

Uncompensated Health Care In Minnesota

**An Interim Report
to the Legislature**

February 1999

Health Economics Program
Health Policy and Systems Compliance Division
Minnesota Department of Health

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Minnesota Department of Health
121 East Seventh Place
St. Paul, MN 55105



Protecting, Maintaining and Improving the Health of All Minnesotans

February 1999

Dear Colleague:

Minnesota has been a national leader in providing access to health insurance for its citizens. We have among the lowest rates of uninsurance in the nation, and have made progress at reducing the number of uninsured children and low-income uninsured individuals in the state. In spite of the state's efforts, however, 280,000 to 400,000 Minnesotans still lack health insurance coverage, and others remain underinsured. The cost of providing care to these individuals who are either unable or unwilling to pay for health care, called uncompensated care, has become a problem of increasing concern in Minnesota. Despite evidence that aggregate levels of uncompensated care have declined in Minnesota since the implementation of MinnesotaCare, the burden of uncompensated care is very unevenly distributed, with a relatively few providers bearing much of the overall burden.

Recognizing these concerns, the 1998 Minnesota Legislature directed the Minnesota Department of Health to conduct a study on the issue of uncompensated care in Minnesota. In particular, the Legislature directed the Commissioner to document the extent of uncompensated care provided in Minnesota and discuss the feasibility of and evaluate options for financing uncompensated care in Minnesota.

This interim report details the findings of the study and provides options to the Minnesota Legislature for addressing the issue of uncompensated care. The issue of uncompensated care is complicated because the nature of health care financing in Minnesota and the U.S. is very complex. It is therefore clear that there is no single solution to the issue of uncompensated care, but it will rather take a variety of approaches to continue to make progress at reducing the burden. In order to refine and build consensus on policy recommendations for future legislative and private sector action, I plan to convene a workgroup of stakeholders on this topic early this spring.

The Minnesota Department of Health looks forward to continued work on this important issue. Questions and comments on the report can be directed to the Health Economics Program at (651) 282-6367.

Sincerely,

A handwritten signature in black ink, appearing to read "Jan K. Malcolm".

Jan K. Malcolm
Commissioner of Health

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Introduction

Minnesota has been a leader in providing health insurance coverage to its citizens, both through private-sector employer-based offerings and through public-sector health insurance programs. As a result, Minnesota boasts one of the nation's lowest uninsurance rates, and through targeted subsidy programs, has substantially reduced the number of uninsured low-income Minnesotans and uninsured children. However, in spite of its efforts to expand coverage options, Minnesota still has 280,000 to 400,000 individuals who lack health insurance coverage at any point in time. In addition, many individuals have health insurance coverage which, while providing insurance against catastrophic illnesses, have large co-pays and deductibles, which can be difficult to cover for some low-income Minnesotans.

The provision of care to individuals who either lack health insurance coverage, or who have coverage but are unable or unwilling to pay for deductibles or copays, has become an issue of increasing concern among Minnesota legislators. Although evidence suggests that the aggregate levels of such care, often called "uncompensated care," provided to these individuals has stabilized or declined since the implementation of MinnesotaCare, the distribution of such care among Minnesota's health care providers is unevenly and disproportionately distributed, with a large amount of the burden of uncompensated care falling on a relatively few providers.

The consequences of the level and uneven distribution of uncompensated care are many. Tax payers in counties with public hospitals providing large levels of uncompensated care carry a disproportionate burden. Hospitals providing large levels of uncompensated care, which also frequently see large numbers of public program enrollees, may find it more difficult to compete and to maintain their safety-net infrastructure. In addition, individuals seeking care in a charity care setting frequently access the health care system in the most expensive ways, using emergency rooms to receive care. Not only is this a cost inefficient manner to access health care, but it also limits the likelihood of early intervention and continuity of care.

For those reasons, among others, the 1998 Minnesota Legislature directed the Department of Health to study and report on uncompensated care in Minnesota, in consultation with the Minnesota Department of Human Services, associations representing health care providers and institutions, and representatives of consumer advocates and Minnesota counties.¹ The statute directs the department to:

- (1) document the extent of uncompensated care provided in Minnesota;
- (2) discuss the feasibility of and evaluate options for financing uncompensated care, including but not limited to:
 - (i) modifying the eligibility standards for the MinnesotaCare and general assistance medical care programs, and
 - (ii) allowing providers to bill other counties for uncompensated care provided to residents of those counties;
- (3) evaluate approaches used by other states to monitor and finance uncompensated care; and
- (4) describe alternative approaches to encourage health care coverage.

In the course of this study, Department of Health staff met with representatives of Hennepin County Medical Center and Regions Hospital and staff of the Minnesota Hospital and Health Care Partnership. Staff also met with organizations representing community health clinics, such as the Neighborhood Health Care Network, the Minnesota Primary Care Association, the Hennepin County Community Health Department, and the Association of Community Mental Health Care Providers. In addition, staff met with the Association of Minnesota Counties and various consumer advocates, including the Minnesota Legal Services Advocacy Project, the Minnesota State Council on Disability, the Mental Health Association, the Minnesota Aids Project, the Minnesota Seniors Association, and the Minnesota Nurses Association. In order to solicit input from other organizations that might have an interest in the study, a survey on uncompensated care was mailed to 26 associations representing health care providers, health care institutions, and consumer advocates. Department of Health staff consulted with the Department of Human Services throughout the course of the study.

This report documents and highlights the complicated causes and financing of uncompensated care in Minnesota and the U.S. As the report details, a lack of health insurance coverage and a patchwork of health care financing mechanisms lead to a problem that does not have a single solution. In recognition of this and to refine and build consensus on policy recommendations for future legislative and private sector activity, the Department intends to convene a work group of stakeholders starting in the spring of 1999 to work and develop consensus on this important issue prior to the 2000 legislative session.

This interim report is intended as a starting point for those discussions. It presents findings and a list of options for addressing uncompensated care. These options fall into a number of categories of approaches, and serve to highlight the complex nature of the uncompensated care problem. Part One of the report presents our findings. Part Two of the report describes options for reducing the levels of uncompensated care and for financing the cost of such care, based on the findings. The Appendices provide background information on the study methodology and data sources, including issues related to the collection of data.

Uncompensated Care

Uncompensated care is defined as the sum of “charity care” and “bad debt.”² Charity care is the dollar amount of care a provider rendered with no expectation of payment. Charity care is in general provided to a population deemed eligible by the provider of medical care. Bad debt is the dollar amount that has not been paid in full or in part from a patient or third-party, but for which the provider expected payment. For the purpose of this report, and consistent with accepted definitions, contractual adjustments and losses due to low reimbursement rates are excluded from uncompensated care.³

The distinction between charity care and bad debt is helpful in understanding the components of uncompensated care. Charity care services are provided at no cost or on a sliding fee scale. Individual hospitals and clinics typically determine eligibility standards based on one of the following criteria or combination of the criteria:

- (a) income as some percent of the Federal Poverty Guidelines;
- (b) assets; and/or
- (c) denial of an application for public program assistance.

Clearly, the provision of charity care is targeted to benefit persons who are unable to pay for their hospital care or health care expenses, frequently perhaps because they are uninsured. Knowledge about the level of charity care provided is important for the community and the legislature, as well as for hospitals and clinics in order to understand the level of health care needs in the community, to examine the progress toward health care access goals, and to help understand the degree to which providers are stepping in to provide access to services for those individuals without insurance coverage.

Bad debt illustrates a different type of financial burden that providers are exposed to and that affects the financial health of hospitals and clinics. Bad debt occurs when patients do not pay their bills, i.e. they are losses from the hospital extending credit. The level of bad debt amassed by hospitals, clinics, and other providers therefore, is a “measure of the effectiveness of the organization’s credit and collection process.”⁴

These definitions, while generally accepted in the areas of health research and accounting, are not universally applied within the health care industry. As a result, comparing reported data on charity care and bad debt across hospitals and providers is difficult. Two accounting practices are responsible for the large variations in reporting. Some providers overstate charity care because they attempt to collect on bills classified as charity care. Other providers overstate bad debt because they include charity care in bad debt. The issue of lack of uniformity in the reporting of uncompensated care resulting from the use of inconsistent definitions of charity care and bad debt is discussed further in part one and part two of this report, and is significant because of policy implications.

The Department of Health recognizes and wishes to stress the need to collect accurate and verifiable information on charity care and bad debt. The legislature, in examining these issues, should focus efforts on reducing the need for the availability of care without compensation. Accurate information on the levels of charity care provided is therefore crucial.

Table 1 shows an aggregation of uncompensated care from known and available data sources. The Department of Health recognizes that this list is incomplete and does not include the charity care and bad debt burdens of other providers, such as ambulance services, chiropractors and dentists. In addition, we do not know the extent to which cities and counties incur medical costs for persons in detention. However, this is the first attempt to aggregate data across provider types and should be considered a first step toward developing accurate and complete overall uncompensated care estimates.

Table 1: Estimated Aggregate Minnesota Uncompensated Care (Millions of Dollars) and as a Percent of Total Costs in 1996

	Charge-Based	Cost-Based
Clinics*		
Uncompensated Care	\$71.8	\$71.8
Uncompensated Care as Percent of Expenses	2.2%	
Hospitals		
Uncompensated Care	\$130.5	\$81.2
Uncompensated Care as Percent of Expenses	2.8%	1.7%
Neighborhood HC Network**		
Uncompensated Care †	\$4.1	\$3.6
Uncompensated Care as Percent of Expenses	14.0%	12.3%
MN Primary Care Association		
Uncompensated Care ‡*	\$3.9	\$3.9
Uncompensated Care %		17.2%
MN Association of Community Mental Health Programs		
Uncompensated Care †	\$5.0	\$5.0
Uncompensated Care as Percent of Expenses	7.7%	
Total Minnesota Uncompensated Care	\$215.3	\$165.5^Y

Sources: Minnesota Department of Health, Health Care Cost Information System with adjustments, December 1998; Provider Financial and Statistical Report, December 1998; Neighborhood Health Care Network/Community Clinic Reporting System, January 1999; Minnesota Primary Care Association, January 1999; Minnesota Mental Health Association, January 1999.

Notes: Hospital uncompensated care is reported charge based, calculated from the hospitals charges, and cost-based, calculated using a hospital-specific cost-charge ratio. This ratio adjusts uncompensated care downwards to a level reflecting closer the cost associated with providing the medical care.

* Clinic information is based on self reporting of clinics with revenue income greater than 1 million dollars. This represents approximately two-third of the clinic population.

** Four of the Neighborhood HC Network clinics reported under the "clinic" category also.

† Five clinics report to the Neighborhood Clinic Network data set as well as to that of the MN Primary Care Assoc.

‡ The data from the Minnesota Primary Care Association and the Minnesota Association of Community Mental Health Programs includes only reporting member clinics and programs. Therefore, these dollar amounts are understated.

Y Total cost-based uncompensated care is an estimate which includes values from those provider categories being able to provide cost-based data.

General

During 1996 Minnesota's health care system provided uncompensated care at levels of \$215 million charge-based or an estimated \$165 million cost-based. Based on data collected through known and available resources, Minnesota's health care system provided \$215 million (on a charge basis) worth of uncompensated care in 1996. However, there are providers not accounted for in this data (for example dentists and ambulance services). Including these provider types, we estimate that approximately 2% of overall health care spending in the state of Minnesota is for uncompensated care.

Aggregate uncompensated care at Minnesota's health care providers has stabilized or declined since 1990. Stable levels of uninsured, the implementation of the MinnesotaCare subsidized health insurance program, and initiatives to make health insurance more available to small employers all have likely played a role in stabilizing and reducing the amount of uncompensated care provided in Minnesota.

There is no current common definition of uncompensated care. As noted earlier in this interim report, discussion of the issue of uncompensated care is clouded by the lack of a common definition among providers of what constitutes uncompensated care. Some providers view uncompensated care as strictly charity care, that is care provided to those unable to pay. Others consider both charity care and bad debt (care provided where payment was expected, but not received) to be uncompensated care, while some providers also include negotiated discounts and payments below cost from government programs to be uncompensated care. In addition, even within individual categories, such as charity care, hospitals use differing definitions and methods to determine amounts of such care reported.

Uncompensated care is directly related to a lack of health insurance coverage. Nationally, Minnesota is recognized as a state with comparably high levels of insurance coverage and relatively rich benefit packages. Comparable national data shows Minnesota to have among the lowest rates of uninsurance in the country.⁵ However, a significant percent of Minnesotans are still uninsured or should be considered underinsured. Depending on the data source, an estimated 6 percent to 9 percent of Minnesotans lack health insurance. Because these individuals still need to seek and receive medical care, these 300,000 to 400,000 Minnesotans contribute significantly to the State's level of uncompensated care.

Access to health insurance coverage will reduce the levels of uncompensated care provided. Uncompensated care is a direct result of the gaps of insurance in a system that provides coverage through employment-based or individually purchased health insurance. Although Minnesota has been a leader in expanding publicly-subsidized health insurance coverage options, a significant number of eligible individuals are not enrolled in public-sector insurance programs, and a large number of Minnesotans lack coverage.

Under the current health care system, it is unlikely that all Minnesotans will have health insurance. As long as health care coverage is voluntary and linked to employment or eligibility for a public program, it is unlikely that the need for uncompensated care will be completely eliminated. There will always be some segment of the population who is unable to afford private coverage, who will be in transition between public programs or who chooses not to purchase health insurance coverage.

The issue of uncompensated care is complicated because our system of financing health care is complicated. Minnesota's (and the nation's) health care financing system is a patchwork of private payments, public programs, and cost shifting. The financing streams for health care are complex because payments flow through private insurers, employers, individuals, and local, state, and federal government. The ability of providers to identify and secure health care financing for individuals who lack coverage is equally complex. In addition, the ability of providers to cost-shift to help provide care, is diminished in today's highly competitive and cost-conscious health care marketplace.

Enrollment in the state's public health care programs does not match eligibility. The Minnesota Department of Human Services estimates that a large percentage of Minnesota's uninsured children are likely eligible for either Medical Assistance or MinnesotaCare. This is a concern, because program expansion was specifically intended to address gaps in the health care system, and relative to other states, Minnesota providers have a low burden of uncompensated care.

Minnesota's providers of hospital services have lower levels of uncompensated care than providers in other states because of Minnesota's relatively low uninsurance rate and the stable Minnesota economy. For example, nationally hospitals spend in 1995 an average of \$17.5 billion or 6.1 percent of expenditures for uncompensated care.⁶ In contrast, Minnesota hospitals spent in 1996 an average of 2.8 percent (charge-based) or 1.7 percent (cost-based) of their expenditures on uncompensated care. This amounts to \$130.5 million charge-based and \$81.2 million cost-based.

The burden of uncompensated care is unevenly distributed. Although the overall levels of uncompensated care are low in Minnesota relative to other states, certain providers bear a large portion of uncompensated care. For example, 10 hospitals in Minnesota provide 62% of all hospital-based uncompensated care, while two hospitals alone (HCMC and Regions) provide one-third of all such care. In addition, Minnesota's community health clinics report that up to 35 percent of their expenses go for uncompensated care. These clinics are organized in the MN Primary Care Association⁷ and the Neighborhood Clinic Network,⁸ which both play a crucial role, providing primary care services to uninsured individuals.

The impact of welfare reform is largely unknown. The reform of the nation's welfare system is still in its early stages, and it is unclear how reform will impact uncompensated care. Large declines in Medicaid rolls in other parts of the country has raised concern over the ability of former public program enrollees to maintain access to health care. Because Minnesota's reforms have only recently taken effect, it is largely unknown in Minnesota how welfare reforms will affect the level of uncompensated care in Minnesota.

Providers concerned over low payment levels. While distinct as an issue from uncompensated care, providers and counties indicated a concern over low payment levels for public programs. For example, Hennepin County indicated that payments received for MinnesotaCare, General Assistance Medical Care, and Medical Assistance failed to cover the costs incurred for providing care for these individuals. In particular, providers expressed concern over low payments for outpatient services. Data from the Department of Human Services indicates, for example, that payments for outpatient hospital services cover approximately 53 percent of charges.⁹

Low reimbursement rates negatively influence providers of uncompensated care in several ways. First, low payment rates relative to costs reduces the ability of providers to continue to finance uncompensated care out of current resources. Second, as public program payment rates continue to diverge from market rates, it increases the likelihood that fewer plans or providers will continue to participate in these programs, thereby decreasing access to care. Third, many providers who serve a large number of public program enrollees also serve uninsured patients, and must find ways to recoup costs for both of these patient groups.

Policy changes to the MinnesotaCare program, and provisions intended to reduce private market erosion, have added to its complexity and have made it more difficult for individuals to become and stay enrolled. Over time, MinnesotaCare has become more complex. This has happened for a number of reasons, including attempts to limit the degree or possibility of erosion of private market coverage. However, some of these policy decisions have the effect of making it difficult for individuals to obtain or maintain MinnesotaCare coverage or Medical Assistance. Among these are:

- ◆ financial verification requirements for determining eligibility in the MinnesotaCare and Medical Assistance programs;
- ◆ the stipulation requiring a four period of ineligibility for late payment of MinnesotaCare premiums;
- ◆ the requirement that individuals be uninsured for at least four months prior to enrollment in Minnesota Care;
- ◆ the stipulation that individuals are not eligible for MinnesotaCare if they currently have, or had in the past 18 months, access to employer based coverage;
- ◆ the requirement denying MinnesotaCare eligibility to those individuals whose employer subsidizes at least 50 percent of an employer-sponsored health insurance policy; and
- ◆ the varying age-dependent levels of income standards within a family for those on Medical Assistance.

Many types of providers have uncompensated care burdens, and it is important to recognize the role played by these providers. While most attention is focused on the levels of care provided by hospitals and physician clinics, primarily because data from these providers are readily available, other providers also bear a burden of uncompensated care:

- ◆ The Minnesota Association of Community Mental Health Programs has recently begun collecting information on uncompensated care provided in their programs. Currently, the providers' varying accounting mechanisms and a general unfamiliarity with the concepts of bad debt and charity care result in data that may underestimate or fail to accurately estimate uncompensated care.
- ◆ Ambulance services report that a significant share of their expenses (up to 25 percent) is uncompensated care.
- ◆ County and city administrations often bear the cost of care provided to individuals in need of medical care when in detention. The extent of this service and the related costs in Minnesota are currently unclear.
- ◆ Finally, providers such as dentists and chiropractors provide charity care. However, as with other types of providers, good information on the levels of charity care and bad debt of these providers is not available at the present time.

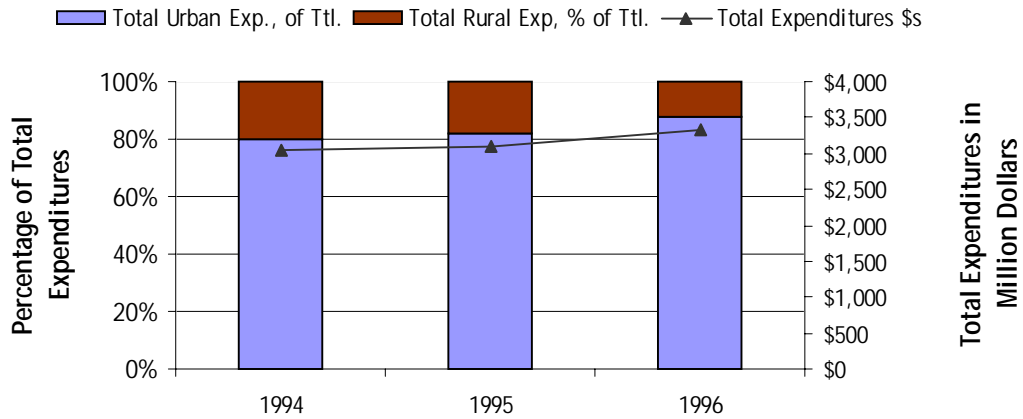
Little information is known regarding the demographics of the recipients of uncompensated care and the services provided to them. While the characteristics and demographics of Minnesota's uninsured population is generally well-known, the demographics of the population receiving uncompensated care is less well-known. Even though many uninsured individuals are also likely recipients of uncompensated care, it is equally likely that there are substantial differences in the demographics of the uninsured and those receiving uncompensated care. It is, however, very important for the purposes of targeting and developing effective policies, that this population be well defined and described. Information such as discharge databases collected by associations serving Minnesota's hospitals could be valuable in helping to describe the population that is receiving uncompensated care.

Clinic Findings

Data from Minnesota clinics suggest that although aggregate spending on uncompensated care is stable, when viewed as a percentage of expenditures, uncompensated care has declined. From 1994 to 1996 Minnesota clinics reported relatively stable levels of aggregate uncompensated care. In 1994 the clinics' uncompensated care burden was \$68.3 million, it dropped slightly to \$62 million in 1995, and in 1996 it increased to \$71.5 million. Over that same period, however, the percentage of overall clinic expenditures or costs going for uncompensated care dropped from 3.3% to 2.1%. Minnesota's clinics may be finding alternative methods to provide charity care or reduce bad debt, thereby reducing their uncompensated care burden.

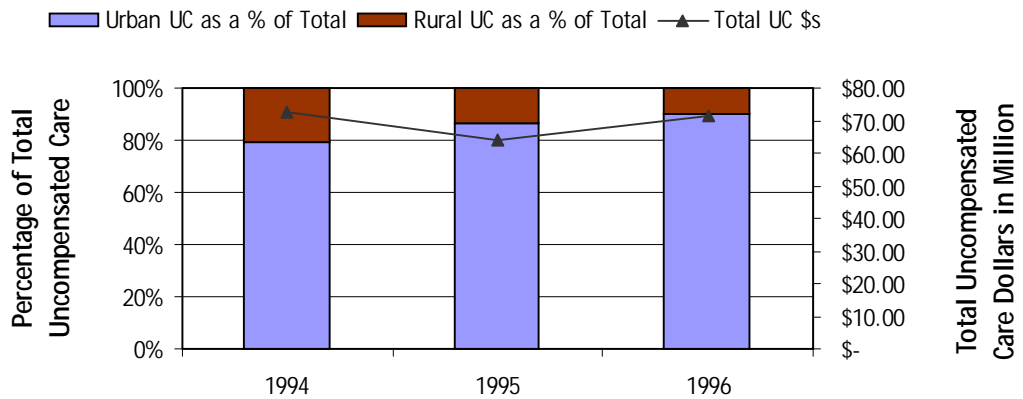
The majority of clinic-based uncompensated care is provided in urban settings. In 1994, urban-based clinics accounted for 79% of clinic uncompensated care. While expenditures increased each year, so did the percentage of uncompensated care provided by urban clinics. In 1996 urban clinics share of total Minnesota clinic uncompensated care was 90%.

Figure 1: Total Expenditures in Minnesota's Physician Clinics



Source: Provider Financial and Statistical Report, December 1998.

Figure 2: Total Uncompensated Care in Minnesota's Physician Clinics



Source: Provider Financial and Statistical Report, December 1998.

Federally qualified health centers, rural health centers and other community clinics play an important role as safety network providers. FQHCs, RHCs, and other community based clinics serve disproportionately the uninsured and those on public health care programs that are at greater risk of becoming uninsured. The clinics play an important role in providing primary care services to low-income populations, recent immigrants, and non-English speaking populations. These clinics often provide care often without a stable funding source, with available funding supplemented through grants. As Minnesota continues to experience increased immigration, it is likely the role these clinics play will continue to be very important.

Aggregate clinic data masks the variations among clinics in providing uncompensated care. Community clinics report uncompensated care costs at levels between 5 and 6 percent of expenditures. In contrast, private clinics report uncompensated care costs of approximately 2 percent of their expenditures.

Changes to reimbursement for FQHCs and RHCs required in state law will likely have a negative impact on their ability to continue to provide care. Under Minnesota Statutes § 256B.0625, FQHCs and RHCs will begin receiving payment of a market rate rather than payment based on cost, starting in January 2000. Because of the safety-net nature of these providers, there is a concern that there may be a loss of access to care if lower market rates lead to a decreased ability of FQHCs and RHCs to remain viable.

Table 2: Number of Clinic Based Medical Care Providers

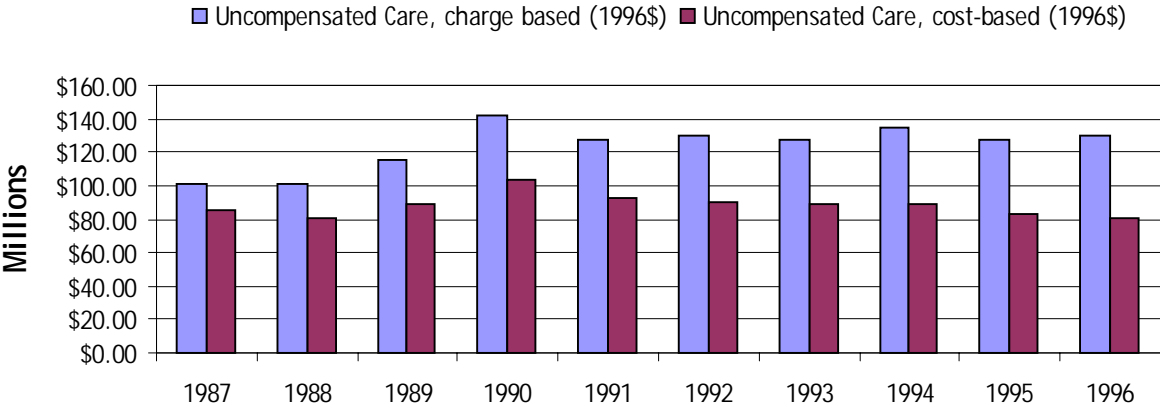
	Number of Clinics
Physician Clinics (reporting to MDH)	530
MN Primary Care Association	14
Neighborhood Health Care Network	26
MN Community Mental Health Assoc.	27

Note: Clinics may be associated with more than one category.

Hospital Providers

Traditionally, hospitals have been the largest provider of indigent medical care. Consequently, Minnesota hospitals report a large amount of uncompensated care (charity care plus bad debt and Hill Burton obligations). In 1996, Minnesota hospitals provided \$81.2 million of care on a cost basis, or approximately \$130 million on a charge basis, for which no fee was charged or payment received.

Figure 3: Inflation-Adjusted Uncompensated Care Costs in Minnesota Hospitals



Source: Minnesota Department of Health, Health Care Cost Information System, December 1998; Bureau of Census, Twin Cities CPI.

Note: Under the charge-based measure, hospitals calculate the value of uncompensated care at the level the hospital would have *charged* for services. Because payment is rarely made for the value of charges (due to negotiated discounts), a ratio developed by the American Hospital Association has been applied to adjust charges downward to reflect costs.

In aggregate Minnesota hospitals received in 1996 a minimum of \$42.5 million in grants, donations, and public funding which is also used to partially offset uncompensated care. This includes about \$35 million of public funding for operating costs, about \$6.5 million of donations and grants targeted as well at operating cost, and about \$1 million earmarked to support charity care.

Hospital-based uncompensated care has decreased since 1990. The level of uncompensated care (adjusted for inflation) provided at Minnesota hospitals in 1996 compared to the peak value of 1990 reflects a steady decline of approximately \$22 million (cost-based) or \$12 million (charge-based). This decline parallels the increase in public program eligibility as a result of the MinnesotaCare legislation and the expansion in Medical Assistance.

Uncompensated care as a percent of total hospital expenses has also declined. In aggregate, cost-based spending on uncompensated care in 1996 was 1.7 percent of expenditures contrasted with 2.5 percent of expenditures in 1987. Charge-based spending on uncompensated care as a percentage of expenditures in 1996 was approximately 2.7 percent compared to 3 percent in 1987.

The burden of uncompensated care at Minnesota’s hospitals is unevenly distributed. The 10 hospitals with the largest share of uncompensated care account for about 62 percent of such care provided in Minnesota hospitals. In 1996, two hospitals alone, Hennepin County Medical Center and Regions Hospital, provided 35 percent of the hospital-based uncompensated care. As a result, taxpayers in the counties with hospitals providing large amounts of uncompensated care are frequently asked to shoulder a larger share of the overall uncompensated care burden.

Uncompensated care as a share of total hospital expenditures is also unevenly distributed among Minnesota hospitals. The uneven distribution of uncompensated care is also reflected by the relative financial burden that uncompensated care poses for hospitals. While, on average, Minnesota hospitals have a burden of uncompensated care equal to 1.7 percent of patient-related hospital expenses, the 10 hospitals with the largest amount of uncompensated care provide between 4 percent and 9 percent of patient-related expenses on uncompensated care.

Table 3: Minnesota Hospitals with the Highest Levels of Shares of Uncompensated Care 1996

Name	City	RCB	Lic. Beds	Uncompens. Care in cost-based \$	Expend. in \$	UC as percent of MN UC	UC as percent of Expend.
Hospitals with the Highest Share of Minnesota Uncompensated Care							
Hennepin County Medical Center	Minneapolis	4	910	26,641,463	295,389,450	20.6%	9.0%
Regions Hospital	St. Paul	4	427	17,129,551	205,526,000	13.2%	8.3%
Abbott Northwestern Hospital	Minneapolis	4	926	6,777,662	338,578,796	5.2%	2.0%
Fairview Riverside Medical Center	Minneapolis	4	981	5,149,970	176,808,651	4.0%	2.9%
Mercy Hospital	Coon Rapids	4	271	4,569,849	104,213,268	3.5%	4.4%
Fairview Southdale Hospital	Edina	4	390	4,382,819	146,882,604	3.4%	3.0%
North Memorial Medical Center	Robbinsdale	4	518	4,309,590	215,349,690	3.3%	2.0%
Saint Mary's Hospital	Rochester	6	1157	4,011,754	306,885,758	3.1%	1.3%
United Hospital Inc.	St. Paul	4	556	3,859,410	212,241,569	3.0%	1.8%
St. Mary's Medical Center	Duluth	2	380	3,388,532	135,099,278	2.6%	2.5%
Hospitals with the Highest Share of Uncompensated Care Relative to Expenditures							
Hennepin County Medical Center	Minneapolis	4	910	26,641,463	295,389,450	20.6%	9.0%
Regions Hospital	St. Paul	4	427	17,129,551	205,526,000	13.2%	8.3%
St. Francis Medical Center	Breckenridge	1	95	740,607	11,993,509	0.6%	6.2%
Northern Itasca Health Care Center	Bigfork	2	20	139,264	2,882,716	0.1%	4.8%
Madison Hospital	Madison	5	21	76,339	1,621,675	0.1%	4.7%
Mille Lacs Health System	Onamia	3	28	242,852	5,519,462	0.2%	4.4%
Mercy Hospital	Coon Rapids	4	271	4,569,849	104,213,268	3.5%	4.4%
Rush City Hospital	Rush City	3	29	109,656	2,560,736	0.1%	4.3%
Fairview Ridges Hospital	Burnsville	4	150	2,280,126	53,977,707	1.8%	4.2%
St. Francis Regional Medical Center	Shakopee	4	126	927,873	22,995,628	0.7%	4.0%

Source: MN Department of Health, Health Care Cost Information System, December 1998.

Hospitals' classification and accounting of the components of uncompensated care, charity care and bad debt, is inconsistent. Inconsistencies in classification and accounting practices, alluded to earlier in this interim report, make a direct comparison of the uncompensated care components, charity care and bad debt, difficult across providers. This is particularly true for the two major providers of uncompensated care in the Twin Cities area, Regions Hospital and Hennepin County Medical Center (HCMC). The different methods of accounting for charity care and bad debt lead to widely different ratios between bad debt and charity care between these two hospitals, even though it is likely that, proportionately, the levels of charity care and bad debt for the two hospitals are similar. Therefore, until uniform definitions and standards are in place, both components are combined for analysis.

Public program reimbursement rates continue to place a financial burden on safety-net providers. Safety-net providers are, in general, also hospitals that provide a comparative large amount of uncompensated care. Low reimbursement rates relative to costs, coupled with a competitive provider market and price pressure exerted by managed care organizations and traditional insurers, may result in increased difficulty for providers being able to meet the need for uncompensated care.

The main providers of hospital uncompensated care do not follow aggregate trends. While the hospital sector, in aggregate, experienced a decline in uncompensated care, the major providers of uncompensated care show for the period after 1991 an average annual increase of greater than 2.6 percent. This underscores the unequal distribution of uncompensated care provided by Minnesota hospitals.

National ratios of uncompensated care to hospital expenses continue to be larger than those of Minnesota hospitals. This means, on average, hospitals in the U.S. find themselves allocating a larger share of resources to uncompensated care than Minnesota hospitals.

Within the Twin Cities Metropolitan Area, there is a noteworthy amount of cross-county traffic resulting in greater overall costs and uncompensated care costs for the hospitals providing the care. Hennepin County Medical Center and Regions Hospital report a sizable burden of cross-county traffic which is believed to increase administrative, inpatient, and outpatient uncompensated care costs. This reflects the status of HCMC and Regions as large downtown trauma centers which unlike other area hospitals, provide 24 hour emergency care.

Table 4: Origin of Uncompensated Care Patients for HCMC and Regions Hospital

Patients Home County	Regions Hospital	HCMC
Anoka	2.0%	2.6%
Dakota	10.0%	1.4%
Hennepin	6.0%	78.4%
Washington	6.0%	0.3%
Ramsey	68.0%	3.3%
Scott		0.4%
Wright		0.8%
Unaccounted		12.2%
Other	8.0%	
Cross-county Totals	24.0%	19.5%

Source: Information supplied from accounting systems of Hennepin County Medical Center and Regions Hospital.

More research and data collection is necessary to determine whether the decrease of uncompensated care shown in hospitals was primarily a result of increased levels of health insurance coverage or a shift to other types of providers as the source of uncompensated care. To determine whether the observed decrease in uncompensated care is the result of decreased demand (number of uninsured) or of a shift of uncompensated care to outpatient and primary care providers such as physicians and community clinics, further research is necessary. This research needs to develop a provider-wide definition of uncompensated care and assist in implementation of data collection processes according to that definition.

Urban hospitals bear a larger share of the uncompensated care costs. This is true for both the measure of total dollars of uncompensated care as well as the measure of uncompensated care as a share of expenditures. Urban hospitals incurred in 1996 expenses of approximately \$70 million, which represents 2.6 percent of expenses while rural hospitals incurred uncompensated care cost of approximately \$10 million, representing 1.8 percent of expenses.

Options for Addressing Uncompensated Care in Minnesota

Part 2

As mentioned in the findings section of this report, the issue of uncompensated care is complicated because the financing of health care in Minnesota and the United States is extremely complex. Health care is paid for through a variety of mechanisms, including private health insurance coverage, out of pocket payments, public sector health insurance such as Medicare, MinnesotaCare, and Medical Assistance, and cost-shifting between payers. Many of the ways of paying health care overlap, and yet there are also gaps in the system. This report has identified the extent of uncompensated care in Minnesota, and has highlighted many of the reasons why it continues to exist and be a concern, in spite of Minnesota's efforts to help individuals access health insurance.

Recognizing the complex nature of health care financing and the resulting complicated issue of uncompensated care also means recognizing that one single solution will not eliminate or substantially reduce the ongoing problem of uncompensated care. It will take a combination of approaches to begin to make progress toward reducing the burden of uncompensated care. Because of the variety of options available to address uncompensated care, it is also important that there be consensus among stakeholders on the approach or combination of approaches taken by the state to reduce uncompensated care. **Therefore, the Minnesota Department of Health will convene a work group starting in the spring of 1999 and work during the interim prior to the 2000 Legislature to develop a consensus on the policy approach or combination of approaches to be used to address uncompensated care.**

In this same spirit, this report provides *options* in a variety of areas to address the issue of uncompensated care. These options show the various approaches that could be used to reduce and spread the burden of uncompensated care, and also serve to highlight the complicated causes and financing of uncompensated care. Options are provided in the following areas:

- ◆ **Increasing Access and Ensuring Continued Eligibility to Public and Private Health Insurance**

The findings section of this report showed that uncompensated care is a function of a lack of health insurance coverage. There is a strong correlation between those states with high rates of uninsured and large levels of uncompensated care. We know that, in Minnesota, we have substantially reduced the number of children who are uninsured for long periods of time. However, we have *not* reduced the number of children who move in and out of insurance coverage. The first section of options, therefore, focuses not only on ways to help more people become insured, but also on strategies to help them maintain continuous coverage.

◆ **Stabilizing Funding for Community Clinics**

The funding section of this report cited the important role that community clinics play as a source of primary care for uninsured and low income individuals. Often times these clinics also serve as a first source of care for recent immigrants to Minnesota. Unfortunately, these clinics frequently do not have a stable, ongoing funding source. The second section of options provides a number of ways to help to stabilize the ongoing funding of these clinics.

◆ **Spreading the Burden of large Uncompensated Care Providers**

This report's findings were clear in showing that the burden of uncompensated care in Minnesota is disproportionately spread over providers. While there are a number of approaches that could be used to help spread the burden, the third section of options provides ways in which to directly offset the costs incurred by large providers of uncompensated care. It provides options to help ensure that, should this method of spreading the burden be chosen, payments are targeted at those providers most burdened.

◆ **Other Options**

Finally, the fourth section of options provides some additional areas that merit further examination and topics where additional work is needed. These include moving toward developing common, universally applied definitions of charity care and bad debt, developing better data on uncompensated care at providers such as dentists, chiropractors, and others, examining the demographics of those who are the users of uncompensated care, and developing a better understanding of the current and future effects of welfare reform on safety-net providers and the uninsured.

The Department recognizes that many of these options come with substantial costs. However, it was the goal of this interim report to highlight the complex issue of uncompensated care and to begin the discussion of the variety of options and combination of approaches that might be used to address this issue.

1 Increase Access and Assure Continued Eligibility

Option 1.1:

Make program changes to better ensure continuity of coverage of eligible individuals. For example:

- ♦ **Reduce the period that individuals are ineligible for MinnesotaCare for non-payment of premiums from 4 months to 1 month, for those individuals who pay their premium within 30 days of the due date.**
- ♦ **Allow additional flexibility in MinnesotaCare premium payments. One option the Legislature could consider would allow individuals to pay a flat enrollment fee which is discounted from the monthly rate. For example, individuals now paying \$4 per month could be offered the option of paying \$30 for a year of coverage.**

Eligibility standards for public health insurance programs are intended to fill three functions. First, the standards are intended to define an eligible population for publicly funded or publicly subsidized programs. Second, eligibility standards, and premiums in particular, were set as provisions to emphasize personal responsibility. Third, eligibility standards were designed as a framework for public programs that would help prevent private insurance market erosion (crowd out).

Unfortunately, the enforcement of several of these eligibility standards have created barriers to continuity of coverage for enrollees on MinnesotaCare. For example, current law requires a four month period of ineligibility for individuals who are late in MinnesotaCare premium payments. This requirement works against continuity of coverage. An option to consider would reduce the period of lock-out from 4 months to a lesser period of time, perhaps 1 month for those individuals who, in good faith, make their premium payment within 30 days after the premium due date.

Everyone enrolled in MinnesotaCare pays a premium. While we support the continuation of this premium, there are policy options for consideration which would make premium payment options available for individuals to support prepayment and continuity of coverage. One option to consider in this regard is to allow individuals, who prepay 12 months of premium, to pay a discounted amount. One suggestion would be that individuals now paying the minimum premium of \$4 per person per month be allowed to pay for example, \$30 per person for 12 months of coverage. In addition, an option to consider would cap premium collection at a given family size. For example, the \$30 annual premium would be collected for the first three family members, with additional family members able to enroll without additional costs.



Option 1.2:

Provide 12 month guaranteed eligibility for enrollees in the Medical Assistance program.

Information from the Minnesota Department of Human Services shows that Medical Assistance enrollees tend to move in and out of the program. While program expansions in Minnesota have helped reduce the number of children who are uninsured for 12 months or more, we have not reduced the number of children who are intermittently uninsured. Many of these uninsured children are likely children who at one period or another had access to and were enrolled in Medical Assistance. It is likely that a great deal of progress could be made toward reducing additionally the number of uninsured children in Minnesota by allowing for 12 months eligibility on Medical Assistance.



Option 1.3:

Put mechanisms in place to ensure seamless transition between Medical Assistance and MinnesotaCare. For example:

- ◆ **Provide MinnesotaCare coverage retroactive to the first month following Medical Assistance or General Assistance Medical Care termination for persons in transition from GAMC or MA.**

Uncompensated care is generated, in part, by Minnesotans who are eligible for coverage in one of the public programs but are in transition between programs. Oftentimes, those most at risk for becoming or being uninsured are those individuals who are transitioning off Medical Assistance. These individuals may not be offered employer-based health insurance and frequently find individual market insurance unaffordable. While many ultimately end up on MinnesotaCare, delays in application processing and enrollment can create gaps in coverage. One option to help fill these gaps is to provide coverage which is retroactive to the first month following Medical Assistance or General Assistance Medical Care termination for those individuals transitioning off MA or GAMC and moving to MinnesotaCare and who follow through on the MinnesotaCare application process.



Option 1.4:

Continue and enhance current DHS efforts to consolidate all relevant information regarding public *and* private insurance options in a centralized information site accessible to applicants and their advocates. This may include:

- ◆ **Training individuals to act as resource professionals for the community regarding available health care coverage options.**
- ◆ **Establish an 800 information number staffed with employees knowledgeable about the various public insurance program and private market options.**

Further, the Department of Human Services found that “... there is significant turnover in the population of the MinnesotaCare program.”¹⁰ This transition should be further monitored in order to ensure continuous care and seamless transition into the private market. This is particularly important since there is a steep learning curve for Minnesotans enrolled in public programs to understand their complex options at the point of disenrollment. An option to consider would be to continue and enhance current DHS efforts to provide better information to enrollees about their private sector options.



Option 1.5:

Continue the work started at DHS to shorten the MinnesotaCare application, understanding that there are tradeoffs between a shorter form and a form which is easily comprehensible by applicants. In addition:

- ◆ **Continue DHS work with consumer advocates and representatives of health care providers to shorten and streamline the application form.**

Public programs in Minnesota were intended to provide access to insurance for indigent and working poor populations, thereby reducing the need for the level of uncompensated care currently made available by providers. Several layers of provisions are in place to guarantee that programs reach the targeted population. The addition of provisions such as asset tests, verification of child support, and a desire to have applications which are readable, has led to a relatively long application form. In particular, efforts by DHS to ensure ample white space and room to write has lengthened the form. Applicants’ literacy problems and language barriers contribute further to problems experienced in the application process. In addition, applicants do not always have access to the assistance required to complete the forms, and may not understand the implications of failing to provide verification of elements on the application.

DHS has begun a voluntary effort to examine ways to shorten the application form. We support the continued effort to shorten the form, but also believe that the form should be as readable as possible.



Option 1.6:

Examine ways to assist individuals with access to employer-based health insurance coverage to become and stay insured. This could include:

- ◆ **Subsidizing the employee contribution for Minnesotans in income brackets below 275% of Federal Poverty Guidelines (FPG) who have access to private insurance through their employer.**
- ◆ **Increasing the percentage subsidy level necessary for an employer-sponsored health insurance plan to be considered, for the purposes of MinnesotaCare, employer subsidized from 50 to 60 percent.**

Most Minnesotans (between 62 and 65 percent ¹¹) received their health insurance through an employer. The employer market is therefore still the link to health insurance for most people. Additionally, most uninsured Minnesotans have a connection to the workforce, either by being employed themselves, by being self-employed, or by being a dependent of a worker: 58 percent of the uninsured adults are employed by someone else and 24 percent are self-employed.¹² We also estimate that between 75 and 80 percent of children have at least one parent who is employed. It is, therefore, important to examine ways to assist individuals who are working to obtain and maintain health insurance coverage.

Under current law, individuals who have access to an employer health insurance policy, where the employer pays at least 50 percent of the coverage, are ineligible for the MinnesotaCare subsidized insurance program. While this provision, which was implemented to help guard against private market erosion, has likely assisted in limiting the degree to which the private market was impacted by MinnesotaCare, it has also likely resulted in some lower-income individuals being denied access to affordable health insurance. For example, we estimate that as many as 15,000 uninsured children in Minnesota may currently meet MinnesotaCare eligibility guidelines except that their parents have access to employer-subsidized health coverage.

This report presents two options to consider with regard to employer-sponsored health insurance coverage. The first option is currently under consideration at the Department of Human Service. This option would provide a subsidy to uninsured individuals who meet all MinnesotaCare guidelines except they have access to employer-subsidized insurance. In lieu of providing MinnesotaCare eligibility, the state would provide a subsidy for these individuals to purchase the employer coverage. Employers would continue subsidizing the same portion of the premium and the state would subsidize the difference between the employee share of the premium and the MinnesotaCare sliding fee schedule. Employees would pay according to the MinnesotaCare sliding fee scale.

Alternatively, an option to examine would raise the level by which an employer must subsidize coverage for it to be considered “employer subsidized” for the purposes of MinnesotaCare. One byproduct of the current MinnesotaCare eligibility standards is that the 50 percent employer subsidy provision is regressive, in that it requires lower income individuals to pay a larger portion of a given employer premium than higher income individuals. Currently, on average, Minnesota employers subsidize 64 percent of cost of employee health insurance coverage. This means that individuals are locked out of MinnesotaCare at levels of employer subsidy which are below the state average. An option would be to raise the level of employer subsidy for the purposes of MinnesotaCare to 60 percent or perhaps the statewide average level of employer subsidy.



Option 1.7:

Adopt more uniform income standards in determining eligibility for the Medical Assistance program.

- ◆ **The income standard with current disregard could be raised to 100% of the Federal Poverty Guidelines (FPG) for individuals presently below that level.**
- ◆ **Certain disregards could be eliminated and a higher income standard could be established at, for example, 125% of FPG.**

A variety of publicly funded and publicly subsidized programs offer Minnesota residents access to health insurance.¹³ Eligibility for these programs is determined by a variety of income standards which may vary even within a single program.

Either option for developing more uniform income guidelines for Medical Assistance would decrease the complexity, preparation time, and processing time of the application process. This may encourage more individuals to follow-through with the application process, thereby providing greater health insurance coverage and decreasing the need for uncompensated care.

2 Stabilize Funding for Community Clinics

Option 2.1:

Examine ways to stabilize funding for community clinics. This may include:

- ◆ **Providing a stable public funding source**
- ◆ **Adopting the Balanced Budget Act of 1997 payment schedule for FQHCs and RHCs**

The most cost effective health care is preventive and primary care. Hospital-based care, including emergency room care, is often the most expensive care and frequently not the most appropriate care. Community clinics are a unique resource for providing preventive and primary care to the uninsured and a significant asset in efforts to reduce overall uncompensated care costs.

In the Metro area, and in some parts of greater Minnesota, community clinics are providing free or sliding fee health care services. Data from two community clinic associations demonstrate their level of services to the uninsured. During 1996, the Minnesota Primary Care Association (MPCA) served approximately 91,200 patients who made over 260,000 medical and dental encounters. 37% of the MPCA patients have no insurance. 4 out of 5 patients have no insurance or receive public assistance. The Neighborhood Health Care Network (NHCH) reports that 83% of their patients have no insurance or receive only public assistance: 42% of NHCH patients are uninsured. These safety-net providers have also played an important role of providing a first source of care for many of Minnesota's increasing immigrant population.

These clinics report that they receive no ongoing state general revenue appropriations, only special grants for identified projects, such as grants for sexually transmitted disease/HIV, breast and cervical cancer screening, and maternal and child health. Reliance on grants to fund basic

staff positions creates job insecurity and staff turnover, and grant management can prove cumbersome and time consuming. This option would provide a stable, ongoing source of funding for these community clinics.

Another option to be considered would be to adopt the Balanced Budget Act of 1997 phase-down payments for Federal Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs). Under current law, FQHCs and RHCs will move from cost-based reimbursement to market reimbursement as of January 1, 2000. Adopting Balanced Budget Act requirements would provide a slower phase-down in funding for these providers, thereby allowing them to adjust over a longer time period.

3 Spreading the Burden of Large Providers of Uncompensated Care

Option 3.1:

Implement a pool from which hospitals providing above a certain threshold of uncompensated care would receive funding to help offset costs.

- ◆ **Nationwide pools are funded by provider taxes, direct appropriations, and alternative state revenue streams.**

An option to consider would directly offset the costs of uncompensated care for large providers. Should this option be used to help directly offset the costs of uncompensated care, we believe the focus should be narrowly targeted at lending financial assistance to those providers who have a high level of uncompensated care both in total dollars and as a share of their operating expenses. Providers receiving assistance from the pools should have to meet a certain threshold of uncompensated care spending.

Nationwide, a number of pools have been instituted in an attempt to balance the burden of care among the state's providers, and assist those "safety-net" institutions providing the highest levels of uncompensated care for the indigent or under-insured. Various state pools have been or are currently funded through legislatively earmarked funds, provider taxes, and implicit cost shifting into pools from revenue sources such as sales taxes, income taxes, tobacco or alcohol taxes, and lottery funds. Some of the states that currently have or have had an uncompensated care pool are New Jersey, New York, and Massachusetts. New Jersey's charity care hospital pool, for example, includes long-term funding and was established mainly by an increased tobacco tax. Half of the state's nearly \$1 billion uncompensated care costs are supported by the pool.¹⁴

As mentioned above, were a pool to be established, funds in the pool should be available only to those hospitals which provide above a certain threshold of uncompensated care. Funds would then be distributed to hospitals in proportion to their share of total uncompensated care above

the threshold. This mechanism of allowing eligibility for the pool only for those hospitals providing a threshold level of uncompensated care would be an inducement for hospitals to continue to provide a certain level of free care to those with low incomes.



Option 3.2:

Explore various methods by which regional hospitals such as HCMC and Regions Hospital are given the opportunity to “bill-back” other counties for uncompensated or under-compensated services provided to their residents.

The findings of this report indicate that uncompensated care, as measured by the financial burden to the institution, is unevenly distributed among Minnesota’s hospitals. When looking at uncompensated care both in overall dollars and as a percent of expenditures, Hennepin county Medical Center (HCMC) and Regions Hospital provide the highest levels of uncompensated care. These two large regional trauma centers provided 35 percent of the hospital-based uncompensated care in Minnesota. This includes UC of \$26.6 million for HCMC and \$17.1 million for Regions for calendar year 1996.¹⁵ Twenty-four percent of this cost for Regions and 19.5 percent for HCMC (See Table 5 of *Findings*) was provided to non-residents of Ramsey County and Hennepin County, respectively.

Hennepin County and, to a lesser extent, Ramsey County taxpayers, through their direct payments to the two hospitals, respectively, bear an additional burden as these hospitals finance care of residents of other counties.

An option raised during the 1998 Legislative Session would have allowed these counties and hospitals to bill counties back for services provided to their residents. While there is some valid concern raised by the degree to which these two hospitals are required to provide care to non-residents, there also appear to be some legal and administrative barriers to implementing such a system. For example, the issue of establishing residency and who is responsible for establishing residency may raise a concern. It may be administratively costly for the Department of Human Services to establish who is a resident of a county and there is a potential legal cost involved for the state if counties choose to challenge residency rulings. In addition, there may be a concern over the degree to which smaller counties would be able to pay for high cost cases billed back to them. Finally, it may be difficult for hospitals to set up systems to bill back 87 countries.

As a result, some of the other options listed in this report should be explored prior to implementing a county bill-back system. Many of the same results desired, such as spreading the risk and the burden more broadly, may be achieved through other mechanisms.

4 Other Options

Option 4.1:

Conduct further study and develop a better understanding of the components of uncompensated care that affect levels of uncompensated care. This may include:

- ♦ **Developing inter-industry definitions of the components of uncompensated care and support data collection and reporting mechanisms.**
- ♦ **Studying the demographics of patients receiving uncompensated care and the type of services received by them.**
- ♦ **Researching and better understanding the levels of uncompensated care of providers such as dentists, chiropractors, pharmacists and other provider types.**

Although the Minnesota Department of Health data collection efforts are assumed to track the majority of uncompensated care spending, the department currently has limited information as to the demographic characteristics of the people incurring the costs. Moreover, the department does not have access to data on uncompensated care dollars spent by service rendered. Simply put, while the department knows, to some extent, the level of the uncompensated care burden in Minnesota, the department has far less knowledge about the population who receives the care and the type of services that make up the overall uncompensated care costs.

The Minnesota Department of Health collects general information regarding the State's burden of uncompensated care. Two data sets are maintained. One is specifically for hospitals and hospital systems which is called the *Health Care Cost Information System* (HCCIS). The other data set is collected in the form of a survey titled the *Health Care Provider Financial and Statistical Report* (PFSR). Both sets of data contain bad debt and charity care, but the HCCIS differentiates the two and the PFSR does not. Certain providers, including those regional trauma centers which have large uncompensated care costs, are included in the department's data collection. However, the department collects only a portion of uncompensated care costs for community clinics and Federally Qualified Health Centers (FQHCs), and the department does not collect uncompensated care costs for mental health centers, pharmacists, physical therapists, dentists, chiropractors or other provider types. In addition, patient-based data, the key to demographic information on the uninsured, is currently still proprietary and not available to the Minnesota Department of Health for analysis.



Option 4.2:

Study the effects of welfare reform to gain a better understanding of its effect on safety-net providers, the uninsured, and uncompensated care.

Nationally, and in Minnesota, welfare reform is just taking effect. This reform includes many provisions which would seemingly have an impact on health insurance coverage for those individuals currently or formerly on public programs. For example, Wisconsin has seen large declines in Medicaid rolls with limited information as to whether these individuals ended up in private health insurance. We believe that further study into the impact that welfare reform in Minnesota is having on safety-net providers, the uninsured, and uncompensated care is important. While Minnesota has put safety nets in place to help ensure individuals don't go without coverage after leaving welfare, a recent study in Massachusetts (another state that has invested in safety-net programs) showed that a large percentage of those who lost Medicaid coverage had at least one family member now uninsured.¹⁶



Appendix A: Methodology

The Department of Health databases on hospitals, the Health Care Cost Information System (HCCIS), and providers, the Provider Financial and Statistical Report (PFSR), were used to identify uncompensated care costs for hospitals and physician clinics, respectively. A short supplemental survey of providers with less than one million dollars in revenue annually was conducted because these providers are not required to submit uncompensated care costs in their PFSR. Additionally, aggregated data were provided to us by the Neighborhood Health Care Network, the Minnesota Primary Care Association, the Minnesota Association of Community Mental Health Providers, the Department of Human Services, as well as by hospitals with exceptionally large shares of uncompensated care.

Appendix B: Data Issues

The department has developed a methodology to address some of this imbalance at the aggregate level. Trend information on aggregated charity care and bad debt, presented in Part One of the report, reflects the application of this methodology.¹⁷

Data Caveats

The analysis of data on which our findings are based revealed the following shortcomings:

- ◆ Data are self-reported and have, until 1996, not been systematically audited for accuracy.
- ◆ Reporting by providers has been done under different financial accounting standards of which the result was, at times diametrically, opposite reporting on charity care and bad debt.
- ◆ Historical data is across providers available to different degrees. Often times the first observation point proves to be inaccurate and unuseable.
- ◆ Differences in provider size and technical sophistication of accounting systems has, over the years, contributed to the varying degrees of accuracy in data reporting.
- ◆ Based on the information available to us we are unable to calculate cost-to-charge ratios for all providers. Where we are attempting cross-provider analysis we therefore report charge-based information only. However, we realize, that charges are, especially for the hospital market, significantly overstated when compared to costs.

Appendix C: 1998 Minnesota Laws, Chapter 407, Article 4, section 65

Sec. 65. Uncompensated Care Study.

The commissioner of health, in consultation with the commissioner of human services, associations representing Minnesota counties, consumer advocates, associations representing health care providers and institutions, and representatives of institutions providing a disproportionate share of uncompensated medical care shall submit to the legislature by January 15, 1999, a report and recommendations on the provision and financing of uncompensated care in Minnesota. The report must:

- (1) document the extent of uncompensated care provided in Minnesota;
- (2) discuss the feasibility of and evaluate options for financing uncompensated care, including but not limited to:
 - (i) modifying the eligibility standards for the MinnesotaCare and general assistance medical care programs, and
 - (ii) allowing providers to bill other counties for uncompensated care provided to residents of those counties;
- (3) evaluate approaches used by other states to monitor and finance uncompensated care; and
- (4) describe alternative approaches to encourage health care coverage.

Endnotes

¹ 1998 Minnesota Laws, Chapter 407, Article 4, section 65

² Sloan, F.A., Valvona, J., and Ross Mullner, *Identifying the Issues: A Statistical Profile in Uncompensated Hospital Care, Rights and Responsibilities* 16, (1986).

³ See *id.* See also, Atkinson, G., Helms, W.D., and Jack Needleman, *State Trends in Hospital Uncompensated Care*, 16 Health Affairs, 233-41: (July/August 1997); Zollinger, T.W., *A Determination of Institutional and Patient Factors Affecting Uncompensated Hospital Care*, 36 Hospital and Health Services Administration, 243-56: (Summer 1991).

⁴ Healthcare Financial Management Association, Principles and Practices Board, *Statement No. 15: Valuation and Financial Statement Presentation of Charity Service and Bad Debts by Institutional Healthcare Providers* 3, (January 1997).

⁵ The Urban Institute, *Snapshots of America's Families: Health Insurance Coverage of Non-Elderly Adults, Health Insurance Coverage of Children*, (1999).

⁶ Mann, J.M., Melnick, G.A., Bamezai, A., and Jack Zwanziger, Health Affairs, *A Profile Of Uncompensated Care, 1983-1995*, 226: (July/August 1997).

⁷ The Minnesota Primary Care Association, which has 13 members representing the interests of federally funded Community and Migrant Health Centers (C/MHCs), certified Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), and other primary care providers paid on a sliding fee scale basis, reports that 35 percent of expenditure go for uncompensated care.

⁸ The Neighborhood Clinic Network, which includes 26 community based clinics in the Metropolitan area, reports that 14 percent of its expenses are for uncompensated care.

⁹ Minnesota Department of Human Services, *CY 1997 Fee for Service Charge to Payment Ratio 2*: (September 9, 1998).

¹⁰ Minnesota Department of Human Services, *The MinnesotaCare Program: Transition Plan*, 6: (March 1998).

¹¹ MDH, Health Economics Program, *Distribution of Insurance Coverage in Minnesota*, Issue Brief 98-5.

¹² University of Minnesota Health Insurance and Access Survey, (1995).

¹³ Medical Assistance, General Assistance Medical Care, MinnesotaCare, AIDS Program, MCHA, Medicare.

¹⁴ The Urban Institute, *Health Policy for Low-Income People in New Jersey*, 4: (August 1998).

¹⁵ Minnesota Department of Health, *Health Care Cost Information System*, (December 1998).

¹⁶ Weissman, Joel, et.al. "Termination from Medicaid: How Does it Affect Access, Continuity of Care, and Willingness to Purchase Insurance," *Journal of Health Care for the Poor and Underserved*, Volume 10, Number 1, February 1999.

¹⁷ Previously unused data are available to MDH that allow estimating shares of charity care in bad debt for hospitals that have commingled these two accounts. Starting in 1989 and using five data points a trend was developed. This method, however does not correct for the overstating effects of classifying bad debt as charity care until it is determined that collection on any amount of the outstanding bill is impossible.

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