MDH Minnesota Department of Health

HEALTH ECONOMICS PROGRAM

Issue Brief: Uncompensated Care at Minnesota Community Hospitals in 2014

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Lack of protection from health care costs, either through inadequate health insurance coverage or insufficient patient financial resources, can result in health care providers not being reimbursed for provided services. This unreimbursed care, also known uncompensated care is composed of charity care and bad debt. It is viewed as an indicator of financial burden that can restrict access to health care services. The Affordable Care Act (ACA) attempts to reduce this type of burden by increasing the number of people with health insurance and limiting total out-of-pocket costs for people with health insurance.

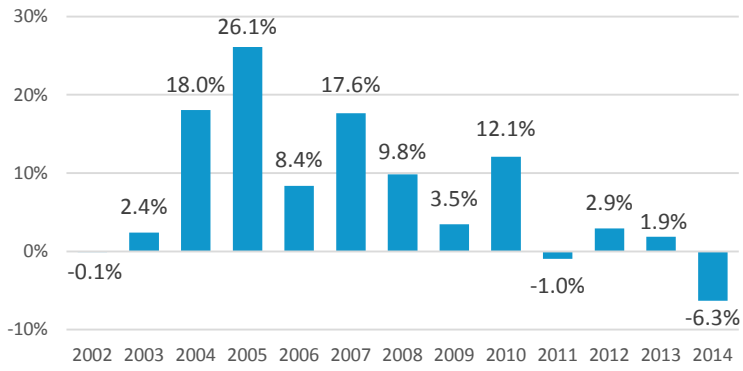
This new Minnesota Department of Health (MDH) analysis of hospital financial data finds that total hospital uncompensated care in Minnesota decreased significantly in 2014, by 6.3 percent, reaching $294 million.[1] Other findings include:

- The decrease in uncompensated care was driven entirely by a sharp decline in the need for charity care – care provided as free or discounted care to patients deemed eligible by hospitals;
- Charity care fell to a greater extent for patients without insurance (24.6 percent) than patients who had coverage (17.8 percent);
- Bad debt – uncompensated care for patients not eligible for free care – did rise by 9.4 percent; and
- The $35 million reduction in charity care greatly exceeded the simultaneous $15 million increase in bad debt.

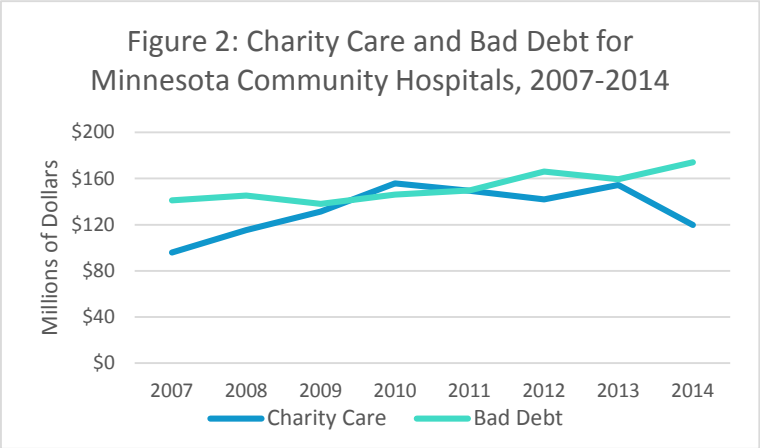
Changes in Hospital Uncompensated Care in Minnesota

Uncompensated care provided by Minnesota hospitals declined by an unprecedented 6.3 percent in 2014 (Figure 1), falling to $294 million, its lowest level since 2009. This decline is only the second drop recorded since 2001; it coincides with a significant drop in the proportion of Minnesotans who lacked health insurance. Uncompensated care in 2014 accounted for a smaller share of operating expenses, 1.9 percent, than in the preceding nine years.

Figure 1: Percent Change in Total Hospital Uncompensated Care from Previous Year, 2002-2014



Source: MDH Analysis of Preliminary Hospital Annual Reports



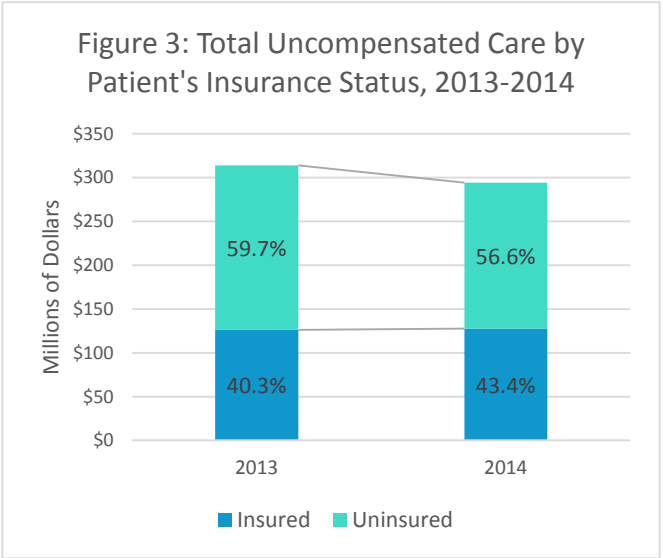
Source: MDH Analysis of Preliminary Hospital Annual Reports

Uncompensated care consists of two components: charity care, services for which no payment is expected because the patient is eligible for free or discounted care; and bad debt, unreimbursed care for patients deemed ineligible for free or discounted hospital care. The decline in uncompensated care in 2014 was driven by a sharp drop in charity care, which declined 22.4 percent ($34.6 million) (Figure 2).

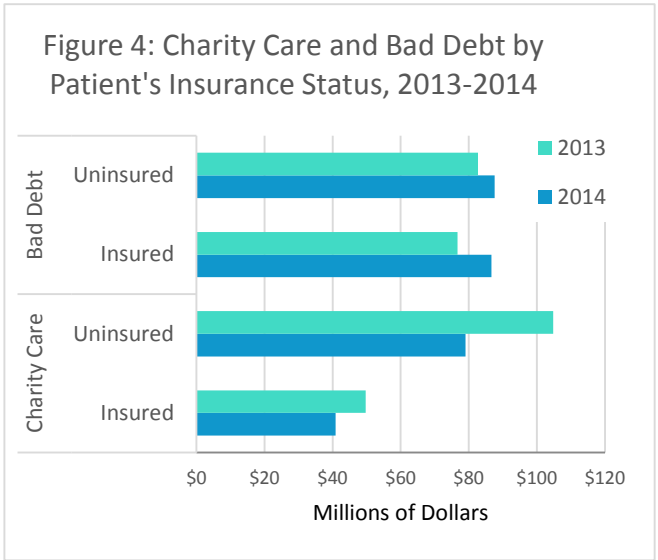
In contrast, bad debt increased by 9.3 percent ($14.9 million) in 2014, to $174.2 million. While bad debt has generally been rising at rates below 10 percent, charity care grew at double-digit rates through the recession, until growth moderated in 2011. The 22.4 percent drop in charity care in 2014 was preceded by an uptick in 2013 of nearly 9 percent.

Uncompensated Care by Health Insurance Coverage Status

Both uninsured and insured patients can cause providers to incur uncompensated care. Historically, people without health insurance accounted for the majority of uncompensated care. While this remains the case in 2014, the drop in uncompensated care for the uninsured was so significant that it more than offset a small increase in uncompensated care for patients with insurance coverage (Figure 3). Uncompensated care for the uninsured decreased by 11.2 percent, from $187.5 million to $166.6 million, between 2013 and 2014. In contrast, uncompensated care for insured patients rose slightly by 0.9 percent, from $126.3 million to $127.4 million.



Source: MDH Analysis of Preliminary Hospital Annual Reports



Source: MDH Analysis of Preliminary Hospital Annual Reports

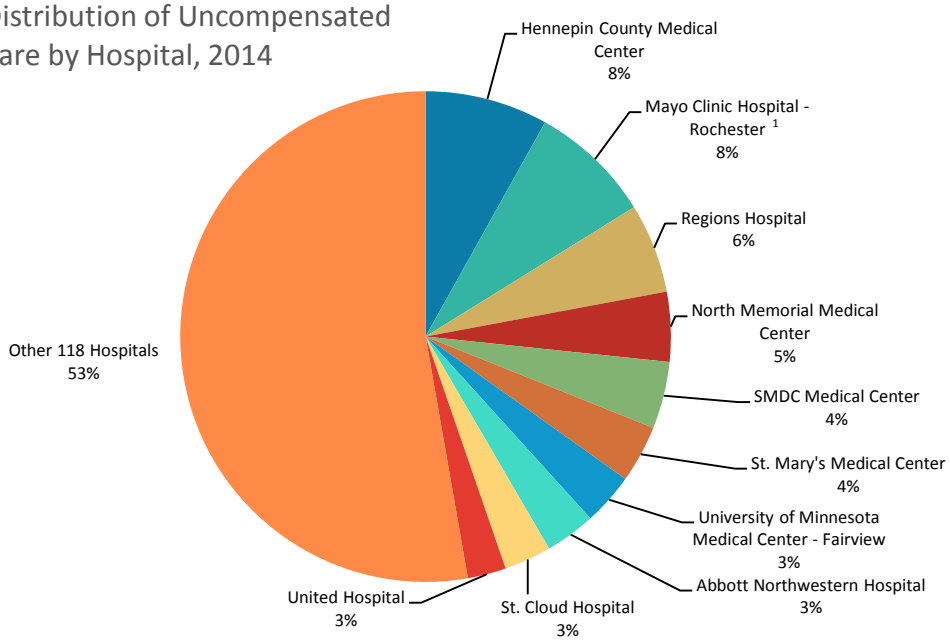
There are consistent patterns within each component of uncompensated care when reviewed by insurance coverage status, as shown in Figure 4. Charity care decreased for all patients, regardless of insurance status. However, charity care for uninsured people decreased by a larger margin than for insured people (24.6 percent and 17.8 percent, respectively).

While bad debt increased regardless of insurance status, the increase in bad debt was more pronounced for people with insurance coverage (13.0 percent) than for people who lacked health insurance that year (5.9 percent). This increase likely reflects the growing impact of cost-sharing requirements, and their effect on insured patients deemed ineligible for charity care.

Largest Providers of Uncompensated Care

As in the past, Hennepin County Medical Center was the single largest provider of hospital uncompensated care in 2014, followed closely by the two Mayo Clinic hospitals in Olmstead County. The largest providers of hospital uncompensated care accounted for about half (47 percent) of total uncompensated care. Uncompensated care represented a smaller share of these hospitals' operating expenses in 2014 than the year before. In aggregate, uncompensated care as a share of operating expenses fell from 2.1 percent in 2013 to 1.9 percent in 2014.

Figure 5: Distribution of Uncompensated Care by Hospital, 2014



Source: MDH Analysis of Preliminary Hospital Annual Reports
[1] Two Rochester facilities merged into one hospital with two campuses

Conclusions

Hospital uncompensated care in Minnesota fell at unprecedented levels in 2014, the same year in which major coverage provisions of the ACA took effect in Minnesota and throughout the U.S. The coverage expansion provided by the ACA, the establishment of MNSure, and the new insurance benefit requirements may all be factors contributing to lower unreimbursed care at hospitals. The highly aggregated data used in this analysis cannot prove a causal relationship

between the ACA's policy changes and changes in hospital uncompensated care. Nonetheless, three factors suggest the ACA's coverage changes likely played a major role in the decline in hospital uncompensated care in Minnesota in 2014:

- The decline in uncompensated care overlapped in its timing with the substantial fall in uninsurance brought on by the ACA;
- Numerically, the drop in uncompensated care was driven primarily by a decline in charity care for the uninsured; and
- The magnitude of the decline in uncompensated care (as well as the uninsurance rate) was large relative to historical trends.

Minnesota can make a more empirically-based assessment of the impact of coverage changes on uncompensated care trends by studying data from other states and monitoring future trends for Minnesota hospitals. Additionally, the increase in bad debt suggests it is important to also monitor and assess the sources and causes of bad debt.

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[1] This issue brief represents conclusions drawn from preliminary data for hospital fiscal year 2014 from 126 hospitals, out of a total of 139 community hospitals. Fiscal year 2014 for some hospitals may include service dates for 2013 and for others, in calendar year 2015.