

# Finance in rural and urban hospitals

## Introduction

This brief provides a snapshot of key financial trends in rural hospitals from 2011 to 2015, a period that saw the implementation of the Affordable Care Act (ACA). It does not provide an exhaustive analysis of rural hospital finance; rather, it focuses on those aspects that might reflect impacts of the ACA's changes on insurance coverage and reimbursement for services.

The brief uses data from the Hospital Annual Report (HAR).<sup>1</sup>

Hospitals in Minnesota were divided into three groups:

- **Critical Access Hospitals (CAHs, 78 hospitals)** is a federal designation for a rural hospital that meets certain criteria such as being non-profit and having 25 beds or less. This designation limits patients to a 96-hour inpatient stay.<sup>2</sup>
- **Other rural hospitals (20 hospitals)** are also located in a rural community but do not have critical access designation. Some are similar in size to CAHs but they do not have the same limitations of 25 beds and there are no limits on the length of time a patient can stay. Other-rural hospitals receive reimbursement for their services on a prospective-payment system.
- **Urban hospitals (33 hospitals)** are all other facilities; they are located in urban areas and are typically large. For the purposes of this brief, behavioral-health hospitals were excluded.

## ACA changes<sup>3</sup>

The period covered by this brief saw a number of important changes to the health care market. These changes include:

- **Coverage mandates** required individuals to have health insurance coverage and employers with over 50 employees to offer health insurance to their employees.<sup>4</sup>
- **Medicaid expansion and other changes** increased the number of individuals that were eligible for Medical Assistance in Minnesota. See Appendix 1 for details.
- **Health insurance marketplaces (in Minnesota, MNsure)** enabled individuals who directly purchase health insurance coverage to compare coverage options.
- **Individual market subsidies** such as income-based tax credits and cost sharing supports helped to increase the affordability of individuals plans purchased on the marketplace.

See Appendix 1 for more detail on these changes.

## Payer mix

Reimbursement for services that hospitals provide to patients makes up the largest percent of hospital revenue. Government and private insurance companies reimburse hospitals differently, depending on the hospital, and payment arrangements such as contracts. To receive payment, hospitals report charges for services provided to the insurance companies.

The amount reimbursed and turned into revenue varies by insurance type and hospital type.<sup>5</sup> For this reason, looking at charges more accurately reflects the patient populations receiving services, while looking at revenues better indicates where dollars are coming from.

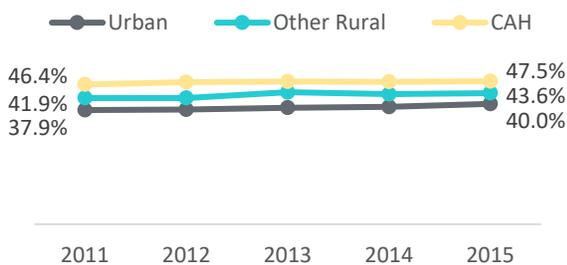
## Public programs

Public insurance programs include Medicare (federal health insurance for the elderly and disabled) and two state publicly funded health programs: Medical Assistance (Minnesota’s Medicaid program) and MinnesotaCare (Minnesota’s Basic Health Plan).

CAHs have a cost-based reimbursement system in which they receive close to allowable costs, although the exact percentage has varied.<sup>6 7</sup> Due to the older population demographics of rural and most small Minnesota communities (where CAHs are located) as well as their reimbursement structure, CAHs receive a higher percentage of their total revenue from Medicare payments compared to other rural and urban hospitals.

From 2011 to 2015, the percent of total charges billed to Medicare increased among all Minnesota hospitals (Figure 2). This likely relates to the increase in Medicare enrollees over this period.<sup>8</sup>

**Figure 2. Percent of Medicare charges**

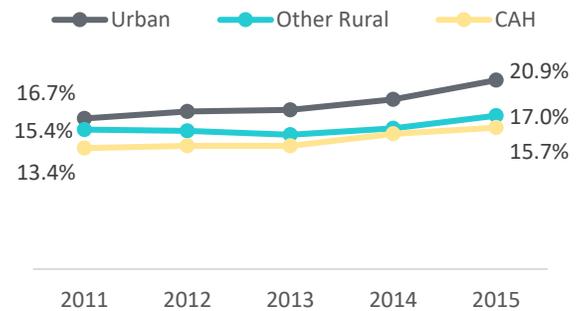


Source: Hospital Annual Report 2011-2015

State public programs reimburse hospitals by a percentage of the payment-to-cost rate, which varies by hospital type. From 2011 to 2015, urban

hospitals had a greater share of charges billed to state public programs compared to CAHs and other rural hospitals, but the percent of charges that went to state public programs increased for all types of hospitals (Figure 3). Proportionally, state public programs cover more of urban hospitals’ patients than other payers do.

**Figure 3. Percent of state program charges**



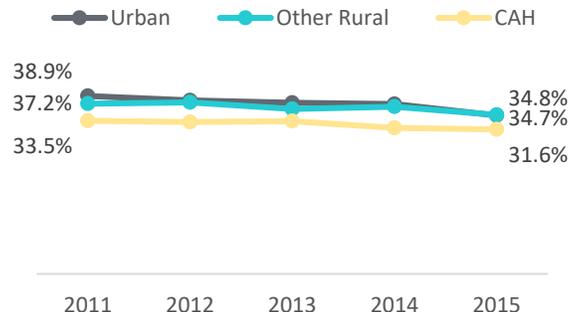
Source: Hospital Annual Report 2011-2015

## Private insurance

Private insurance includes commercial insurers such as employer-based insurance and insurance purchased individually.<sup>9</sup> These companies negotiate the amount they reimburse hospitals. Among hospitals, urban hospitals receive the highest percent of total revenue from commercial charges.

From 2011 to 2015, the trends in the percent of charges from commercial payers decreased among all hospital groups (Figure 4).

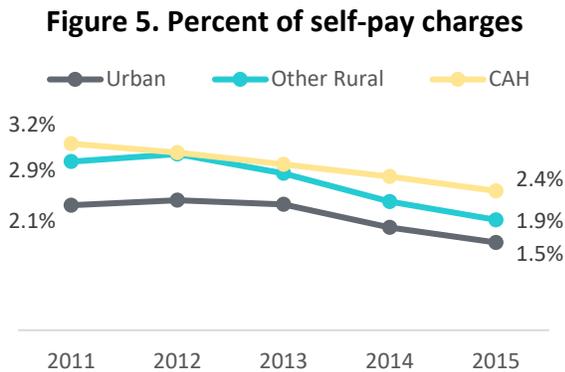
**Figure 4. Percent of commercial insurer charges**



Source: Hospital Annual Report 2011-2015

## Self-pay charges

Self-pay charges are out-of-pocket payment by individuals who do not have health insurance coverage. The percent of revenue generated by self-pay was small in 2011 and decreased still further in 2015 (Figure 5). Compared to urban hospitals, both types of rural hospitals (CAHs and other rural hospitals) continue to receive a larger percent of their revenue from self-pay.

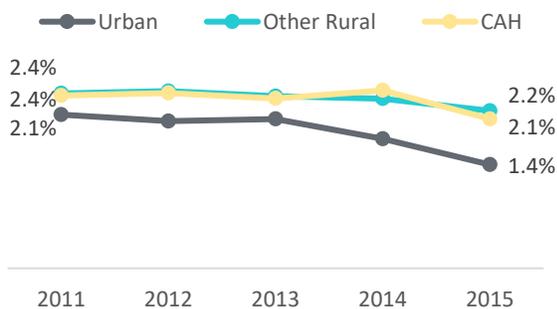


Source: Hospital Annual Report 2011-2015

## Uncompensated care

Uncompensated care is care provided to patients where no payment is received, either expectedly (charity care) or unexpectedly (bad debt). Charity care represents discounted or free care based on patient income. Bad debt occurs when payments are expected but not received.<sup>10</sup>

**Figure 6. Uncompensated care as a percent of operating expenses**

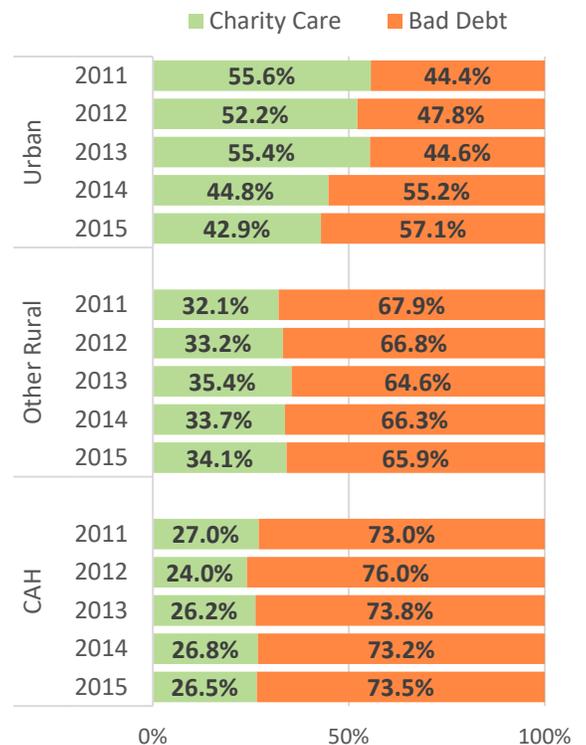


Source: Hospital Annual Report 2011-2015

In 2013, following ACA implementation, uncompensated care decreased by 16.7 percent among Minnesota hospitals.<sup>11</sup> That is, more hospitals received payment for services provided. The percentage of expenses that went to uncompensated care changed most in urban hospitals; CAHs and other rural hospitals had only a slight decrease between 2011 and 2015 (Figure 6).

In CAHs and other rural hospitals, a larger proportion of uncompensated care was from bad debt rather than charity care (Figure 7) – a trend consistent with CAHs across the nation.<sup>12</sup> National research shows that various factors contribute to these higher rates of bad debt, including billing policies and the way CAHs set the threshold that determines if a patient will qualify for charity care.

**Figure 7. Percent of uncompensated care that is charity care and bad debt**



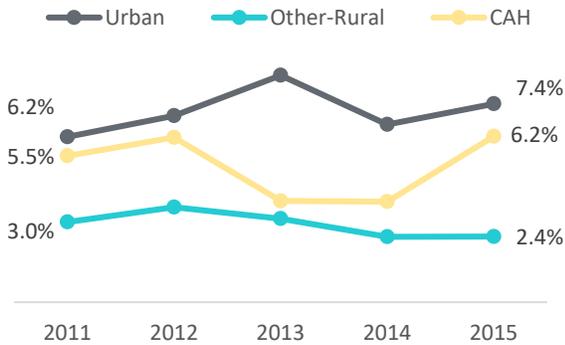
Source: Hospital Annual Report 2011-2015

## Operating margins

Operating margin represents operating income calculated by excess operating revenue (income) over operating expense as a percent of operating revenue.<sup>13</sup> Operating margin is a broad measure of hospital profitability because it takes into account a wide range of factors such as patient services and non-patient related operating expenses.<sup>14</sup> This report uses the median value, a common way to report the average performance of a hospital.

CAHs and other rural hospitals had a lower operating margin than urban hospitals between 2011 and 2015 (Figure 8). Both CAHs and urban hospitals saw an overall increase in their operating margins during this period. This was not the case for other-rural hospitals, which saw decreased operating margins from 2011 to 2015.

**Figure 8. Median hospital operating margin**

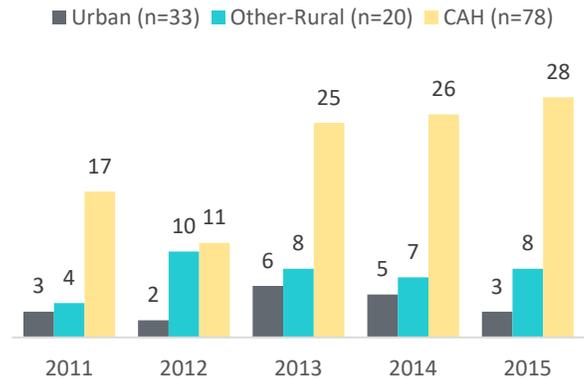


Source: Hospital Annual Report 2011-2015

The year-to-year variation from 2011 to 2015 among CAHs and other-rural hospitals would require more in-depth analysis. Factors that drive this type of variation include repeatedly low margins for the same hospital or year-to-year financial fluctuations. Differences in the presence of negative margins are another possible cause for the year-to-year variation as the median value can mask the presence of negative margins. More CAHs have negative

operating margins than other hospitals, and this increased from 2011 to 2015 (Figure 9).

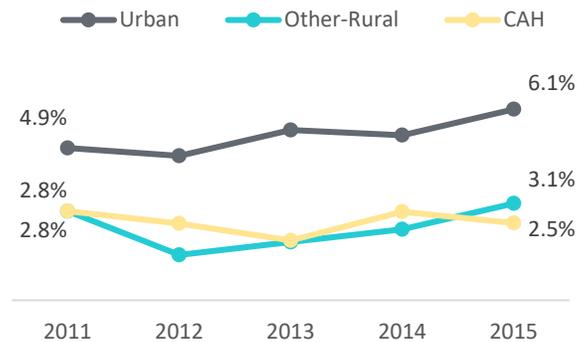
**Figure 9: Number of hospitals with negative operating margins**



Source: Hospital Annual Report 2011-2015

Minnesota hospitals report institution-wide financial data as well as hospital-only data. Many CAHs and other rural hospitals are comprehensive community health institutions that own and operate the local nursing home, medical clinic, ambulance service and other community services. Often, although not exclusively, the financial pressures on these other services result in a lower operating margin for the institution as a whole, as reflected in Figure 10, particularly for CAHs.

**Figure 10. Median institution-wide operating margin**



Source: Hospital Annual Report 2011-2015

## Discussion

The findings in this brief demonstrate the importance of health insurance coverage to the financial stability of CAHs and other rural hospitals, among which median hospital and institution operating margins are consistently lower than urban facilities. A greater number of CAHs and other rural hospitals report negative operating margins.

Medicare and Minnesota state public program charges increased among all types of hospitals. For CAHs and rural hospitals, the percent decline in commercial insurance charges and the percent increase in public programs charges - combined with the differences in reimbursement rates between public and private insurance programs - may explain the small increase in rural hospital revenues. Critical access and other rural hospitals saw an increase in their public program insurance charges, programs that typically have a lower reimbursement rate than private insurance.<sup>15</sup>

The increase in charges to public insurance programs and decrease in the percent of self-paid charges implies that many individuals who were previously paying out of pocket for health care now have insurance, many through public programs. Further investigation into the complexity of insurance reimbursement, as well as trends in patient deductibles and copays, and their impact on hospital finance, will be important to continuing to improve the stability of CAHs and rural hospitals in Minnesota. It is

important for policy makers to consider the implications that changes to health coverage will have on the availability of services and health outcomes for rural Minnesotans.

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## Appendix 1. Key milestones in ACA implementation in Minnesota

### March 2010

- Patient Protection and Affordable Care Act (ACA) signed.

### March 2011

- **Minnesota expands eligibility for its Medicaid program - known as Medical Assistance (MA)** - opening the program to childless adults with incomes at 75 percent of Federal Poverty Guidelines (FPG).<sup>16</sup>

### November 2013-March 2014

- First open enrollment period through the state's new health insurance marketplace, MNsure.
- **Tax credits and cost-sharing reductions now available** for those with income between 200 percent and 400 percent FPG who enroll in private coverage through MNsure.

### January 2014

- **MA eligibility further expanded**, now to childless adults up to 133 percent FPG. The income limit for children ages 2-18 also was raised from 150 percent to 275 percent FPG. The ACA requires that all income-eligible MinnesotaCare populations be shifted into Medical Assistance.<sup>17 18 19</sup>
- **MinnesotaCare converted to an ACA "Basic Health Plan,"** which brings expanded benefits but reduces the maximum income allowed; eligibility now limited to those with more than 133% FPG (the new income maximum for MA) but not more than 200 percent FPG.<sup>20</sup> Exceptions to the income floor are made for certain children under age 19 and legal noncitizens, who are not eligible for MA.
- Federal "individual mandate" kicks in, requiring all Americans to have health insurance coverage or pay a penalty.

### November 2014-March 2015

- Second open enrollment period through MNsure.

### November 2015-January 2016

- Third open enrollment period.

### November 2016-January 2017

- Fourth open enrollment period.

## Endnotes

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- 1 The Hospital Annual Report (HAR) is part of the Minnesota Healthcare Cost Information System (HCCIS). More information is available at <http://www.health.state.mn.us/divs/hpsc/dap/hccis/info.htm>
- 2 Minnesota Hospital Association, Critical Access Hospitals. Available at <http://www.health.state.mn.us/divs/orhpc/flex/cah/index.html>
- 3 This list is not exhaustive; the ACA included many changes to the insurance landscape, nationally and in Minnesota.
- 4 Kaiser Family Foundation. 2013. Summary of the Affordable Care Act. Available at <http://kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act/>
- 5 Minnesota Hospital Association. Hospital Financing 101. <http://www.mnhospitals.org/mn-hospitals/hospital-financing-101>
- 6 Prior to 2011, this was 101 percent; however, the Budget Control Act, decreased Medicare payments 2%. This type of reduction in payment is sequestration. Following this act, CAHs no longer receive the full 101 percent reimbursement for their inpatient and outpatient services. Other rural and urban hospitals have a prospective payment system (PPS) of reimbursement, where they receive a predetermined amount for a set of services related to a diagnosis from Medicare.
- 7 Kaiser Family Foundation. 2012. The Budget Control Act of 2011: Implications for Medicare. Available at <http://kff.org/medicare/issue-brief/the-budget-control-act-of-2011-implications/>
- 8 Minnesota Department of Health/Health Economics Program, Health Care Markets Chartbook Section 2, available at: <http://www.health.state.mn.us/divs/hpsc/hep/chartbook/section2.pdf>
- 9 This excludes revenue by smaller payers, including Workers' Compensation, TriCare, Indian Health Services and other federal payers.
- 10 Gale JA, Croom J, Croll Z, Coburn A. 2015. Charity care and Bad Debt Activities of Tax-Exempt Critical Access Hospitals. Flex Monitoring Team Policy Brief #38. Available at <http://www.flexmonitoring.org/wp-content/uploads/2015/06/PB38.pdf>
- 11 MDH Health Economics Program. 2015. Uncompensated Care in Minnesota Hospitals. Available at <http://www.health.state.mn.us/divs/hpsc/hep/publications/legislative/HospitalUncompensatedCare15ig.pdf>
- 12 Gale JA, Croom J, Croll Z, Coburn A. 2015. Charity care and Bad Debt Activities of Tax-Exempt Critical Access Hospitals. Flex Monitoring Team Policy Brief #38. Available at <http://www.flexmonitoring.org/wp-content/uploads/2015/06/PB38.pdf>
- 13 Defined by the Hospital Annual Report, 2015 dataset.
- 14 Pink GH, Howard HA, Holmes GM, Thompson RE, Slifkin RT. 2008. Analyzing Financial and Operational Performance of CAHs. Flex Monitoring Team Policy Brief #17. Available at <http://www.flexmonitoring.org/publications/bp17/>.
- 15 This brief does not examine how reimbursement differences between insurance types affect hospital profitability.
- 16 Before the ACA, adults without children were ineligible for MA. The only public options were a state-funded program (General Assistance Medical Care, or GAMC) for childless adults ineligible for MA and <75% FPG and MinnesotaCare for individuals up to 250% FPG. GAMC ended in February 2011 and those enrollees were automatically enrolled in MA.
- 17 The law expanding Medicaid a second time was enacted in February 2013, but enrollment began in early 2014. [Minnesota Individual State Report: State-Level Field Network Study of the Implementation of the Affordable Care Act](#). Brookings Institute; Nelson A. Rockefeller Institute of Government. August 2015. RA395.A4 M5673 2015.
- 18 Sonier J, Lukanen E, Blewett L. Minneapolis, MN: State Health Access Data Assistance Center, University of Minnesota; 2014. Early impacts of the Affordable Care Act on health insurance coverage in Minnesota. Available at: <http://www.shadac.org/MinnesotaCoverageReport>.
- 19 [Minnesota Individual State Report: State-Level Field Network Study of the Implementation of the Affordable Care Act](#). Brookings Institute; Nelson A. Rockefeller Institute of Government. August 2015. RA395.A4 M5673 2015.
- 20 Pre-ACA, the income maximum for MinnesotaCare was 275% FPG for children and families, and 250% for childless adults.