are not conducive to reducing the high amount of uncompensated care provided by safety-net hospitals. The policy that came up time and again throughout previous literature as well as in my interview with the financial services employee was the Emergency Medical Treatment and Active Labor Act (EMTALA). As long as this policy is in place and hospitals are required to provide emergency medical care without questioning a patient's ability to pay for the services provided, uncompensated care will continue to be prevalent. Also, both of the employees I interviewed discussed how inadequate Medicaid's reimbursement is. While the Americans covered by Medicaid would likely not have any form of health insurance otherwise, Medicaid's nonnegotiable reimbursement rates to hospitals highlight another policy that presents unfavorably to safety-net hospitals.

To be sure, I, along with both of my interviewees, believe that a policy like EMTALA and basic coverage like Medicaid are necessities under the current fabric of the American health care system, because people should have the right to adequate medical care. However, looking at the issue purely from a financial standpoint, EMTALA and Medicaid are financially devastating to safety-net hospitals across the United States.

## **Practical policy implications**

### *Single-payor health insurance system: the ideal choice*

These various conclusions (especially those about the effects of EMTALA and Medicaid) raise the question of whether there are indeed any policies that could actually reduce the incidence of uncompensated care, and truly be favorable to safety-net hospitals. The most radical, but possibly the most effective policy that comes to mind is the United States implementing a single-payor health insurance system that is not tied to employment. This solution would effectively end all uncompensated care in the United States because of two main factors. First and foremost, everyone would have health insurance coverage through the government, be it through the federal government or the state government. Therefore, hospitals and other health care providers would always be reimbursed the same amounts for all people, leaving no discrepancies. The second main factor is that with every American holding the same health insurance coverage, hospitals would no longer feel the need to charge their patients higher prices for services because they would know the set government-controlled reimbursement rates beforehand (Anderson 2007:785). In this situation, for all intents and purposes, there really would not be any charges all, just a set reimbursement. This type of uniform reimbursement would also take the guesswork out of budget planning, at least when it concerns attempting to predict the future provision of uncompensated care. Instead of having to look at variables such as market trends, and recent relevant legislation, hospital budget-planning teams could simply look at the patient population and health trends to negotiate their budgets.

Implementing a single-payor health insurance system separate from employment would also satisfy the Universal Declaration of Human Rights (UDHR) much more



effectively than EMTALA and Medicaid currently do. Passed in 1948 by the United Nations General Assembly, UDHR was meant to produce a comprehensive definition of what constitute “human rights” in thirty articles. Article 25, Section 1 of UDHR is as follows: “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control” (United Nations 1948). In the context of uncompensated care and safety-net hospitals, the important aspects of this article are the “adequate medical care and necessary social services.” With EMTALA in place, people without health insurance use hospital emergency departments as a primary care provider, which presents several fundamental problems. For one it physically slows down the primary care process. People who come to hospital emergency departments with relatively minor acute symptoms such as a common cold often wait several hours to be seen. When they do get seen, it is often very quickly by a clinician who is not trained as a primary care clinician (Grumbach et. al. 1993:373). This scenario does not provide optimal continuity, as true primary care providers are much more skilled in keeping track of their patients and making referrals to specialists. This does not create an image of a system of “adequate medical care.” A single-payor health insurance system would make EMTALA unnecessary, as everyone would hold a form of health insurance, and hospitals would always be reimbursed adequately and uniformly.

When it concerns the aspect of “necessary social services,” the current health care system offers enrollment in Medicaid. However, as the various studies illustrate,

Medicaid only offers coverage to the poorest of the poor (CMS 2010). This translates to certain people not qualifying for Medicaid even if they live at the federally determined poverty line. Therefore, there are millions of poor Americans who do not qualify for Medicaid and who also cannot afford private health insurance. Also, there is the problem of Medicaid's inadequate provider reimbursement, which has been discussed time and again. Again, the many downsides to Medicaid make it so that it does not seem to satisfy UDHR's right to "necessary social services." It should be concluded, therefore, that a single-payor system would indeed provide the social services necessary for all American citizens (and perhaps all permanent residents) to receive adequate medical care, while also providing adequate reimbursement for hospitals. If this were the case, the term "safety-net" hospitals would not have to exist. Every hospital would receive the same single-payor reimbursement, and no hospital would provide uncompensated care, which would solve many problems.

However, as America is the only industrialized nation without a single-payor health insurance system, it would be very difficult to propose a single-payor system for the United States to implement without first looking abroad for the exact structure of the system (Bodenheimer and Grumbach 2009:181). Whether the United States were to implement a universal health care system like that of Canada (Medicare) or one from Europe, it would likely be simpler and more effective than the current system. After researching several viable options for a single-payor health insurance system, it seems that the traditional British National Health Service (NHS) would be both the simplest and most effective health insurance system for the United States to implement. The vast majority of the funding for the British NHS comes from general taxes, and the health

insurance system is administered on the national level (as opposed to the Canadian health insurance system, which is administered on the provincial level), which lowers administrative costs, as all the paperwork and forms are uniform for the entire country. From here, hospitals are reimbursed by a previously negotiated global budget, while general practitioners are paid by way of capitation (per number of patients), and specialists are salaried government employees who work directly for the NHS (Bodenheimer and Grumbach 2009:170-171). In the context of hospital reimbursement, this type of global budget reimbursement would effectively eliminate individual patient reimbursement all together, which again, would also eliminate the concept of the safety net. However, possibly the most attractive feature of the NHS, and one that separates it from the Canadian health care system is the fact that wealthy people can opt to purchase private health coverage that would enable them to receive preferential treatment. This practice is actually subject to change in Canada as well due to the recent developments in Quebec. In the 2005 Canadian Supreme Court case, *Chaoulli v. Quebec*, it was decided upon that Quebec's law prohibiting the possession of private health insurance that has coverage overlapping with Medicare should be done away with (Jost 2006:878). This could potentially be foreshadowing some monumental future legislation affecting the Canadian health care system as a whole. While the rest of the Canadian health care system (for the time being) prohibits its citizens from holding private health insurance that covers the same services that the national insurance covers, about 11.5% of the British population purchases private insurance, which the government allows as long as these citizens continue to pay taxes (Bodenheimer and Grumbach 2009:170). This provision would serve to satisfy the United States' traditionally capitalistic tendencies

(i.e., the opportunity to pay for “better” care). Most importantly, however, the insurance administered by the NHS is completely separate from employment, so all British citizens are guaranteed “adequate medical care and necessary social services” for life.

*PPACA: the next-best choice*

Admittedly, implementing a universal system like the British National Health Service would call for a complete dismissal of the current health care system in favor of starting over from the beginning. It is certainly not the most feasible immediate solution for the large amount of uncompensated care in the United States. While it has been a controversial piece of legislation, the Patient Protection and Affordable Care Act (PPACA), which was signed into United States law by President Barack Obama on March 23, 2010, serves as a more immediate and promising health care reform. Despite the controversy surrounding it, PPACA will undoubtedly benefit hospitals in terms of reimbursement levels. The bill has many sections, but there are several in particular that make this the case. For one, the bill requires all American citizens to hold some form of health insurance by January 1, 2014 (Galewitz 2010). If someone does not comply with this provision, then he or she would be fined \$95 or 1% of his or her annual income, whichever is higher, and this fine would rise to \$695 or 2.5% by 2016 (Galewitz 2010). With all Americans required to have health insurance by 2014, the reimbursement rates for hospitals will increase and their provision of uncompensated care will be eliminated. This is due to the fact that people who would otherwise be uninsured would now hold a form of insurance, meaning that zero reimbursement would turn into partial reimbursement. No matter how low that “partial reimbursement” is, both physicians and

hospital administrators would agree that this partial reimbursement is better than no reimbursement at all. The bill also features a provision dictating that the federal government will increase Medicaid spending enough so that eligibility will widen to include people at 133% of the federal poverty line by January 1, 2014 (Galewitz 2010). This provision will increase access to affordable health insurance coverage, and will therefore make it easier for people to comply with the provision requiring all American citizens to have a form of health insurance. Together, these two provisions will not only increase Americans' access to affordable health insurance, they will also ensure hospital's more adequate reimbursement.

The most important factor in ensuring the success of new legislation such as PPACA is advertisement. Many Americans do not have access to the various media sources that were used to publicize the important aspects of the bill, so it is essential that the United States government continues to publicize the effects of the bill in all conceivable methods. This is very significant because there are surely people without health insurance in the United States who have not heard of PPACA and who will therefore fall through the cracks regarding access to affordable health insurance. These people will most likely be blindsided with the fines for not carrying a form of health insurance, and they will likely continue to suffer in confusion until the government intervenes. If the United States government is able to sufficiently publicize the legislation, then PPACA will seemingly be able to serve as a viable option for the foreseeable future.

*A public option: another alternative*

If a full-fledged universal health care system is not feasible in the near future and the Patient Protection and Affordable Care Act is repealed or does not ultimately work, a third alternative that could increase access to affordable health insurance, while also decreasing the incidence of uncompensated hospital care is a government administered public health insurance option. This would consist of a set health plan controlled by the federal or state governments that would be an affordable alternative to private insurance. Eligibility would be much greater than that of Medicaid, and it would be funded through taxes and/or reduced premiums. There need only be a few specific coverage options, which would likely be marketed to individuals and families that have too many assets and too high an income to be eligible for Medicaid, but are too poor to feasibly afford private health insurance. Like Medicaid and Medicare, the United States government would serve as the third-party payor, and because the reduced premiums and/or taxes would bring in more money than that of Medicaid, the government could afford to reimburse hospitals more sufficiently, even if its rates of reimbursement are not as adequate as those of private insurances. Although a public option like this would certainly not be as comprehensive as a completely universal health care system, it would help immensely because it would be tailored to a population that routinely falls through the cracks of the current health care system, and that much of the time is forced to take advantage of EMTALA to receive their primary care at a hospital emergency department.

### **Limitations of my study**

I was indeed able to conclude a great deal from my study, and there are certainly several policy implications from my findings, but unfortunately there were many

limitations that prevented my study from being more comprehensive. The most significant limitation on my study was the time constraint to conduct my research and analyze the results. Because I was limited on time, I was only able to interview two employees, one from the financial services department of a health system, and one from the budget-planning department. If I had more time, I would have liked to interview employees from other types of departments; financial services and budget planning both are heavily finance based. It would have been beneficial to get input from other points of view, such as emergency physicians or nurses, for instance. It would have also been relevant for me to interview someone who worked for a health insurance company, who perhaps worked in the reimbursement department. This would have given me a mirrored view: I would have been able to get the point of view of someone who represented the payor, in addition to the point of view of health system employees.

In addition to only securing interviews with two employees, I was only able to secure interviews from employees who worked for one hospital consortium. While this hospital consortium was a safety-net health system, which was able to provide great insight, I would have been able to conduct more comprehensive research if I was able to secure interviews from safety-net health system employees from all over the United States. If I had more time to conduct my research, I would have traveled and interviewed employees from safety-net health systems from every region of the United States. This would have better accounted for possible discrepancies caused by differences in variables such as hospital setting (urban, rural, etc.), standard of living, and health status of people by their location. If I had more time to conduct research, I could have put together an

overall more comprehensive study, and I would have been able to ensure to a greater degree that my findings were universally applicable.

### **Future research based on my findings**

In addition to expanding on my study by performing the research in the above manner, I think it might be interesting to take an in-depth look at and compare the payment statistics of several industrialized countries' governments' single-payor health insurance systems to hospitals. It might be very beneficial for the United States to know which country's hospitals are receiving the most money from the government for their services provided. This would not only expand on the policy implications section of my research, but it might also aid the United States in selecting an effective universal health care system if its government and people ever decide that one is necessary. Until then, it is truly important to come to understand the significance and impact of uncompensated care provided by hospitals, especially those that make up the safety net. All individuals need access to health care, and we need to ensure that hospitals, the cornerstone of the American health care system, are able to do just that.



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## Appendix A – Interview Guide

1. What percentage of each hospital's patient base is uninsured? Medicaid? Private Insurance? Medicare?
2. What percentage of the care in each hospital is uncompensated?
3. How has uncompensated care affected each hospital?
4. What measures, in particular, have the hospitals taken to attempt to minimize the financial impact of uncompensated care?
  - a. For example, are patients charged different rates? Please explain.
5. Does your hospital (or hospital consortium) attempt to predict the amount of bad debt for each year? If so, what are some of the criteria that go into allocating the bad debt funds?
6. Is there any other information that you would like to add regarding uncompensated care?
7. Is there anyone else who I should speak with?

### Appendix B – Informed Consent Form

My name is Daniel Dimenstein, and I am a student at Union College. I am inviting you to participate in a research study, which is required as part of my senior thesis in Sociology under the direction of Professor Melinda Goldner. Involvement in the study is voluntary, so you may choose to participate or not. A description of the study is written below.

I am interested in learning more about the financial burden placed on non-profit hospitals due to uncompensated medical care. You will be asked to participate in an interview. This will take approximately 20-30 minutes. If you no longer wish to continue, you have the right to withdraw from the study, without penalty, at any time.

All of my questions have been answered and I wish to participate in this research study.

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Signature of participant

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Date

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Print name of participant

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Signature of participant

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Date

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Print name of participant

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Name of investigator

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Date