



STATE OF WASHINGTON

Public Financing and Uncompensated Care Provided by Washington State Community Hospitals and Community Health Centers

BRIEFING PAPER

WASHINGTON STATE PLANNING GRANT
ON ACCESS TO HEALTH INSURANCE

OCTOBER 2004

EXECUTIVE SUMMARY

IT IS TIME to initiate a fresh public policy debate and clarify our commitment to ensuring the uninsured have access to care – and how best to deal with the expenses. We face reports of growing uncompensated care provided by our community hospitals and community health centers:

- Preliminary estimates of uncompensated care provided in 2003 indicate hospital charity care may have increased an additional 57% and bad debt 48%.
- Community Health Centers in Washington reported a 50% increase in the number of uninsured patients between January 2002 and December 2003.

The numbers of uninsured appear to be growing, and we face budget challenges that continue to pit double digit medical inflation and dramatic increases in populations that are most expensive to cover (the aging and disabled), against state revenue limitations and expenditure lids.

This briefing paper examines the uncompensated care provided at Washington's community hospitals and community health centers, and the intricate link with public coverage and financing. Three main policy recommendations are identified for consideration by state policy makers: Expand Washington's charity care policy; examine performance and accountability expectations for tax expenditures and subsidy payments; and explore the policy tradeoffs of investments in health insurances versus subsidies for uncompensated care.

Expand Washington's Charity Care Policy

Our current charity care law ensures access to free hospital care for emergent medical needs for people with incomes up to 100% of the federal poverty level (FPL); and a sliding scale discount from full charges for those with incomes up to 200% FPL. Changes could include modifications in income eligibility and a move away from using 'full charges' for the uninsured, both in sliding scale discount calculations and in recording charity care provided.

A change in policy would reflect current understanding of affordability and income adequacy (families with incomes below 200% FPL often cannot cover basic living expenses of food, shelter and transportation); bring Washington in step with other states that already include populations above 200% FPL; and align with a potentially precedent setting lawsuit settlement agreement with the largest rural not-for-profit health system in the country (North Mississippi Medical Center). The agreement would require the system to provide free care for patients making up to 200% FPL, and to use sliding discounts from the Medicare rates (not charges) for patients between 200% and 400% FPL. (This is the first settlement agreement in a series of lawsuits filed nationwide against hospitals, including the Providence Hospital System in Washington.)

Examine Performance and Accountability Expectations of Tax Expenditures and Subsidy Payments

A full range of financing mechanisms help support uncompensated care provided at hospitals and community health centers. The array of financing approaches is disconnected, complex and inefficient at targeting the uninsured. In large part, the financing sources are not tied directly to care provided to the uninsured; as a result there is little accountability for ensuring the money supports care for the uninsured.

Principles used for the development of the Governor's budget and the policy priorities widely apply performance and accountability expectations for every agency program and activity in state government. It is time to examine the direct subsidy payments and tax expenditures (e.g., hospital state and local

property tax exemptions of \$32 million in 2001, hospital business and occupations tax exemptions of \$20 million in 2001) and apply performance and accountability expectations to all of our budget expenditures.

Policy Tradeoffs of Investments in Insurance vs. Subsidies for Uncompensated Care

As we examine our policy commitment to ensuring access to care, it is important to understand the tradeoffs (and hidden costs) of investing in insurance programs or in provider subsidy payments for uncompensated care. Investments in insurance coverage are more effective at increasing access to care among low-income populations.¹ In addition, investments in insurance may be more effective at reducing emergency room use than equal investments in subsidy payments to community health centers.² Enrollment in public insurance coverage can significantly reduce hospital uncompensated care and free up financing currently directed at subsidizing providers for uncompensated care.³

¹ John Holahan and Brenda Spillman. Health Care Access for Uninsured Adults: A Strong Safety Net Is Not the Same as Insurance. The Urban Institute. January 2002; Jack Hadley and Peter Cunningham. Availability of Safety Net Providers and Access to Care of Uninsured Persons. Health Services Research, October 2004. Sicker and Poorer: the Consequences of Being Uninsured. Kaiser 2002; Institute of Medicine, Hidden Costs, Value Lost: Uninsurance in America. June 2003; Institute of Medicine. Care Without Coverage: Too Little, Too Late. 2002.

² Peter Cunningham and Jack Hadley. *Expanding Care Versus Expanding Coverage: How To Improve Access to Care*. Health Affairs July/August 2004.; Hadley and Cunningham, October 2004.

³ Lynn Blewett, Gestur Davidson, Margaret E. Brown, and Roland Maude-Griffin. University of Minnesota, State Health Access Data Assistance Center. *Hospital Provision of Uncompensated Care and Public Program Enrollment*. Medical Care Research and Review, December 2003; *Expanding Access to Health Insurance Coverage Lessons the Burden of Uncompensated Care*. SHADAC Issue Brief, December 2003.

PUBLIC FINANCING AND UNCOMPENSATED CARE PROVIDED BY WASHINGTON STATE COMMUNITY HOSPITALS AND COMMUNITY HEALTH CENTERS

This briefing paper examines the uncompensated care provided at Washington's community hospitals and community health centers, and the intricate link with public coverage and financing. Public insurance coverage and public financing play a significant role in hospital and community health center provision of uncompensated care: Hospitals in Washington state receive approximately 50% of their revenues from the public insurance programs Medicare and Medicaid; and community health centers receive nearly 90% of their revenues from public sources including federal and state grants, and the public insurance programs – Medicaid, SCHIP, Medicare and Basic Health.

Policy changes in the insurance programs (in eligibility, enrollment and payment rates) and other financing mechanisms can have sizable ripple effects or unintended consequences that may impact the viability of the entire health delivery system. There is cause for concern, as public insurance programs are cut, employer insurance rates are dropping, and the numbers of uninsured are growing. We face reports of increasing uncompensated care provided by our community hospitals and community health centers:

- Preliminary estimates of uncompensated care provided in 2003 indicate hospital charity care may have increased an additional 57% and bad debt 48%.⁴
- Community Health Centers in Washington reported a 50% increase in the number of uninsured patients between January 2002 and December 2003.⁵

In light of these growing concerns, we undertook a review of uncompensated care provided at Washington hospitals and community health centers, and the funding sources or financing mechanisms that could help support the cost of care for the uninsured. The briefing includes policy considerations and three main recommendations for consideration by state policy makers.

Introduction to Uncompensated Care

The majority of care provided to the uninsured is through the “safety net”, an array of hospitals, community health centers, federally qualified health centers, physicians and other professional providers.

Although sources of ‘free’ care are available, it is important to stress that the uninsured receive about half as much care as privately insured persons. As a result, the uninsured often suffer significant consequences with delayed diagnoses and treatment, and significantly increased mortality rates.⁶

The term “**uncompensated care**” generally includes “charity care” – the care given to the low-income without expectation of payment, and “bad debt” - balances owed on care partially paid for.

⁴ Washington State Department of Health, *hospTrends*, July 2004.

⁵ Rebecca Kavoussi and Erin Burchfield. *Stretching the Safety Net: The Rising Uninsured at Washington's Community Health Centers*. May 2004.

⁶ Jack Hadley and John Holahan, *How Much Medical Care Do The Uninsured Use, and Who Pays For It?* February 2003. Health Affairs. Institute of Medicine. *Care Without Coverage: Too Little, Too Late*. 2002. Jack Hadley. *Sicker and Poorer: the Consequences of Being Uninsured*. Kaiser 2002. Institute of Medicine, *Hidden Costs, Value Lost: Uninsurance in America*. June 2003.

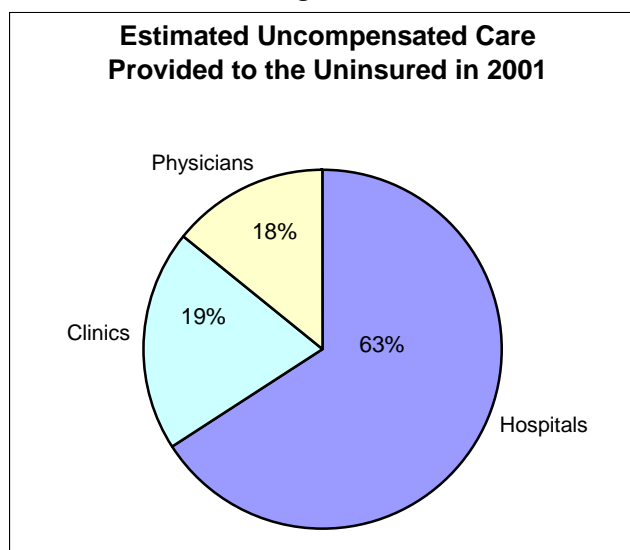
The uninsured pay for approximately 35% of the cost of care provided to them. (In contrast, full-year insured populations pay for just under 20% of their care out-of-pocket.)⁷ The remaining 65% of the cost of care provided to the uninsured is considered fully or partially “uncompensated”, that is, not directly paid for by the uninsured or by insurance.

While 65% of the cost for care received by the uninsured is “uncompensated”, multiple financing options are available to help support the cost of the care. The array of financing sources is a complex reflection of historical developments and ever changing fiscal policies. The adequacy of the financing as a match for the care provided at individual hospitals or clinics varies considerably. In large part, the financing sources are not tied directly to care provided to the uninsured. Rather, many financing sources are provided in block grant formats or through Medicaid add-ons. As a result, there is little accountability for ensuring that the money intended to support care for the uninsured actually does so.

Where is Uncompensated Care Provided

Nationally, the majority of uncompensated care provided to the uninsured, 63%, occurs in hospitals, for both inpatient and outpatient care. Community health centers and direct care programs provide 19% of

Figure 1.



Source: Hadley and Holahan, February 2003

the uncompensated care, and physicians and other community providers cover an estimated 18%.⁸ (Figure 1)

Hospitals provide the majority of uncompensated care, both in patient volumes and cost, for a variety of reasons. In part, hospital inpatient care is the most expensive care; and in part hospitals have a unique obligation to provide care, reflecting a national policy of ensuring some minimal access to care for emergency treatment via hospital emergency rooms. The federal Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA) generally requires hospital emergency rooms to treat patients with emergency conditions and stabilize them prior to transferring, irrespective of ability to pay. Washington State statute requires hospitals to provide care for emergency conditions, provide “charity

care” for those persons with family incomes below the federal poverty level (e.g., \$18,850 for a family of 4 in 2004), and use sliding scale discounts from charges for those persons with income between 100%-200% of the federal poverty level.⁹

⁷ Hadley and Holahan, *The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?* May 2004. The Kaiser Commission on Medicaid and the Uninsured.

⁸ Jack Hadley and John Holahan, *How Much Medical Care Do The Uninsured Use, and Who Pays For It?* February 2003. Clinic and direct care programs include federally sponsored programs in the Bureau of Primary Health Care, Maternal and Child Health Bureau, National Health Service Corps, HIV/AIDS Bureau, Indian Health Service, Veterans Affairs, and local health departments.

⁹ RCW 70.170.060, Laws of 1989.

Hospitals also serve as the major source of specialty care for the uninsured. Community Health Centers/clinics are designed to serve the *primary care needs* of the uninsured and low-income populations, but very few have access to in-house specialty care and a majority of specialty referrals from community health centers are made to hospitals.¹⁰

Uncompensated Care at Washington Hospitals

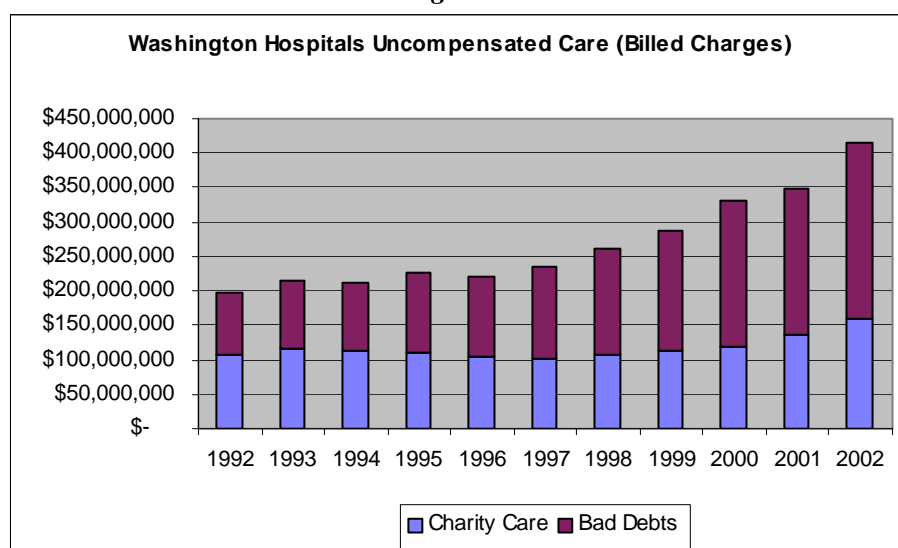
The 95 community hospitals licensed in Washington State submit financial reports to the state Department of Health, including equivalent billed charges (not costs) for charity care and bad debt. Statewide, uncompensated hospital care in Washington totaled \$416 million in 2002, up from \$349 million in 2001. Recorded charges for the *charity care component* totaled \$159 million, and uncollected billings or *bad debt component* totaled \$257 million in 2002.¹¹ Preliminary estimates of uncompensated care provided in 2003 indicate charity care may have increased an additional 57% and bad debt 48%.¹²

Over the last decade, uncompensated care provided in Washington hospitals increased in total billed dollars, as have all medical charges (Figure 2). Charity care charges have increased, though only slightly, while reported bad debt is increasing more rapidly.

Although accurate, this method of tracking uncompensated care may be misleading. For example, counts of charity care and bad debt use the value of ‘full charges’, however hospital charges exceed “costs”. Also, ‘bad debt’ includes a broad mix of revenues not collected, and broadly defined (often related to charges not costs) to achieve the largest allowable tax deduction. For example, the nation’s second largest for-profit hospital chain,

California-based Tenet HealthCare, reported bad debt expenses for 2003 as “70% from treating uninsured patients, 10% from unpaid balances of insured patients, and 20% from managed care firms”.¹³ It’s

Figure 2.



Source: Washington State Department of Health Hospital Financial and Utilization Data, Summary Reports 2002-1992

¹⁰ Suzanne Felt-Lisk. *The Uninsured: Examining Access to Specialty Care for California’s Uninsured*. California Healthcare Foundation. May 2004.

¹¹ Washington State Department of Health *Charity Care Report for 2002*, July 2004, and Hospital Financial and Utilization Data, Summary Reports 1992-2002. The discussion of statewide hospital uncompensated care excludes hospitals not licensed by the state that also provide care for the uninsured, e.g., federal Veterans Administration hospitals, military hospitals and two state-owned psychiatric hospitals. Washington State figures are not exclusively for the uninsured.

¹² Washington State Department of Health *hospTrends*, July 2004.

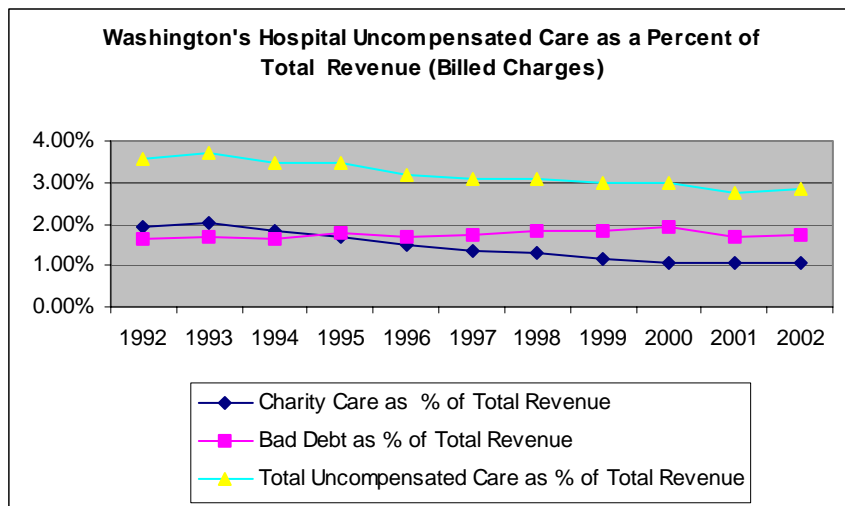
¹³ Kaiser Daily Health Policy Report, May 4, 2004, “Wall Street Journal Looks at Accounting Technique Used by Hospitals To Erase Debt Incurred From Uninsured Patients.”

interesting that they include in their bad debt their negotiated price arrangements with managed care plans.

An alternative view displays statewide hospital uncompensated care as a percentage of total billing revenue, and shows a modest decrease over the past decade. The charity care component in particular has

decreased steadily over the last decade (Figure 3).

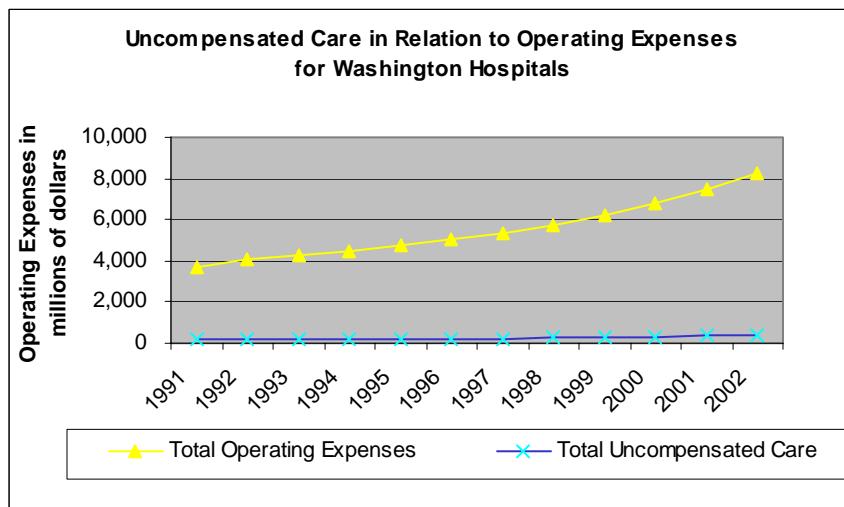
Figure 3.



Source: Washington State Department of Health Hospital Financial and Utilization Data, Summary Reports 1992-2002

While the statewide figures are compelling, it is important to note there is a range of experience across Washington. Experience varies by hospital type (for-profit, not-for-profit, public hospital district), location (urban, rural, frontier rural), and mission. For example, one urban public hospital, Harborview, is the single largest provider of hospital *charity care* (providing 30% of all statewide hospital charity care in 2002).¹⁴

Figure 4.



Source: Washington State Department of Health Hospital Financial and Utilization Data, Summary Reports 1992-2002

Figures 4 and 5 display uncompensated care in relation to rapidly increasing operating expenses for Washington hospitals, and as a percentage of operating expenses over time.

In general, Washington hospitals have fared better than the national experience. Statewide, hospital uncompensated care as a percent of operating expenses averaged 4.69% in 2001, compared to 6% nationally (2000). Although our large safety net hospital,

Harborview, was considerably more stressed than Washington hospitals overall, at 9.07%, it certainly fared better than the collective national experience of large urban safety net hospitals.

¹⁴ Department of Health, *Washington State 2002 Charity Care in Washington Hospitals*. July 2004.

Figure 5.

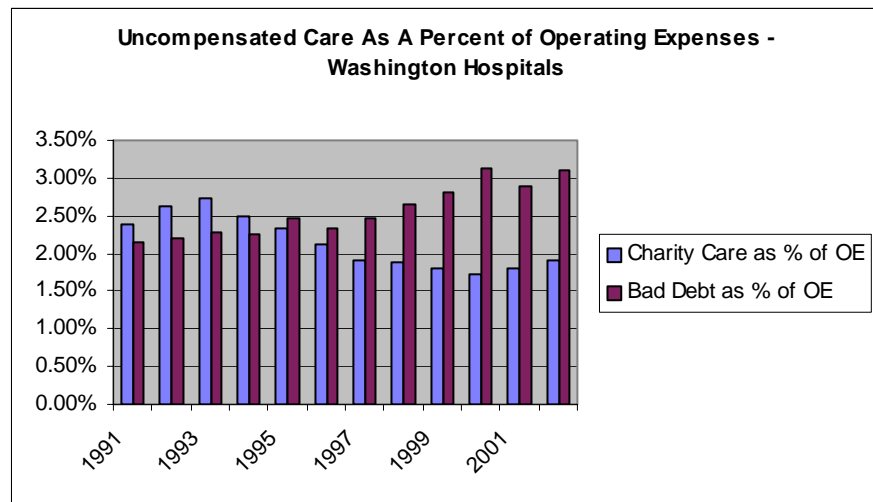
That is, the National Association of Public Hospitals and Health Systems reported that uncompensated care as a percent of operating costs averaged 24% in 2000 for large public hospitals.¹⁵

Community Health Centers - Safety-Net Clinics in Washington

The experience of “safety net clinics” or community health centers is represented here by the array of clinics that had grants in 2001 from

the federal Bureau of Primary Health Care (BPHC). BPHC awarded grants to 21 organizations in Washington, with 205 clinic sites throughout the state. The health centers are often called Federally Qualified Health Centers or FQHC’s. There are also “look-alike” clinics¹⁶ and a range of other safety net service providers, however, for simplification, this discussion focuses on the BPHC reported data. An analysis of historical data for the array of clinics with *state* grants from the Community Health Services program displayed similar demographics and trends.

By design these community health centers are located in areas with high concentrations of low-income and uninsured populations. In Washington, 90% of these clinics’ patients report incomes below 200% of the federal poverty level. Compared to Washington’s uninsured rate of 9.4%¹⁷, almost 34% of the patients served by community health centers are uninsured. An additional 55% of their patients are covered by public insurance programs: Medicaid, SCHIP, Basic Health, and Medicare. Only 11% of their patients are privately insured.¹⁸ (Figure 6, 2001 data)



Source: Washington State Department of Health Hospital Financial and Utilization Data, Summary Reports 1992-2002

¹⁵ National Association of Public Hospitals and Health Systems, *Safety Net Financing*, June 2003. The comparison of 2001 local to 2000 national data may concern some readers. However, we believe it’s safe to assume that uncompensated care nationally increased as it did in Washington. Thus, if 2001 national data were available it would strengthen the case that Washington hospitals, while being increasingly stressed, are better off than the national picture would show.

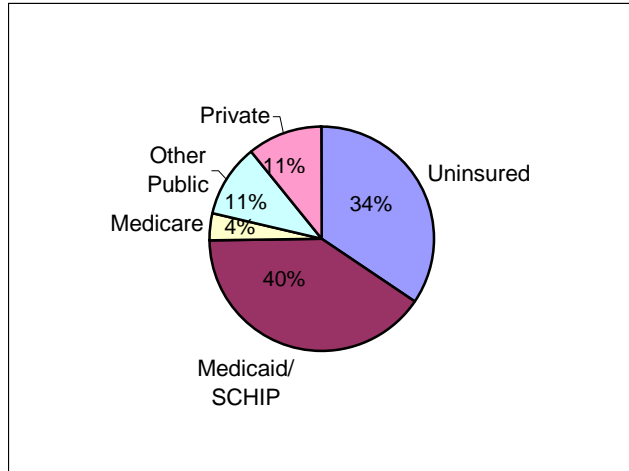
¹⁶ Look-alike clinics are very similar community health centers without federal qualifying grants.

¹⁷ Washington State Planning Grant analysis of State Population Survey 2002, available at <http://www.ofm.wa.gov/accesshealth/accesshealth.htm>.

¹⁸ Bureau of Primary Health Care: State Summary for Washington for 2001. Users by Socioeconomic Characteristics

Figure 6.

Community Health Center Patients by Insurance Status, Washington State 2001



Source: Bureau of Primary Health Care: State Summary for Washington for 2001. Users by Socioeconomic Characteristics

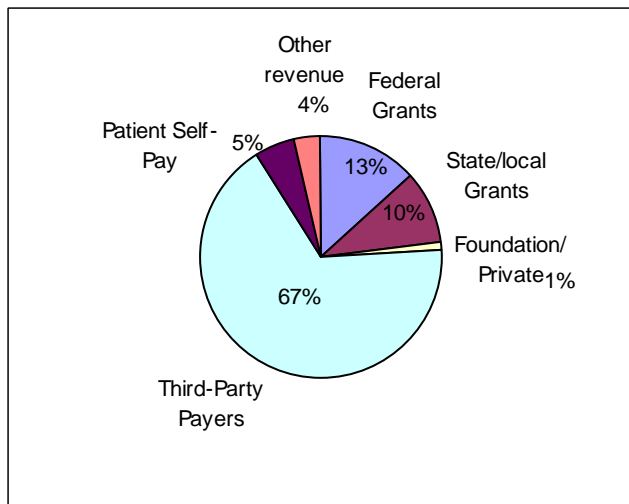
Figure 7.

Insurance Status of Community Health Center Patients – Washington State vs. Nationwide

BPHC Community Health Centers	Washington State ¹⁹	Nationwide ²⁰
Patients uninsured	34%	39%
Patients insured by Medicaid/SCHIP	40%	36%
Other Public insurance (e.g., Basic Health, Medicare)	15%	9%
Private Insurance	11%	15%

Figure 8.

Total Revenues Received by BPHC Grantees in Washington for 2001



Source: Bureau of Primary Health Care: State Summary for Washington for 2001.

During 2001, 24% of total revenues for these community health centers came from grants from federal, state/local governments and private foundations. Seventy-two percent of revenues were from service provided to patients, with approximately 67% from third-party insurance payers. (Figure 8). Of the third-party insurance, Medicaid and Medicare and other public programs represented 94%. All in all, community health centers receive nearly 90% of their total revenues from public sources – including federal, state and local grants; and, public insurance programs like Medicaid, Medicare, and other public insurance like Basic Health.

¹⁹ Bureau of Primary Health Care: State Summary for Washington for 2001. Users by Socioeconomic Characteristics

²⁰ Sara Rosenbaum, Peter Shin, Julie Darnell. *Economic Stress and the Safety Net: A Health Center Update*. June 2004. Kaiser Commission on Medicaid and the Uninsured.

This safety net dependence on public funding is critical in the context of reductions in public insurance programs, and increases in the number of uninsured patients. After recent reductions in public insurance programs (Basic Health and Medical Assistance) community health centers in the Community Health Network in Washington reported a 50% increase in the number of uninsured patients between January 2002 and December 2003.²¹

Public Financing Links

In addition to public insurance, several public financing mechanisms have been designed to help support safety net care provided by hospitals and community health centers. Financing mechanisms include disproportionate share hospital payments (DSH), supplemental payment programs, indirect medical education, indigent payment programs, trauma care payments, state and local taxes (appropriations and exemptions), and direct grants, among others.

The array of financing approaches is disconnected, complex, and inefficient at targeting the uninsured. For example, many financing mechanisms are linked to Medicaid patient loads for calculation and distribution and often do not reflect the distribution of uninsured patients, nor the costs of care provided to the uninsured. The adequacy of the financing as a match for the amount of care provided at individual hospitals or clinics varies considerably. In large part, the financing sources are not tied directly to care provided to the uninsured. Rather, many financing sources are provided in block grant formats or through Medicaid add-ons. As a result, there is little accountability for ensuring that the money in fact supports care for the uninsured.

A summary of some key financing sources that are available to partially support care for the uninsured is in Table 1. While some financing sources are directly targeted at serving the uninsured, others are assumed to provide indirect support and only a small portion may in fact support care for the uninsured. Some will argue that these financing sources, like Medicaid DSH and Medicare DSH, only begin to cover the costs for serving publicly insured patients and thus are not available to support care for the uninsured. Or, that sources such as Indirect Medical Education (IME) have little, if anything to do with serving the uninsured, but are intended to recognize the higher costs of care provided to anyone treated in a teaching hospital (e.g., greater use of technologies, and diagnostic and therapeutic services for teaching purposes). The summary table of potential financing sources is not intended to initiate a debate over the adequacy of payment rates for Medicaid and Medicare nor the adequacy of financing for the uninsured, but portray an array of sources that arguably could help support costs of care for the uninsured.

²¹ Rebecca Kavoussi and Erin Burchfield. *Stretching the Safety Net: The Rising Uninsured at Washington's Community Health Centers*. May 2004. The Community Health Network includes 250 primary care clinics and provider offices throughout Washington, most are BPHC sites but not all.

Table 1.
Financing Mechanisms and Examples in Washington State

Financing Mechanism and Origin of \$	Washington State Examples for 2001 (Aggregate statewide budget figures, sources not available to all facilities)
Medicare (Federal) and Medicaid (Federal and State) <ul style="list-style-type: none"> Disproportionate Share Hospital Payments (DSH) – payment adjustment for large numbers of Medicare and Medicaid patients. Upper Payment Limit (UPL) programs - supplemental payments for some hospitals and nursing homes Indirect Medical Education (IME) adjustment for teaching costs related to graduate medical education (GME) Cost-Based Reimbursements for qualified hospitals and clinics 	Medicaid Examples: ²² <ul style="list-style-type: none"> DSH: \$42.2 million in payments to hospitals UPL: \$9.2 million in flat payments to Hospital-based nursing homes (known as ProShare payments; not directly linked to uninsured) IME/GME: \$8.3 million to two hospitals with graduate teaching programs Medicaid Cost-Based Reimbursement payment adjustments of \$5.6 million for Critical Access Hospitals and approximately \$65 million for Federally Qualified Health Centers
State and Local Payments <ul style="list-style-type: none"> Indigent care programs Trauma Care Payments Uncompensated care pools 	Example of State Funded Indigent Program: ²³ <ul style="list-style-type: none"> Medical Assistance Medically Indigent Program: \$33.6 million payments to 33 hospitals in 2001 (<i>Program eliminated by 2003 Legislature, partially replaced with hospital DSH grants for rural and urban hospitals</i>) Trauma Care Payments (DOH program linked to trauma care for the uninsured = \$5 million.) Medicaid Hospital Trauma Payments: Payments of \$24 million to hospitals for trauma care exclusively for Medicaid patients.
Tax Appropriations (State and Local) Tax income appropriated directly or through exemptions	Examples of Washington Tax Exemptions: ²⁴ <ul style="list-style-type: none"> Hospital property tax exemptions: \$32 million in 2001 (state \$7.33 million; local \$24.69 million) Hospital laundry services – sales tax exemption \$139,000 in 2001 Hospital business and occupations tax exemptions on revenues from public programs (Medicare, Medicaid, Basic Health) – estimated at \$20 million Examples of Washington direct tax appropriations: \$50 million in tax revenues in 2001 (41 local public hospital taxing districts) ²⁵
Direct Grants for Care (Federal, State and Local) Federal examples: Bureau of Primary Health Care; National Health Service Corps; Maternal and Child Health Bureau; Indian Health Service; Department of Veterans Affairs; HIV/AIDS;	Direct Grants for Care – State example <ul style="list-style-type: none"> State grants for medical and dental services through Community Health Services grants to clinics of \$6 million in 2001 to 29 clinics with 120 sites.²⁶ (<i>Grants were increased \$2.5 million, 25%, in FY04</i>)
Private Sources: Private philanthropy; foundation grants; financial surplus; other	

²² Washington State Medical Assistance Administration Hospital Analysis for Calendar Year 2001

²³ Washington State Medical Assistance Administration Medically Indigent Program Payments to Hospitals for 2001

²⁴ Washington State Department of Revenue, Summary of Tax Exemptions for Washington Non-Profit Hospitals cy2001. (Representing approximately 69 non-profit hospitals)

²⁵ Washington State Department of Health hospital financial reports, and Association of Washington Public Hospital Districts

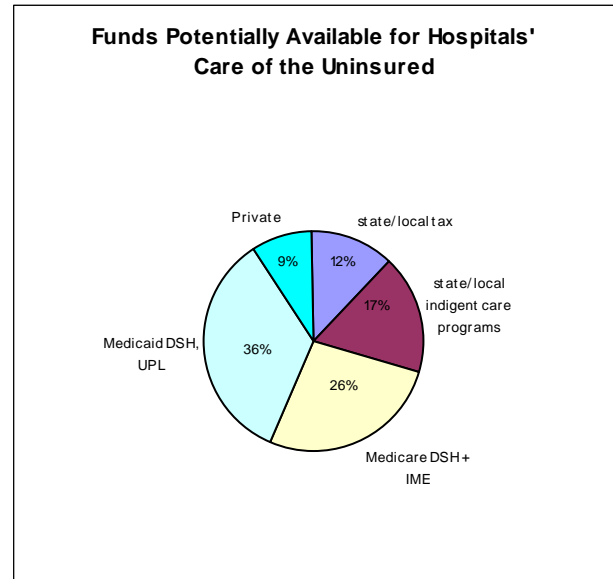
²⁶ Washington State Health Care Authority, Community Health Services grant program.

Although not readily available for Washington, Figure 9 shows the relative distribution of these financing mechanisms for hospitals nationally, and points out the significance of federal/state DSH dollars.

Not only is the mix of sources complex, it's made even more so by the changing nature of some sources. For example, Table 2's contents show the extent to which Congress and federal agencies modify some sources over time.

The majority of resources are directed to hospitals where the majority of uncompensated care appears to be provided.

Figure 9.



National estimates from Hadley and Holahan, 2003

Table 2. Highlights of Federal Action on Key Financing Mechanisms:
Disproportionate Share- DSH, Intergovernmental Transfers-IGTs, Provider Taxes
and Upper Payment Limits -UPLs

1981	Congress requires states to make additional payments to DSH hospitals for inpatient services
1987	<ul style="list-style-type: none"> Congress establishes a minimum federal standard for qualifying as a DSH hospital CMS issues UPL regulation limiting aggregate payments to state operated hospitals and nursing facilities and all other hospitals and nursing facilities
1991	<ul style="list-style-type: none"> Congress establishes detailed rules for provider taxes used to generate revenues as state share of Medicaid spending Congress prohibits CMS from restricting IGTs of state or local tax revenues Congress limits DSH spending in each state to 12% of total Medicaid spending
1993	<ul style="list-style-type: none"> Congress imposes facility-specific ceilings on the amount of DSH payments states may make to DSH hospitals
1997	<ul style="list-style-type: none"> Congress specifies and phases down over FY 1997-FY2002 allotments of federal DSH funds for each state
2000	<ul style="list-style-type: none"> Congress increases state-specific allotments of federal DSH funds for FY 2001 and 2002, and requires CMS to issue regulations applying UPLs to providers owned or operated by local governments, allowing for a transition period of up to 8 years
2001	<ul style="list-style-type: none"> CMS issues regulations establishing UPLs for local public providers and transition periods
2003	<ul style="list-style-type: none"> Congress increases state-specific allotments of federal DSH funds for FY 2004 by 16% Congress increases lid for allowable facility level DSH payments from 100% of costs incurred by the hospital for serving Medicaid and uninsured patients for which it has not been compensated by Medicaid, to 175% of such uncompensated costs. (for two state fiscal years following 9/30/02)

Source: David Rouseau and Andy Schneider, Current Issues in Medicaid Financing – An Overview of IGTs, UPLs, and DSH. April 2004. Kaiser Commission on Medicaid and the Uninsured.

The financing mechanisms that support uncompensated care for the uninsured in community health centers face similar challenges. Although total *federal* funding for community health centers grew roughly 7% between 2002 and 2003, the number of uninsured patients increased more rapidly with a nationwide increase of 11%. Despite increased federal investment in grants, it is estimated that for every uninsured, low-income patient a health center treats, there are four others needing their services.²⁷

Across the nation, *state* support for community health centers has been declining. Of the 31 states that provided direct funding in fiscal year 2004, at least 17 states cut their level of dedicated state funding of health centers; three eliminated funding entirely, nine states provided level funding, and just four increased their funding – including Washington State.²⁸ While state grant support for community health centers in Washington was increased for fiscal year 2004, the funding has not replaced the revenue lost from cuts in public insurance coverage.

POLICY CONSIDERATIONS

Examining trends in uncompensated care provided by Washington's community hospitals and community health centers raises questions and a desire for more detailed analyses. It appears the financing mechanisms that have been available to help support uncompensated care are changing, and the delicate balance of public insurance payments, grants, Medicaid and Medicare-add-ons that our 'safety-net' hospitals and community centers depend on is likely to shift and crumble with an increase in the uninsured and declining financial assistance.

It is time to initiate a fresh public policy debate and clarify our commitment to ensuring the uninsured have access to care – and how best to deal with the expenses. Three main policy recommendations are identified below for consideration by state policy makers. These include expanding our charity care policy; examining performance and accountability expectations for tax expenditures and subsidy payments; and clarifying the policy tradeoffs (and hidden costs) of investing in insurance coverage versus subsidies for uncompensated care.

Expand Washington's Charity Care Policy

Our current charity care law ensures access to free hospital care for emergent medical needs for people with incomes up to 100% of the federal poverty level (FPL); and a sliding scale discount from full charges for those with incomes up to 200% FPL. Changes could include modifications in income eligibility and a move away from using 'full charges' for the uninsured, both in sliding scale discount calculations and in recording charity care provided.

A re-evaluation of our charity care law could be linked with recent studies on affordability and income adequacy, which indicate that people with incomes below 200% FPL, and in some cases to 250% FPL, have no disposable income after taking care of basic living expenses like food and shelter.²⁹

There is a growing interest across the nation in clarifying expectations and accountability for charity care and favorable tax arrangements provided at the state and federal level. Lawsuits filed against hospitals across the country allege hospitals are over-billing uninsured patients. As of October 49 lawsuits have

²⁷ Sara Rosenbaum, Peter Shin, and Julie Darnell. *Economic Stress and the Safety Net: A Health Center Update*. June 2004. Kaiser Commission on Medicaid and the Uninsured.

²⁸ Rosenbaum, Shin, and Darnell. June 2004. Washington State direct grant support for the Community Health Services program increased 25% for FY 2004, to help offset cuts in public insurance coverage.

²⁹ *Income Adequacy and the Affordability of Health Insurance*. Washington State Planning Grant, June 2002. <http://www.ofm.wa.gov/accesshealth/products.htm>

been filed against 370 hospitals across the country, including the Providence Health System in Washington.³⁰ Historically, hospitals have billed uninsured patients “full charges” while billing all insured patients discounted contracted rates. The lawsuits assert that hospitals have an explicit or implicit contract with the federal government to serve the uninsured in exchange for the federal tax breaks they receive as ‘charitable institutions’. Similar discussions have been underway in Illinois regarding non-profit hospitals and their charitable obligations in exchange for state tax breaks. These tax discussions warrant monitoring for their larger implications.³¹

A potentially precedent setting lawsuit settlement agreement with the largest rural not-for-profit health system in the country (North Mississippi Medical Center), provides a potential model for policy change in Washington. The agreement would require the system to provide free care for patients making up to 200% FPL, and to use sliding discounts from the Medicare rates (not charges) for patients between 200% and 400% FPL.

Examine Performance and Accountability Expectation of Tax Expenditures and Subsidy Payments

A full range of financing mechanisms help support uncompensated care provided at hospitals and community health centers. The array of financing approaches is disconnected, complex and inefficient at targeting the uninsured. In large part, the financing sources are not tied directly to care provided to the uninsured; as a result there is little accountability for ensuring the money supports care for the uninsured.

Principles used for the development of the Governor’s budget and the policy priorities widely apply performance and accountability expectations for every program and activity in state government. It is time to examine the direct subsidy payments and tax expenditures and apply performance and accountability expectations to all of our budget expenditures.

For example, Washington State has favorable tax treatment for non-profit hospitals that has been on the books since 1886 - longer than we have been a state.³² Although the tax exemptions likely protect consumers from paying the additional costs, it may be time to formally examine these lost revenues or budget expenditures and clarify the obligations expected in exchange. Are these tax expenditures targeted appropriately, efficiently, and fairly? Should they be considered in conjunction with all other budget and policy decisions, with similar expectations for accountability of these funds?

Policy Tradeoffs of Investments in Insurance vs. Subsidies for Uncompensated Care

As we examine our policy commitment to ensuring access to care, it is important to understand the tradeoffs (and hidden costs) of investing in insurance programs or in provider subsidy payments for uncompensated care. Investments in insurance coverage are more effective at increasing access to care among low-income populations.³³ In addition, it appears that investments in insurance may be more effective at reducing emergency room use than an equal investment in community health center

³⁰ Washington State Hospital Association, *Weekly Report*, October 1, 2004.

³¹ Kaiser Daily Health Policy Reports, June 29, 2004; August 10, 2004.

³² Washington State Department of Revenue. Examples of Washington Tax Exemptions: Hospital property tax exemptions: \$32 million in 2001 (state \$7.33 million; local \$24.69 million); Hospital laundry services – sales tax exemption \$139,000 in 2001; Hospital business and occupations tax exemptions on revenues from public programs (Medicare, Medicaid, Basic Health) – estimated at \$20 million.

³³ John Holahan and Brenda Spillman. *Health Care Access for Uninsured Adults: A Strong SafetyNet Is Not the Same as Insurance*. The Urban Institute. January 2002; Jack Hadley and Peter Cunningham. *Availability of Safety Net Providers and Access to Care of Uninsured Persons*. Health Services Research, October 2004. *Sicker and Poorer: the Consequences of Being Uninsured*. Kaiser 2002; Institute of Medicine, *Hidden Costs, Value Lost: Uninsurance in America*. June 2003; Institute of Medicine. *Care Without Coverage: Too Little, Too Late*. 2002.

expansions.³⁴ (The same investment exclusively in community health centers increases access to primary care but the lack of specialty care available in these centers increases hospital emergency room use.)

Insurance payments also offer a more stable revenue source for community health centers and hospitals that more closely reflect the costs of care provided to individuals at specific facilities, compared to the partial subsidies available for uncompensated care through block grants and Medicaid add-ons. For example, enrollment in public insurance coverage significantly reduced hospital uncompensated care in Minnesota. For each one-percentage point increase in enrollment, there was a \$2.19 decrease in uncompensated care spending per capita. The four-year savings in uncompensated care spending amounted to \$58.6 million.³⁵

Investing in insurance programs to serve the uninsured rather than continuing subsidies for uncompensated care may free up some of the dollars currently supporting subsidies. Dollars associated with financing sources intended to help support the costs of care for the uninsured appear to be roughly equal to reported charity care 'billings'. For example, special payments and tax exemptions for hospitals in 2001 equaled roughly \$224 million; while hospitals reported charity care charges of \$135 million. Although a comprehensive redesign of these funding mechanisms requires federal action, some of these funds could be re-directed at the state level.

At a minimum, it's time to review options and open discussions about placement of dollars to most effectively impact the health of Washingtonians.

MAKING HEALTH CARE WORK FOR EVERYONE

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This paper reflects the research and opinions of the State Planning Grant staff. If you have concerns or desire further information on Washington's uninsured population:

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Additional information is available at: <http://www.ofm.wa.gov/accesshealth/accesshealth.htm>

³⁴ Peter Cunningham and Jack Hadley. *Expanding Care Versus Expanding Coverage: How To Improve Access to Care*. Health Affairs July/August 2004.

³⁵ Lynn Blewett, Gestur Davidson, Margaret E. Brown, and Roland Maude-Griffin. University of Minnesota, State Health Access Data Assistance Center. *Hospital Provision of Uncompensated Care and Public Program Enrollment*. Medical Care Research and Review, December 2003; *Expanding Access to Health Insurance Coverage Lessons the Burden of Uncompensated Care*. SHADAC Issue Brief, December 2003.