

HOSPITAL UNCOMPENSATED CARE COSTS IN VIRGINIA

POLICY BRIEF . SEPTEMBER 2015



Uncompensated care reflects the overall cost to hospitals of providing unpaid services to patients. Uncompensated care includes charity care, defined as free or discounted care provided to those in need that the hospital never expected payment from; and bad debt, defined as payment the hospital expected but did not receive. Bad debt includes both the costs of uninsured people who cannot pay for their care but do not apply for financial assistance and unpaid deductibles, copays, and uncovered services for insured people.

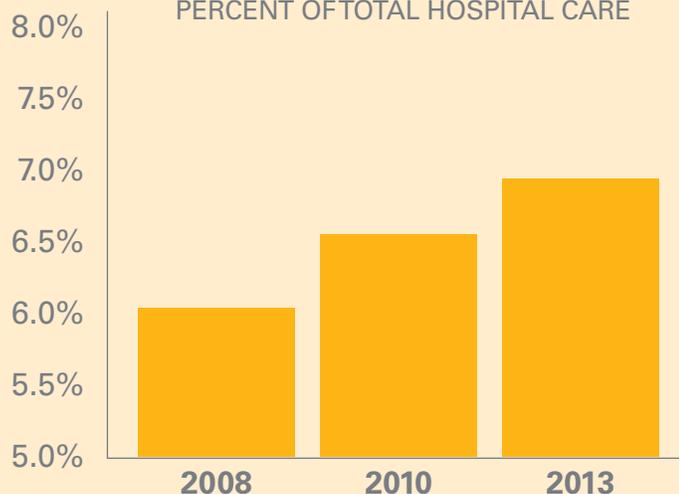
1.2 BILLION DOLLARS

Cost to Virginia hospitals for providing uncompensated care in 2013.¹

Half of all hospital uncompensated care costs in the state is incurred by only 10 hospitals—or about 10 percent of all acute-care hospitals in Virginia. Hospitals with the largest uncompensated care burden include the two large academic medical centers (Virginia Commonwealth University and University of Virginia health systems) as well as mostly large not-for-profit hospitals in urban areas that serve as major regional providers for the uninsured and other patients.

The percentage of total hospital costs accounted for by uncompensated care is a common way of assessing the financial burden on hospitals of providing care to the uninsured and underinsured. In 2013, uncompensated care comprised 6.9 percent of total costs among Virginia hospitals, up from 6.0 percent in 2008 and 6.5 percent in 2010. The upturn in uncompensated care burden likely reflects the increase in uninsured state residents, which has increased by about 11 percent to almost 1 million people.

UNCOMPENSATED CARE COSTS AS A PERCENT OF TOTAL HOSPITAL CARE



UNCOMPENSATED CARE VARIES WIDELY ACROSS VIRGINIA HOSPITALS

Under federal law, all Medicare-participating hospitals with emergency departments must screen and provide stabilizing care to someone with an emergency condition, regardless of their ability to pay. But the law, known as EMTALA (Emergency Medical Treatment and Labor Act), does not provide payment for any required care.

As a result, almost all hospitals provide some level of uncompensated care, but the amount varies across hospitals and is related to the size of the hospital, ownership type, and location. Virginia hospitals include not-for-profit hospitals that must provide community benefits—including charity care—in exchange for local, state, and federal tax exemptions and for-profit hospitals that have no such requirement.

UNCOMPENSATED CARE COSTS AS A PERCENT OF TOTAL HOSPITAL COSTS: BY HOSPITAL TYPE AND LOCATION

LOCATION

URBAN	7.5%
RURAL	7.6%
CRITICAL ACCESS HOSPITALS	10%

OWNERSHIP

NOT-FOR-PROFIT	7.9%
FOR-PROFIT	4.2%

Not-for-profit hospitals provide higher levels of uncompensated care—7.9 percent of total costs on average, compared to 4.2 percent for for-profit hospitals. The 12 hospitals with the highest uncompensated care burden—uncompensated care is 10 percent or more of total costs—are all not-for-profit, while all but one of the 11 hospitals with the lowest uncompensated care burden—less than 4 percent—are for-profit hospitals.

Small rural hospitals in geographically isolated areas, known as critical access hospitals, have average uncompensated care costs of about 10 percent, likely reflecting in part the high uninsured rates in northwestern and southwestern Virginia where these hospitals tend to be located. Other not-for-profit hospitals in rural and urban areas have average care costs of about 7.5 percent.

UNCOMPENSATED CARE AND HOSPITAL FINANCIAL PERFORMANCE

Many factors affect hospitals' financial performance and viability, but rising uncompensated care costs due to increases in the uninsured population are a concern. Among hospitals with uncompensated care of 10 percent or more of total costs, about half experienced financial losses from patient care in 2013. On average, these hospitals had operating margins near zero, indicating that operating revenue barely kept pace with the costs of providing services. In contrast, hospitals with a low burden of uncompensated care—less than 4 percent of total costs—performed much better financially, with average operating margins of 7.8 percent.

POLICY IMPLICATIONS

Many expected that expansions in Medicaid and private insurance coverage through the 2010 Affordable Care Act (ACA) would reduce hospital uncompensated care by increasing the number of patients with insurance. Early findings indicate this is happening in states that expanded Medicaid coverage to people with family incomes less than 138 percent of the federal poverty level, or \$33,465 for a family of four in 2015. Hospital uncompensated care costs have declined by 45 percent in California, 36 percent in Colorado, 60 percent in Kentucky, 56 percent in Arkansas, 43 percent in New Jersey, and 40-50 percent in Ohio since implementation of the ACA's coverage expansions in 2014.²

In contrast, hospitals in states, like Virginia, that have not expanded Medicaid have seen little or no decrease in uncompensated care levels. In many states with substantial decreases in uncompensated care, the savings have allowed hospitals to expand capacity and serve more patients, offer new services, hire new staff, and invest in new technologies and care innovations. They also have generated savings for state budgets in states that provided some funding for the care of uninsured people.

284 MILLION
DOLLARS

Expanding Medicaid coverage could reduce hospital uncompensated care costs by **24 percent** and save \$284 million.

This report examined the potential impact on hospital uncompensated care costs if Virginia expanded Medicaid coverage. The results show that there would be a \$1,060 reduction in hospital uncompensated care costs in Virginia for every uninsured person who gains coverage (see Technical Appendix). Using other research that indicates 268,000 people could gain coverage by 2016 if Virginia expanded Medicaid³, total hospital uncompensated care costs in Virginia would drop by about \$284 million, a 24 percent decrease from 2013 levels.

Another policy option is to increase public subsidies to hospitals to offset the costs of uncompensated care. For example, Medicaid and Medicare disproportionate share hospital (DSH) payments have been used to subsidize care to the uninsured in hospitals that serve a large proportion of low-income and uninsured patients. Currently most of these payments for Virginia go to VCU and UVA health systems, although they are expected to decrease substantially starting in 2018.⁴ Some states, such as Massachusetts, California, Texas, and Florida, have separate state-funded programs to subsidize care for the uninsured in hospitals and other facilities. However, hospital subsidies are less effective than expanding coverage in increasing access to primary care and preventive services, which ultimately may reduce unnecessary hospital utilization and costs.

Without Medicaid expansion or other policies to subsidize hospital care for the uninsured, many Virginia hospitals will continue to struggle with high uncompensated care burdens, especially those in low-income urban and rural areas. High uncompensated care burdens not only threaten the financial viability of many hospitals but also can prevent hospital investments in infrastructure, staffing, and care-delivery that may adversely affect the health of Virginians.



This Policy Brief was prepared by **Peter Cunningham, Ph.D.**, Professor, Department of Health Behavior and Policy at Virginia Commonwealth University; and **Ali Bonakdar Tehrani, Pharm.D., M.P.H.**, doctoral candidate in the Department of Health Behavior and Policy at Virginia Commonwealth University.

The findings and conclusions in this Policy Brief are those of the authors, and no official endorsement by VCU Health or the VCU School of Medicine is intended or should be inferred.

¹Estimates in this report are derived from the Virginia Health Information (VHI) Hospital Detail Reports. Estimates reflect only acute-care hospitals. Long-term care and rehabilitation facilities are excluded. All estimates of uncompensated care reflect costs, based on the methodology used by the American Hospital Association. For more details, see American Hospital Association, Uncompensated Care Cost Fact Sheet, January 2015. ²Bachrach D, Boozang P, Lipson M. The impact of Medicaid expansion on uncompensated care costs: Early results and policy implications for states. The Robert Wood Johnson Foundation: State Health Reform Assistance Network, June 2015. ³Dorn S, McGrath S, Holahan J. What is the result of states not expanding Medicaid? The Urban Institute, August 2014. ⁴The Affordable Care Act reduces Medicaid Disproportionate Share Hospital payments on the assumption that increased patient revenue from insured patients will greatly reduce the amount of hospital uncompensated care requiring these subsidies.

TECHNICAL APPENDIX

The data for this report are from Virginia Health Information (VHI) Hospital Detail Reports for 2008, 2010, and 2013. VHI provides detailed information on revenue, reductions, expenses, balance sheet, cash flow, facility type, tax status, and number of admissions by insurance type for each Virginia hospital. VHI provides information on “charges” for charity care and bad debt, which is different from the costs to hospitals of providing this care. We used the same methodology used by the American Hospital Association to convert charges to costs. This involves computing a hospital-specific cost-to-charge ratio, and multiplying this result by the sum of uncompensated care and bad debt charges.

To estimate the impact of expanding Medicaid coverage on total hospital uncompensated care costs in the state of Virginia, we modeled the change in total uncompensated costs in a geographic area as a function of the change in the number of uninsured, as well as other area and year-specific effects. Geographic areas are based primarily on Core-Based Statistical Areas for metropolitan areas—as defined by the U.S. Office of Management and Budget—and counties for rural areas. In some cases, rural counties with no hospitals were combined with other counties or metropolitan areas based on closest proximity.

Data for 2008, 2010, and 2013 were pooled into a single model using the following specification:

$$UCC_{it} = \beta_0 + \beta_1 Uninsurance_{it} + \gamma_{it} + Y_{it} + \epsilon_{it}$$

UCC is total uncompensated care costs in geographic area i and in year t . (Adjusted for inflation using 2013 CPI value)

Uninsurance is the number of uninsured individuals in geographic area i and in year t , derived from the American Community Survey.

γ is a set of fixed-effects for each of the geographic areas

Y is a set of Year fixed-effects.

Using a set of geographic and year fixed-effects essentially controls for other changes in a geographic area and in a specific year that might be correlated with uncompensated care costs. The results of this model indicate that for every uninsured person who obtains coverage, the uncompensated care would decrease by about \$1,060 (the parameter estimate for β_1). Multiplying that amount by the total number of uninsured who could gain Medicaid coverage if the state expanded Medicaid to 138% of the federal poverty level (268,000 persons) results in potential savings of \$284 million in hospital uncompensated care costs.