

A SHARED RESPONSIBILITY

Academic Health Centers and the
Provision of Care to the Poor and Uninsured

A Report of The Commonwealth Fund
Task Force on Academic Health Centers

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CONTENTS

Prologue	vii
Executive Summary	ix
I. Introduction	1
II. Background on Health Care for the Poor and Uninsured	3
III. Findings	29
IV. Principles and Conclusions.....	49
V. Recommendations	53

LIST OF FIGURES

Figure 1	Risk of Being Uninsured, 1998	25
Figure 2	Health Insurance Coverage by Poverty Level, 1998	25
Figure 3	Growth in the Number of Uninsured Americans, 1988–1999	26
Figure 4	Number of Persons Served in Medicaid, 1980–1997	26
Figure 5	Medicaid Payments to Providers, 1980–1997	27
Figure 6	Hospital Payment-to-Cost Ratios by Payer, 1984–1998.....	27
Figure 7	Medicare Disproportionate Share Hospital Payments, 1988–1997	28
Figure 8	Medicaid Disproportionate Share Payments, 1989–1997	28
Figure 9	Uncompensated Care as a Percentage of Gross Patient Revenues, by Ownership and Type of Hospital, 1996.....	44
Figure 10	Share of Total Charity Care Provided by Public and Private AHCs in Their Communities, 1991 and 1996	44
Figure 11	Relative Concentration of Uninsured Patients, Total and by Level of Competition, 1991, 1994, and 1996	45
Figure 12	Share of Uninsured Patients Served by AHCs in Their Markets, by Ownership and Level of Competition, 1991, 1994, and 1996.....	45
Figure 13	Average Total Margin by Percent of Admissions That Are Self-Pay/Charity, 1991, 1994, and 1996	46
Figure 14	Change in Inflation-Adjusted Charity Care and Patient Revenues for Faculty Practice Plans, 1995 to 1998.....	46
Figure 15	Distribution of Percentage of Self-Pay Patients by Medicare DSH Payment Rate.....	47

Figure 16	Uncompensated Care Costs in Major Teaching Hospitals as a Percentage of Operating Expenses	47
Figure 17	Percent of AIDS Cases Treated in AHCs, by Type of Insurance Coverage	48

LIST OF TABLES

Table 1	Number of Markets with Increases and Decreases in Relative Concentration of Charity Care from 1991 to 1996, by State	32
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PROLOGUE

As part of its continuing work on the social missions of academic health centers (AHCs), The Commonwealth Fund Task Force on Academic Health Centers has now completed its fourth major report. *A Shared Responsibility* reviews the role of the nation's 125 medical schools and their owned and closely affiliated clinical teaching facilities in caring for the poor and uninsured.

The work of the Task Force reveals that AHCs play a disproportionate role in meeting the needs of these vulnerable populations. This is especially true of the publicly owned members of the AHC community, but privately owned AHCs also provide more care to the poor and uninsured than privately owned clinical facilities that are not part of AHCs. In urban communities, AHC facilities frequently provide 20 to 40 percent of all the care provided to poor and uninsured populations. They also are primary providers of highly specialized and high-technology services to these groups of patients.

The Task Force has been particularly attentive to the effects of changes in private markets on the social missions of AHCs. In this regard, one finding of this report deserves special emphasis. During the decade of the 1990s, free care has become increasingly concentrated in AHCs, and this development has been most pronounced in "competitive" markets—those with high levels of managed care penetration. This finding suggests that competitive forces at work in the U.S. health care system may cause some community-based providers to reduce their involvement in caring for financially unattractive patients, with the result that larger numbers of such patients find their way to the nation's AHCs.

The Task Force has identified a number of policy measures that could help AHCs maintain their roles as safety net institutions. Prominent among these are reforms to the Medicare and Medicaid disproportionate share programs, as well as efforts to provide health insurance to uncovered individuals. As always, the hope is that our findings and conclusions will inform discussions already under way on these matters.

We once again express our gratitude to The Commonwealth Fund for its support and to members of the Task Force and its staff for their continuing commitment to this work on the social missions of academic health centers. In the future, we hope that the Task Force will make further contributions to understanding how the nation can promote the effectiveness and efficiency with which it conducts the social missions of AHCs.

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EXECUTIVE SUMMARY

The nation's 125 academic health centers (AHCs)—consisting of medical schools and their closely affiliated hospitals and physician groups—carry out unique social missions of enormous benefit to the entire society. These institutions have primary responsibility for training the next generation of health care professionals, for conducting biomedical research that has continuously improved the quality and effectiveness of this country's medical care, and for providing the highly specialized health care services. In addition, AHCs, as a group, have made caring for the poor and uninsured an integral part of their social missions.

Now, changes in the health care market may threaten AHCs' ability to continue financing their social missions, including the provision of care to the poor and uninsured. The demand for such care has been increasing with the steady growth in the number and share of the population who are uninsured. Despite recent attempts to expand the number of persons insured, nearly 43 million still lack health insurance, leaving many in the United States unable to get the care they need.

The Commonwealth Fund Task Force on Academic Health Centers intends this report to be a resource to guide future policy development and management on the issue of financing care to the poor and uninsured. The report begins with an examination of who the uninsured are and how their care is currently provided and financed. The next section looks at issues relating to this problem, with particular emphasis on the impact of changes in the health care market on the availability and financing of such care. The report concludes with specific recommendations addressing key problems facing AHCs and other segments of the health care safety net as they struggle to carry out their social mission of ensuring access to health care for those who do not have the means to pay for it.

Findings

Over the past year, the Task Force examined the role AHCs and other providers play in assuring access to care for the poor and uninsured. These findings suggest that changes in the health care market are affecting the way disadvantaged persons obtain their care, and, in turn, are affecting the financial status of institutions dedicated to providing such care. In addition, the Task Force found that AHCs play a significant and growing role as health care providers for the poor and uninsured. At the same time, existing policies intended to provide support to institutions that carry out this social mission are poorly targeted, resulting in the ineffective use of limited resources.

The key findings are:

1. Charity care as a proportion of all hospital care has been growing as the number of people without health insurance increases. The amount of free care academic health centers provide to the uninsured is increasing faster than such care provided by other types of hospitals.
2. Competition is changing the patterns of care for the poor. In markets with high managed care penetration, care for the uninsured is becoming more concentrated within the provider community: institutions that provide significant amounts of care to uninsured patients are seeing an increase in such cases, while other facilities are experiencing a decrease.
3. Academic health centers are important sources of care for uninsured patients in their communities. From 1991 to 1996, their share of care for the uninsured grew, in part because of the increased concentration of uninsured patients within AHCs in markets with high managed care penetration.
4. Providing substantial amounts of care to uninsured patients has a negative effect on the margins of all hospitals, including academic health centers.
5. Faculty practice plans are also providing an increasing amount of charity care, but without the subsidies from Medicare and Medicaid that are available to hospitals providing a disproportionate amount of care to the poor and uninsured.
6. Medicare disproportionate share payments are not efficiently targeted to provide additional support to those safety net hospitals that treat a disproportionate share of uninsured patients.
7. The Medicaid disproportionate share payments represent an important source of funding for AHCs and safety net hospitals. However, these funds are inequitably distributed and poorly targeted. In addition, there are wide variations in how these funds are used.
8. Direct funds from state and local governments are a vital resource for financing indigent care. While publicly owned AHCs and major teaching hospitals provide much more care to the poor and uninsured than private hospitals, this additional

cost is generally financed through direct subsidies from state and local governments.

9. Academic health centers provide a disproportionate amount of some types of specialized services to the poor and uninsured.

Principles and Conclusions

Based on these nine findings, the Task Force developed a series of principles and conclusions to guide policymakers in their deliberations of how best to address these issues.

- The provision of care to the uninsured is a social benefit, whose costs should be shared broadly across all society.
- Increasing the number of persons covered by both public and private health insurance is the most appropriate way of reducing the financial burden on providers caring for the uninsured.
- As long as some Americans remain uninsured, all participants in the health care system, including providers, insurers, and employers, should continue to meet their obligations to assure the poor and uninsured access to needed care. Academic health centers must continue to carry out their historic mission to provide such care.
- Policies need to be developed that provide support for care to the poor and uninsured while allowing providers to compete on an equal basis for insured patients.
- Public support for indigent care should be targeted to those providers that deliver the greatest amount of such care.

Recommendations

Building on these general conclusions, the Task Force developed five recommendations.

1. As first priority, the long-term trend of ever increasing numbers of uninsured persons must be reversed.

- a. Federal and state governments should adopt policies that will maximize the number of eligible persons who are actually enrolled and covered under existing public insurance programs, including Medicaid and the Children's Health Insurance Program (CHIP).
 - b. Congress and the Administration should continue to expand the availability of health insurance coverage through incremental reforms.
 - c. The federal government should encourage AHCs to experiment with innovations in providing care to poor and uninsured populations, including demonstration programs involving new methods of reimbursement and organization of services.
2. The Medicare disproportionate share payments regulations should be amended to channel this support to the institutions most involved in providing care to the poor and uninsured.
 - a. The formula for the Medicare disproportionate payment adjustment should be based on each institution's volume of uncompensated care as well as care provided to poor patients who are covered by Medicaid, other indigent care programs, and Medicare. These subsidies should be targeted to those hospitals with the largest shares of low-income patients.
 - b. Medicare payments to Medicare+Choice plans should be determined without regard to Medicare disproportionate share payments. As with Medicare support for graduate medical education, disproportionate share payments should be carved out of the Medicare+Choice premiums and made directly to the institutions providing care to Medicare+Choice enrollees who qualify for such payments under traditional Medicare.
 - c. Medicare's system of higher payments to providers of disproportionate amounts of care to the poor and uninsured should be extended to cover a broader array of services, including those provided in hospital outpatient departments and clinics and by faculty practice plans.
 3. The Medicaid disproportionate share program should be reformed to target these funds to acute care hospitals and other organizations that provide care to the poor and uninsured.

4. The federal government should increase support for studies designed to improve the quality of care provided to the uninsured and to members of racial and ethnic minorities.

5. AHCs should ensure that medical students and residents have appropriate training and experience in providing care to the poor, uninsured, and racial and ethnic minorities. The goal of these activities should be to reduce the disparities in health care use and outcomes for these populations.

I. INTRODUCTION

Academic Health Centers (AHCs) have a unique combination of missions that include medical education and training, basic and applied research on new medical practices and technologies, and the delivery of state-of-the-art and technologically advanced patient care. For many AHCs, their mission also includes the provision of care to the poor and uninsured.

The mission of providing care to the poor goes back over 200 years to the establishment of the first teaching hospitals and medical schools in America. In 1769, Dr. Samuel Bard gave the commencement speech to the first graduating class of Kings College Medical School in New York City. Urging the establishment of a hospital, Dr. Bard laid out what he believed should be the missions of this new organization—patient care, research, and teaching. In describing the patient care mission, he said, “Let those who are at once the Victims, both of Poverty and Disease, claim your particular attention.”¹ In many respects, this statement was simply a reflection of the state of medical care in America from pre-revolutionary times up through the end of the nineteenth century. Rich and middle class patients were treated in their homes. Hospitals were to be avoided. Only the poor were left to be treated in institutions, and to provide the raw material for medical education and research. Hospitals were charitable institutions, funded and maintained through gifts, donations, and fund-raising.

During the twentieth century, both the role of hospitals and the financing of care went through major changes. Improvements in technology brought both middle and upper class patients into hospitals. Hospitals were no longer sources of care of last resort. The emergence of the health insurance industry revolutionized the financing of these institutions and the financing of care provided to the poor. No longer solely dependent on charitable giving, AHCs and other hospitals began financing charity care through cross-subsidies from paying patients. Local governments used tax revenues to provide additional support to public hospitals.

As we begin the new millennium, the mission of charity care is facing formidable challenges. Health care competition is reducing hospital revenues, threatening the availability of the cross-subsidies that support hospitals' social missions, including indigent care. At the same time, the number of individuals without insurance has been growing. In

¹ E. Larrabee, *The Benevolent and Necessary Institution* (Garden City, N.Y.: Doubleday & Company, 1971).

1998, 18 percent of the nonelderly population lacked insurance, an increase of nearly 10 million uninsured individuals over the preceding decade.

For financial reasons alone, not many institutions take on the mission of providing indigent care. Few hospitals seek to expand their obligations; some have actively sought to reduce their commitments to the poor. The obvious exceptions are public hospitals, which are specifically charged with caring for the poor. The fact that so many AHCs have, thus far, maintained their indigent care missions is the result of a combination of factors: tradition and their sense of community responsibility, their location in the central core of our largest cities, the continued availability of sufficient financing, and the large number of AHCs that are public institutions.

The purpose of this report is to present background information, current data, and recommendations on the indigent care mission of AHCs. The remainder of this report is divided into four sections. Section II presents background information on the uninsured, Medicaid, financing of indigent care, and recent legislation. Section III presents the findings of the Task Force relating to care for the poor and uninsured. Section IV describes the general conclusions and principles on which the Task Force based its recommendations. The recommendations themselves are presented in Section V.

II. BACKGROUND ON HEALTH CARE FOR THE POOR AND UNINSURED

Who Are the Uninsured?

In 1998, there were nearly 43.9 million uninsured people in the United States, accounting for 18.4 percent of the nonelderly population.² While people without health insurance are generally characterized as being relatively young, poor, male, and unemployed, a significant number of employed, middle class men, women, and children are also without health insurance.

The majority of uninsured Americans are adults ages 18 to 64. Largely because of Medicare, only 1 percent of elderly persons (300,000 individuals) are without some form of insurance coverage. Eighty-five percent of children are covered by some form of insurance, most often as dependents on a working parent's health insurance plan (63.2%). Medicaid has also traditionally provided significant coverage to children (15.2%) under the Aid to Families with Dependent Children program, and now under the Temporary Assistance for Needy Families (TANF) program.³

Most of the nonelderly population (64.9%) obtain their health insurance as a benefit of their employment or the employment of a parent or spouse. Yet, nearly three-quarters of the uninsured (74%) live in families in which at least one or more members of their immediate family work full-time.⁴

The reasons these people are not covered are complex. In some cases, a worker is self-employed, or may be employed by a firm that either does not provide any health insurance benefits or excludes dependents. In 1999, nearly 20 percent of workers were employed in firms that did not offer health insurance benefits, a common plight of employees in small firms or in low paying service industry jobs.⁵ This is typically true for employees in small firms, or in low-wage jobs in the service industry. However, even in these cases, a significant number are insured through the employment of another family member. Figure 1 (see page 25) shows the risk of being uninsured by various characteristics of employment, income, size of firm, and type of business.

² Kaiser Commission on Medicaid and the Uninsured, *Uninsured in America: A Chart Book*, 2nd ed. (Washington, D.C.: The Henry J. Kaiser Family Foundation, March 2000). Hereafter cited as the *Kaiser Chart Book on the Uninsured*.

³ Ibid.

⁴ Ibid.

⁵ Kaiser Family Foundation and Health Research and Education Trust, *Employer Health Benefits: 1999 Annual Survey* (Menlo Park, Calif., and Chicago: The Henry J. Kaiser Family Foundation and Health Research and Education Trust, October 1999).

On the other hand, there are some workers who are not insured even though they work in industries that typically offer such benefits. For example, 7 percent of government workers are uninsured, as are 12 percent of the workers in mining and manufacturing industries. Some people simply do not enroll themselves or their dependents in health insurance plans, even when the opportunity is available. Both surveys⁶ and research utilizing sophisticated econometric models⁷ suggest that the high cost of such coverage is a major deterrent, discouraging these people from obtaining available insurance for themselves and their families. Cost factors probably contribute to the fact that the employer sponsored system serves low-income workers poorly. A low-income worker, earning \$7 per hour, would have to contribute nearly 8 percent of annual earnings to pay the average employee share of premiums, \$1,092 per year in 1998.⁸

Some people also may be temporarily uninsured as a result of a change in work status or employer. Thirteen percent of nonelderly adults had at least one gap in coverage during a two-year period. While this gap was relatively short for some adults—a gap of 3 months or less for 15 percent—nearly half (44%) experienced a gap in coverage of 2 or more years.⁹

Although the majority of the uninsured are white, in percentage terms, nonwhites are clearly most at risk of being uninsured. Hispanics have the highest risk—38 percent uninsured in 1996. Twenty-four percent of African-Americans and 24 percent of Asian/Pacific Islanders were uninsured, while only 14 percent of whites did not have health insurance in 1996.¹⁰

Finally, there is a strong relationship between poverty status and being uninsured. Figure 2 displays the relationship by income levels, measured as a percent of poverty, and type of insurance. For the poorest segment of our population (below the federal poverty line), Medicaid is the predominant form of coverage, providing benefits to 41 percent of this group. More than one-third (36%) of this population is uninsured. Slightly less than one-third (31%) of the group between 100 and 200 percent of poverty is uninsured.

⁶ L. Duchon, C. Schoen, E. Simantov, K. Davis, and C. An, *Listening to Workers: Findings from the Commonwealth Fund 1999 National Survey of Workers' Health Insurance* (New York: The Commonwealth Fund, January 2000).

⁷ R. Kronick and T. Gilmer, "Explaining the Decline in Health Insurance Coverage, 1979–1995," *Health Affairs* 18 (March/April 1999): 30–47.

⁸ J. Gabel, "Job-Based Health Insurance, 1977–1998: The Accidental System Under Scrutiny," *Health Affairs* 18 (November/December 1999): 62–74.

⁹ *Kaiser Chart Book on the Uninsured*, pp. 5–6.

¹⁰ K. S. Collins, A. Hall, and C. Neuhaus, *U.S. Minority Health: A Chart Book* (New York: The Commonwealth Fund, May 1999), p. 117.

Medicaid, however, covers a much smaller percent (17%), with the difference being made up primarily through increases in employer sponsored coverage. Of the population that is not poor (persons above 300 percent of the federal poverty line, about \$41,000 in 1998), only 9 percent were uninsured and only 2 percent covered by Medicaid.

Trends in the Number of Uninsured

The number of uninsured in this nation has been growing steadily. The number of uninsured increased by nearly 10 million people (30%) from 1988 to 1999 (Figure 3).¹¹ In percentage terms, the proportion of the uninsured, nonelderly population grew from 16.2 percent in 1989 to 18.4 percent in 1998. The most recent census figures show a slight decline from about 43.9 million to 42.6 million in the number of uninsured Americans. This may be only a one-year interruption in what has been a long-term trend of rising numbers of uninsured.

Most of the increase that occurred during the first half of this period can be attributed to erosion of private, employer sponsored coverage. From 1988 to 1993, the proportion of the nonelderly population covered by employer sponsored plans declined from 65.9 to 60.5 percent. This drop in employer based coverage was partially offset by increases in Medicaid enrollment, which targeted primarily pregnant women and children. Although the proportion of the nonelderly population covered by Medicaid increased from 7.0 to 10.1 percent, the number of nonelderly uninsured grew by nearly 6 million.

With the economic expansion in the second half of this 10-year period, the dynamic changed somewhat. Employer based coverage not only stabilized, but even marginally increased, growing from 63.6 percent of the nonelderly in 1994 to 64.9 percent in 1998. Medicaid coverage, however, began to decline. In 1995, Medicaid covered 12.5 percent of the nonelderly. As a result of welfare reform and other factors, Medicaid enrollment declined to only 10.4 percent of the nonelderly in 1998. The net impact of these two trends was to increase the number of uninsured by nearly 4 million.

The fall in coverage under Medicaid is believed to be due, in part, to enactment of welfare reform in 1996. Traditionally, low-income women and children were covered under the Aid to Families with Dependent Children (AFDC) program. As part of the welfare reform legislation, AFDC was replaced by a program of block grants to the states called Temporary Assistance for Needy Families (TANF). The intent of the legislation was to sever the link between cash assistance and Medicaid eligibility, not to change the

¹¹ Except where otherwise noted, the information in this section is from the *Kaiser Chart Book on the Uninsured*.

eligibility criteria. Actual eligibility for Medicaid remained the same. In practice, however, there appears to have been significant confusion about how this change was to be implemented, resulting in many Medicaid-eligible families either dropping their Medicaid coverage or simply remaining uninsured. Immigrants, both legal and illegal, seem to have been particularly hard hit, because so many feared that accessing these benefits could threaten their stay in this country or their chance of becoming citizens. The Health Care Financing Administration (HCFA) has just begun taking steps to assure that these individuals are once again covered.

Medicaid

Medicaid is a state-administered health insurance program for poor and low-income individuals, jointly financed by the states and the federal government.¹² The federal government pays states a share of their expenditures. That share is known as the Federal Medical Assistance Percentage (FMAP). In 1999, the FMAP varied from a low of 50 percent (10 states) to a high of 76.78 percent (Mississippi). Prior to enactment of the Temporary Assistance for Needy Families (TANF) provisions of the Balanced Budget Act (BBA) (described on page 20 below), eligibility for Medicaid benefits was generally linked to receipt of cash welfare benefits.

Describing Medicaid eligibility criteria can be extremely complicated. Depending on how they are grouped, there are at least 18 different categories of eligibility, some federally mandated and others available at the option of individual states. In general, poor women, infants, and children who would have been eligible for cash benefits (prior to 1997), poor pregnant women, persons receiving Supplemental Security Income (SSI) benefits, persons who are blind or disabled, certain Medicare beneficiaries, and other specific groups are eligible for Medicaid. During the late 1980s, eligibility for Medicaid was gradually expanded. Figure 4 displays the growth in number of persons served by Medicaid since 1980.

Even with the wide range of eligibility categories, many poor people are still either not eligible or have failed to successfully negotiate the enrollment process. In 1998, 12.1 million nonelderly persons were below the federal poverty line (FPL) and were uninsured. Twenty-six percent of children living in families with income below the FPL were uninsured.¹³ Thirty-one percent of families with uninsured children and income below

¹² Except where otherwise noted, this description of Medicaid is taken from: U.S. Department of Health and Human Services, Health Care Financing Administration, "Medicare and Medicaid Statistical Supplement, 1999," *Health Care Financing Review*, Washington, D.C., 1999, pp. 9–17.

¹³ *Kaiser Chart Book on the Uninsured*, pp. 23 and 36.

their state's eligibility criteria had never tried to enroll in Medicaid. Among these who tried, over half (57%) did not complete the process or were denied.¹⁴

Medicaid provides a broad benefit package, including inpatient hospital services, physician services, diagnostic tests, prescription medications, prenatal care and other preventive services, nursing facility services, and services provided in community and rural health centers. In addition, states may elect to obtain federal matching funds for other coverage, such as care in intermediate care facilities for the mentally retarded, eyeglasses and optometry services, transportation, and rehabilitation. States may, within broad federal guidelines, determine the scope and duration of the services covered.

Generally, states have substantial flexibility in determining the amount of Medicaid payments, which usually go directly to the service providers. Aggregate Medicaid vendor payments have risen rapidly, due to both expanding enrollment and health care inflation. Payments to providers increased from \$23 billion in 1980 to \$123 billion in 1997, an average annual rate of 11.0 percent (Figure 5).

States may impose a nominal deductible, coinsurance, or copay requirements on Medicaid recipients, with the exclusion of pregnant women, children under age 18, and certain institutionalized patients.

Over the past eight years, to control costs, state Medicaid programs have increasingly relied on managed care plans to deliver services. In 1990, only 2.7 million Medicaid beneficiaries received care through managed care plans. By 1998, over half of Medicaid recipients (16.6 million persons or 53.6%), predominantly women and children, received their health care through such plans. Medicaid managed care models include risk-based plans that are fully capitated and primary care case management plans. In the latter models, a primary care "gatekeeper" approves and monitors services, without assuming financial risk. Forty states have implemented mandatory managed care in part of their states or for certain categories of beneficiaries.¹⁵

Implications of Poverty, Race, and Lack of Insurance on Health Care

A large number of studies have examined the health implications of poverty, race, and lack of health insurance. Obviously, lack of insurance presents a major financial barrier to individuals seeking care. Nevertheless, the uninsured do receive a significant amount of

¹⁴ Kaiser Commission on Medicaid and the Uninsured, *Medicaid Facts: Enrolling Uninsured Children in Medicaid* (Washington, D.C.: The Henry J. Kaiser Family Foundation, January 2000).

¹⁵ Kaiser Commission on Medicaid and the Uninsured, *Medicaid Facts: Medicaid and Managed Care* (Washington, D.C.: The Henry J. Kaiser Family Foundation, June 1999).

care, as evidenced by the amount of uncompensated services hospitals and clinics provide. Studies also have shown that, even when insured, patients who are poor or members of a racial or ethnic minority have very different sources and patterns of care than whites. The relationship of insurance status to both poverty and race makes it difficult to disentangle the separate effects of these three variables.

Studies show that the uninsured and the poor more commonly report difficulties in getting and paying for care. The uninsured were four times more likely than the insured to report an episode of needing but not seeking care.¹⁶ Uninsured children were three times more likely to go without some needed service (medical or dental care, medications, or eyeglasses).¹⁷ Uninsured children in poor health have many fewer physician contacts than insured children in poor health (4 vs. 16 visits).¹⁸

Reliance on a usual source of care is generally associated with better access to care. Minorities, the poor, and the uninsured are much less likely to have a usual source of care. Thirty-eight percent of the uninsured reported no usual source of care, compared to 15 percent of privately insured Americans and 13 percent of Americans with public coverage.¹⁹ While 26 percent of white adults reported no usual source of care, 39 percent of blacks and 46 percent of Hispanics had no usual source.²⁰ Approximately half of blacks and Hispanics (47% and 53%, respectively) rely on hospital emergency rooms and outpatient departments for care.²¹

Poor, minority, and uninsured populations are also more likely to suffer adverse health outcomes.²² They need to be hospitalized more frequently for problems that do not necessarily require inpatient treatment. For example, the uninsured are twice as likely as those with private insurance to be hospitalized for diabetes, hypertension, and asthma, all problems that often can be managed on an outpatient basis.²³

¹⁶ R. M. Weinick, S. H. Zuvekas, and S. K. Drilia, "Access to Health Care—Sources and Barriers, 1996," MEPS Research Findings No. 3, AHCPH Pub. No. 98-0001, Agency for Health Care Policy and Research, Washington, D.C., 1997.

¹⁷ P. W. Newacheck et al., "Health Insurance and Access to Primary Care for Children," *New England Journal of Medicine* 338 (1998): 513–519.

¹⁸ Ibid.

¹⁹ Weinick et al., Op cit.

²⁰ K. S. Collins, A. Hall, and C. Neuhaus, *U.S. Minority Health: A Chart Book* (New York: The Commonwealth Fund, May 1999), p. 77.

²¹ Ibid., p. 89.

²² American College of Physicians–American Society of Internal Medicine, *No Health Insurance? It's Enough to Make You Sick* (Philadelphia: American College of Physicians–American Society of Internal Medicine, White Paper, 2000).

²³ J. Weissman, C. Gastonis, and A. M. Epstein, "Rates of Avoidable Hospitalizations by Insurance Status in Massachusetts and Maryland," *Journal of the American Medical Association* 268 (1992).

The high risk of not seeking care is especially evident in the case of breast cancer, where early diagnosis and treatment have led to significant improvements in treatment and survival. However, uninsured women are more likely to be diagnosed at a later stage of the disease, and are 49 percent more likely to die within four to seven years following the initial diagnosis.²⁴ Black women have a lower incidence of breast cancer than whites, 101 cases per 100,000 women for blacks compared to 115 per 100,000 for whites. However, they have a lower five-year survival rate, 71 percent and 81 percent for blacks and whites respectively. The disparities in survival rates have been related to a number of factors, including lower use of routine mammography, poorer access to care, and diagnosis at a later stage of the disease.²⁵

Providing the uninsured with insurance has tangible effects. As would be expected, health care utilization and costs go up. Expanding Medicaid eligibility for children increases the probability of a doctor visit and nearly doubles the likelihood of a hospitalization during a year.²⁶ As utilization goes up, health outcomes improve. For instance, a woman eligible for Medicaid is much more likely to obtain timely prenatal care.²⁷ From 1983 to 1996, Medicaid expansions were associated with a 27 percent decline in preventable hospitalizations.²⁸ The increase in Medicaid eligibility for children from 1979 to 1992 was associated with an 8.5 percent decrease in infant mortality and a 7.8 percent reduction in low birthweight infants.²⁹

Certainly, the lack of insurance can have a serious impact on a person's health, but another separate and important factor is the effect of race. Populations with the same insurance show significant racial differences in how they access the health care system and the kinds of services they receive. Among elderly Medicare beneficiaries, whites are more likely than blacks or Hispanics to have a doctor's office as their usual source of care (83%, 64%, and 62%, respectively) and to receive an influenza vaccine (65%, 43%, and 49%, respectively).³⁰ Also, black Medicare beneficiaries are about half as likely as whites to receive certain specialty services, such as angioplasty, coronary artery bypass surgery, and

²⁴ J. Z. Ayanian, B. A. Kohler, T. Abe, and A. M. Epstein, "The Relationship Between Health Insurance Coverage and Clinical Outcomes Among Women with Breast Cancer," *New England Journal of Medicine* 329 (1993).

²⁵ Collins et al., op. cit., p. 48.

²⁶ J. Gruber, "Health Insurance for Poor Women and Children: Lessons from the Past Decade," in *Tax Policy and the Economy*, ed. J. M. Poterba (Cambridge, Mass.: Massachusetts Institute of Technology Press, 1997).

²⁷ Ibid.

²⁸ L. Dafney and J. Gruber, "Does Public Insurance Improve the Efficiency of Medical Care? Medicaid and Child Hospitalizations," NBER Working Paper 7555, February 2000.

²⁹ Gruber, op. cit.

³⁰ Collins et al., op. cit., pp. 79 and 103.

hip fracture repairs.³¹ A recent study³² examined the relative likelihood of preventable hospitalization for whites, blacks, and Hispanics while controlling for sociodemographic factors and type of insurance (private, Medicaid, and uninsured). Controlling for insurance status clearly reduced the differences among the races in the incidence of preventable hospitalizations. Within each type of insurance, however, Hispanic children, black adults, and both black and Hispanic elderly persons ran a significantly greater risk of not being admitted for a preventable hospitalization.

Many factors have been suggested as contributing to these racial differences within insured populations. In some cases, these are patient-related, such as differences in the incidence and prevalence of disease, delays in seeking treatment, difficulties in communication, or cultural factors. However, a recent study suggests that a portion of these differences also can be attributed to the way physicians view and treat patients in different racial groups. Using videotaped actors with identical scripts to control for insurance, socioeconomic factors, and presentation of symptoms, Schulman et al. found significant differences in the likelihood of referral for cardiac catheterization for reported chest pain and positive stress test. Black and female patients were less likely to be referred than white males. The authors noted that their study could not determine whether this outcome was the result of overt prejudice or subconscious perception, whereby a patient in a target group automatically triggers a cultural stereotype in the physician's memory. Whatever the source, this study suggests that the behavior and perceptions of physicians do contribute to the sexual and racial differences that have been observed in health care utilization.³³

The Safety Net: Providing Care to the Poor and Uninsured

Virtually all hospitals, clinics, and physicians provide some care to poor and uninsured patients who cannot pay. There are, however, a number of institutions—generally referred to as “safety net” providers—that, by design or default, provide a disproportionate amount of such care. These institutions are available to meet the needs of those who fall through the cracks of the mainstream systems of care and/or coverage. In many instances, safety net providers have an explicit mission to care for the poor and uninsured. They often receive federal, state, and local government support.

³¹ M. G. Gornick, P. W. Eggers, T. W. Reilly, et. al., “Effects of Race and Income on Mortality and Use of Services Among Medicare Beneficiaries,” *New England Journal of Medicine* 335 (Sept. 12, 1996): 791–799.

³² D. Gaskin and C. Hoffman, “Race and Ethnic Differences in Preventable Hospitalizations Across Ten States,” IWP 00-101, Institute for Health Care Research and Policy, Georgetown University, Washington, D.C., January 2000.

³³ K. A. Schulman et al., “The Effect of Race and Sex on Physicians’ Recommendations for Cardiac Catheterization,” *New England Journal of Medicine* 340 (February 25, 1999): 618–626.

Although there is no accepted definition of a “safety net” provider, those that generally fall into this category are many AHCs and other public hospitals; community, migrant, and rural health centers; a variety of free clinics; and local health department clinics. As a rule, most of the nearly 1,400 public general acute care hospitals fulfill that role in their communities, as do the 900 Federally Qualified Health Centers (community, migrant, and rural health care centers). On the other hand, not all of these institutions provide a disproportionate amount of care to the poor and uninsured, while many private and, even, for-profit institutions do. A recent study used high Medicaid utilization (one standard deviation above the mean for the state) as a criterion for determining which urban hospitals were performing a safety net function. Using this criterion, 226 urban hospitals were determined to be safety net hospitals. Of these, 33 percent were public, 55 percent were not-for-profit, and 12 percent were for-profit institutions.³⁴ Different communities also have different approaches to providing safety net services. In some communities, for example, Los Angeles and Dallas, charity care and Medicaid patients are highly concentrated in a relatively small proportion of hospitals, while these patients are relatively spread out in other communities, such as New York, Philadelphia, and Detroit.³⁵

Many AHCs play a safety net role in their communities, partly because of the high proportion of AHCs that are closely affiliated with one or more public hospitals (43%), and partly because of institutional traditions. In addition, many AHC hospitals are located in the central core of large cities. Using 1996 discharge data from nine states, researchers at Georgetown examined the concentration of charity and poor patients in AHCs. In the metropolitan statistical areas/primary statistical areas (MSA/PMSAs) in these nine states served by at least one AHC, these hospitals accounted for more than a quarter (26.9%) of all charity discharges, and nearly one-fifth (19.5%) of all Medicaid discharges.³⁶

Another important component of the health care safety net is the approximately 900 community, migrant, and rural health centers providing services through 3,000 sites. With total budgets of \$2.6 billion in 1996, these centers served nearly 10 million persons.³⁷ Approximately two-thirds of all health centers receive federal grants from the

³⁴ D. Gaskin, *Safety Net Hospitals: Essential Providers of Public Health and Specialty Services* (New York: The Commonwealth Fund, February 1999).

³⁵ R. J. Baxter and R. Mechanic, “The Status of Local Health Care Safety Nets,” in *The Future U.S. Healthcare System: Who Will Care for the Poor and Uninsured?*, ed. S. Altman, U. Reinhardt, and A. Shields (Chicago: Health Administration Press, 1998), pp. 99–122.

³⁶ J. Reuter, unpublished analysis of state discharge data, Georgetown University, Washington, D.C., 1999.

³⁷ D. R. Hawkins and S. Rosenbaum, “The Challenges Facing Health Centers in a Changing Healthcare System,” in *The Future U.S. Healthcare System: Who Will Care for the Poor and Uninsured?*, ed. S. Altman, U. Reinhardt, and A. Shields (Chicago: Health Administration Press, 1998), pp. 99–122.

Health Resources and Services Administration (HRSA). The federal funding for these centers has increased dramatically in recent years, from \$247 million in 1995 to \$1.02 billion in 2000.

A recent report presents a snapshot of the patient profile and revenue sources at the 600 community, migrant, and rural health centers that received federal grants in 1998.³⁸ The majority of their patients are poor (65 percent in families with incomes below the federal poverty level) and nonwhite (25 percent black; 32 percent Hispanic). One-third are covered by Medicaid; 40 percent are uninsured. Among these 600 centers, 35 percent of 1998 revenues came from Medicaid reimbursements, 23 percent from HRSA grants, and 13 percent from state and local government grants. In spite of the significant increase in federal grants, these revenues have not kept pace with the growth in the number of patients the centers serve. In 1994, federal appropriations for health centers were about \$105 per patient served, but had fallen by 1998 to only \$82 per patient. At the same time, Medicaid has become a much more important source of revenues, increasing from 20 percent of revenues in the 1980s to 35 percent in 1998.

Financing Hospital Care to the Poor and Uninsured

In general, AHCs and other hospitals depend on four sources to finance uncompensated care and the higher costs of treating the poor: excess payments from private payers; additional payments from Medicare to hospitals that treat a disproportionate share of low-income patients; disproportionate share payments from Medicaid; and state and local government tax appropriations.

Excess Payments from Private Payers. Historically, AHCs and other hospitals have used excess payments from private payers to fund uncompensated care and other social missions. Until the beginning of the 1990s, many private payers reimbursed hospitals on the basis of charges or modified costs. Hospitals were able to increase the amounts they received from private payers to offset losses from uncompensated care and relatively low Medicare and Medicaid payment rates.

It is difficult, empirically, to measure payer-specific ratios of payments to costs. This analysis requires a number of assumptions regarding the allocation of costs among payers. The Medicare Payment Advisory Commission (MedPAC) has developed (and continues to improve) a model for making these allocations that provides a consistent measure of relative payment to cost ratios over time. Excess payments from private payers

³⁸ U.S. General Accounting Office, "Community Health Centers: Adapting to Changing Health Care Environment Key to Continued Success," GOA/HEHS-00-39, Washington, D.C., March 2000.

peaked in 1992, when payments exceeded costs by 31 percent (Figure 6). As competition increased, private payers have forced hospitals to accept lower payments. By 1998, payments from private payers exceeded the costs of their care by only 15.8 percent. During this interval, however, the payment-to-cost ratios for Medicare and Medicaid increased, allowing hospitals to cover their costs of uncompensated care and, so, maintain positive total margins. It should be emphasized that these trends are based on national averages. As noted below in the section on Medicaid disproportionate share payments (DSH), there remains great variation in the amounts states reimburse hospitals for Medicaid patients. While some states have used Medicaid DSH payments to substantially increase payments to hospitals, others have not. Thus, despite the relatively high Medicaid payment-to-cost ratios shown in Figure 6, in many states Medicaid payments remain far below actual costs.

For many public hospitals, payments from private payers account for a relatively small proportion of total revenues. According to the National Association of Public Hospitals, payments from commercial insurers accounted for only 17 percent of total revenues for their members in 1996. Excess payments from commercial payers to these hospitals came to only 3 percent of their total uncompensated care costs.³⁹

The Medicare Disproportionate Share Program. Beginning in 1986, Medicare has made additional payments to hospitals that treat a disproportionate share of low-income patients. Initially, this payment was viewed as an adjustment to reimburse hospitals for higher costs they may incur caring for poor patients. More recently, these payments have come to be viewed as serving the more general purpose of maintaining access to care for low-income patients.⁴⁰

Medicare's disproportionate share (DSH) payments are made as a proportional add-on to the regular diagnosis related group (DRG) based payments. The amount of the payments is determined through a complex formula based, in part, on the proportion of a hospital's inpatients that are low-income. The proportion of low-income patients is calculated as the sum of two ratios: the ratio of total Medicaid patient days to total inpatient days, and the ratio of inpatient days for Medicare patients receiving cash benefits under the Supplemental Security Income (SSI) program to total Medicare inpatient days.

³⁹ L. Fagnani and J. Tolbert, *The Dependence of Safety Net Hospitals and Health Systems on the Medicare and Medicaid Disproportionate Share Hospital Payment Programs* (New York: The Commonwealth Fund, November 1999).

⁴⁰ Ibid.

Medicare DSH payments are made only to hospitals with a proportion of low-income patients exceeding a certain threshold. The qualifying threshold varies as a function of a hospital's size and location (urban or rural). In 1997, 37.3 percent of hospitals were eligible to receive Medicare DSH payments.

The formula used to calculate the DSH payment adjustment also varies by hospital size, location, and proportion of low-income patients. Thus by design, Medicare DSH payments vary substantially by hospital type and location. The majority of Medicare DSH payments are made to large urban hospitals; 75 percent went to urban hospitals with more than 200 beds. Rural hospitals received less than 5 percent of Medicare DSH payments.

AHCs and other major teaching hospitals receive a large proportion of Medicare DSH payments. While these hospitals accounted for only 12 percent of Medicare discharges in 1997, they received nearly 35 percent of Medicare DSH payments.

Medicare DSH payments have risen rapidly, from \$1.1 billion in 1988 to an estimated \$4.5 billion in 1997 (Figure 7).⁴¹ This growth was due to a combination of health care inflation and legislated expansions in the number of institutions qualifying for payments. In 1988, DSH payments accounted for only 2 percent of total payments to hospitals. By 1995, it had increased to 5.8 percent of payments. Under the Balanced Budget Act (BBA), DSH payments will be reduced by 1 percent each year, from 1998 through 2002.⁴²

Several issues have been raised about Medicare's DSH payments. They have been criticized as too expensive, unfair to certain classes of institutions, such as rural hospitals, and for the extremely complex formula upon which payments are based. The threshold creates a "notch" in benefits, whereby a hospital with a proportion of low-income patients just under the threshold receives no adjustment, while a similar hospital with a proportion just above the threshold can receive much higher Medicare payments.

In addition, concerns have arisen about the formula used to calculate a hospital's proportion of low-income patients, which reflects utilization by only two groups: Medicaid patients and Medicare SSI beneficiaries. The formula specifically does not reflect uncompensated care or use of the facility by uninsured patients. While uncompensated care and volume of Medicaid cases may be correlated, this relationship is far from perfect.

⁴¹ Ibid.

⁴² MedPAC, "Report to Congress: Medicare Payment Policy. Volume I: Recommendations," Washington, D.C., March 1998.

At the same time, variations in Medicaid eligibility among states has led to significant variations in Medicare DSH payments. Hospitals in states with more liberal Medicaid eligibility standards have more Medicaid cases and, thus, are more likely to receive Medicare DSH payments.

Another concern centers on the way Medicare DSH payments to managed care plans are calculated. Prior to enactment of the BBA, the calculation of capitation amounts paid to Medicare managed care plans reflected Medicare DSH and the direct and indirect costs of graduate medical education (GME), whether or not patients enrolled in these plans actually used teaching or disproportionate share hospitals. The BBA reformed Medicare's managed care plans, creating Medicare+Choice plans. The House version of this legislation excluded both GME and DSH payments from the calculation of Medicare+Choice capitation rates. This provision was modified in conference to exclude only the GME payments, but DSH payments are still included in the calculation of these rates.

Finally, it must be recognized that the value of Medicare DSH payments to a particular institution generally depends upon the volume of Medicare patients using that facility. That is, a hospital may have a very high Medicare DSH payment adjustment, but if it has a small Medicare caseload, the actual benefit the hospital receives may be quite modest. For example, many public hospitals have relatively low Medicare caseloads but high volumes of Medicaid and uncompensated care. As a result, Medicare DSH payments are only 9 percent of the amount of uncompensated care provided by public hospitals.⁴³

MedPAC made recommendations to reform Medicare's DSH program in each of its last three reports.⁴⁴ As fully refined in the most recent report, these recommendations suggest that the disproportionate share percentage should be determined using a broad definition of care to the poor, including Medicare SSI patients, Medicaid patients, patients covered under state and local indigent care programs, and uninsured and underinsured patients. In addition, the DSH formula would be modified to eliminate the threshold effect and to increase the number of hospitals eligible for DSH payments. Under MedPAC's most recent recommendations, 60 percent of hospitals would become eligible for DSH payments and the amount of additional payments would increase gradually from

⁴³ L. Fagnani and J. Tolbert, *The Dependence of Safety Net Hospitals*.

⁴⁴ See MedPAC "Report to Congress: Medicare Payment Policy. Volume I: Recommendations," Washington, D.C., March 1998; MedPAC, "Report to Congress: Medicare Payment Policy," Washington, D.C., March 1999; and MedPAC, "Report to Congress: Medicare Payment Policy," Washington, D.C., March 2000.

zero at the threshold point. Finally, a single, uniform formula would be used to determine the DSH adjustment for all hospitals.

The Medicaid Disproportionate Share Program. When enacted in 1981, the Medicaid Disproportionate Share (DSH) was meant to give additional support to hospitals providing a disproportionate share of care to the poor and uninsured—the same purpose as the subsequent program for Medicare, mentioned above. Hospitals often lost money on their Medicaid cases because of low reimbursement rates. Moreover, the hospitals with high volumes of Medicaid patients often were the same institutions that provided a disproportionate share of care to the uninsured and medically indigent. By providing financial relief to these hospitals, the Medicaid DSH program would help maintain hospital access for the poor.

During the late 1980s and early 1990s, states began using this policy as a mechanism for achieving vast increases in federal matching payments. While the specifics vary from state to state, many states have financed their share of Medicaid DSH payments through a combination of provider taxes and intergovernmental transfers from counties or publicly owned hospitals. A recent survey of 40 states found that health care provider taxes and transfers account for nearly 85 percent of the nonfederal revenues used to finance the Medicaid DSH program. Health care institutions and counties agreed to these taxes and transfers because these funds were then returned to them in the form of higher Medicaid payments and explicit DSH subsidies. In the absence of federal matching payments, these provider taxes and transfers might have been little more than an accounting shell game. However, the higher payments to providers resulted in substantial increases in federal contributions. The program grew exponentially, from nearly \$600 million in 1989 to \$17.4 billion in 1994. Slightly more than half of these funds were accounted for by federal Medicaid matching payments (Figure 8).

In 1989, Medicaid DSH payments were only 1.1 percent of total Medicaid payments to all types of providers. In 1992, just three years later, these payments had grown to represent 19.0 percent of all payments, although they dropped back to 12 percent by 1997.

At a minimum, the federal share represents a substantial new source of funds to provide subsidies to safety net hospitals and other institutions providing care to the poor and uninsured. For many safety net institutions, Medicaid DSH is a critical source of

revenues. In 1997, total Medicaid DSH funding was more than three and a half times larger than total Medicare DSH payments.⁴⁵

The Medicaid DSH program has had a beneficial effect on patient access. The average payment rate for Medicaid inpatient services has increased dramatically. Medicaid payments for hospital services were only 76 percent of the cost of providing this care in 1989. By 1994, Medicaid payments had increased to 94 percent of costs (Figure 6). The increasing payment rates have made Medicaid patients much more attractive to private hospitals. For example, the share of total Medicaid admissions treated in for-profit hospitals increased from 6.2 percent in 1991 to 9.7 percent in 1996.⁴⁶ A Georgetown University study of patterns of care in urban area communities served by AHCs showed an even greater impact. In these communities, public hospitals accounted for more than a fifth (22%) of all inpatient admissions of Medicaid beneficiaries in 1991. By 1996, public hospitals accounted for only 15 percent of Medicaid discharges. While the proportion of Medicaid admissions treated in not-for-profit hospitals in these urban communities remained relatively constant, the share treated in for-profit hospitals more than doubled, from 4.5 percent in 1991 to nearly 9.4 percent in 1996.⁴⁷

On the other hand, funds that counties have historically used for their public hospitals in many cases are now transferred to the state to support their share of Medicaid DSH financing. In a study of 30 public hospitals, local subsidies and self-pay revenues declined from 34 percent of total revenues in 1988 to only 20 percent in 1995.⁴⁸ During the same period, Medicaid revenues for these same hospitals increased by nearly the same percentage, from less than 42 percent of net patient revenues to nearly 54 percent. Thus for some hospitals, a significant proportion of the increase in Medicaid DSH spending may not result in a net increase in resources but only a redirection of existing funds.

Another issue concerns the significant portion of Medicaid DSH expenditures being directed to state institutions, including both AHC hospitals and mental institutions. In a survey of 40 states, state-owned institutions received 36.1 percent of total Medicaid DSH payments. Twenty percent of the total was paid to state mental health institutions

⁴⁵ T. A. Coughlin, L. Ku, and J. Kim, "Reforming the Medicaid Disproportionate Share Hospital Program in the 1990s," Discussion Paper #99-14, The Urban Institute, Washington, D.C., January 2000.

⁴⁶ Georgetown University analysis of AHA Annual Survey data for 1991 and 1996.

⁴⁷ Georgetown University analysis of AHA Annual Survey data for 1991 and 1996.

⁴⁸ L. S. Gage, "The Future of Safety-Net Hospitals," in *The Future U.S. Healthcare System: Who Will Care for the Poor and Uninsured?*, ed. S. Altman, U. Reinhardt, and A. Shields (Chicago: Health Administration Press, 1998), pp. 123–150.

and 16.1 percent was paid to state-owned acute care hospitals, principally AHCs.⁴⁹ Traditionally, the principal source of financing for state mental hospitals has been state general revenues. Clearly, states are taking advantage of this program to obtain federal funds in order to reduce the use of state revenues to support these institutions. Again, it is not obvious whether this has resulted in a net increase in support to these institutions, or simply a smaller demand for state funds, which are then freed up for other purposes.

Several amendments to the Medicaid DSH program have been enacted to curb its rapid growth and what were seen as abuses of the program's intent. Legislation in 1991 and 1993 banned provider donations as a source of funds, limited both the use of provider taxes and the overall growth in federal contributions, and capped payments to individual institutions at 100 percent of the total unreimbursed costs of Medicaid and uninsured patients. In 1997, the BBA established further limits on federal payments, capping the amounts paid to mental institutions to no more than 33 percent of a state's federal DSH allotment. The effects of these limits are evident in the stabilization and decline of Medicaid DSH spending (Figure 8). The impact of the BBA limits varies significantly among states, depending on how their programs were designed and implemented. In some states, these provisions will have minimal effect. However, a state, such as Kansas, that spent nearly 90 percent of its DSH revenues on payments to state mental institutions⁵⁰ will have to dramatically amend its program or face significant reductions in federal payments.

Finally, it should be noted that, as of 1998, 13 states have established "supplemental payment programs" akin to DSH but not subject to the same legislative limitations. While the specifics vary among states, these programs provide payments above Medicaid's regular payments. For example, Alabama's program provides additional funding to public hospitals. Massachusetts took this approach to fund "enhanced" capitation amounts to managed care plans operated by two public hospitals. Supplemental payment programs have grown from \$0.6 billion in 1995 to \$2.8 billion in 1998. Unlike DSH payments, the vast majority of these funds (98%) are paid to private and county/local public providers. Federal dollars have accounted for slightly more than half of this funding, with intergovernmental transfers from counties and public hospitals making up the bulk of the remainder. Only 4 percent of the funds to finance these programs came from state revenues.⁵¹

⁴⁹ Coughlin, T. A., L. Ku, and J. Kim, "Reforming the Medicaid Disproportionate Share Hospital Program in the 1990s," Discussion Paper #99-14, The Urban Institute, Washington, D.C., January 2000.

⁵⁰ Ibid.

⁵¹ Ibid.

Tax Appropriations. State and county governments provide support, known as “tax appropriations,” to both public and private hospitals. These funds are intended to support various activities, including indigent care, general operations, deficit financing, medical education, and research. AHCs use most of these funds for indigent care (37.5%) and general operating support (34.8%).⁵² Tax appropriations are paid primarily to public hospitals (85%).

According to Medicare cost report data, the amount of tax appropriations to acute care hospitals increased from 1990 to 1994, from \$4.0 to \$5.1 billion. However, by 1996, the total had dropped to \$4.6 billion. In aggregate, the amount of this type of support is approximately equal to Medicare DSH payments.

The interaction between tax appropriations and Medicaid DSH, however, makes it difficult to determine how much these funds actually contribute to the support of indigent care. A significant proportion is being diverted to finance states’ share of Medicaid DSH financing. According to a National Association of Public Hospitals and Health Systems survey of 48 public hospitals,⁵³ these institutions provided \$2.4 billion to their states in 1996 through intergovernmental transfers and provider taxes. Subsequently, they received nearly \$3.5 billion back in Medicaid DSH support. This sample of institutions clearly benefited from these transactions. Nevertheless, there is a potential for double counting Medicaid DSH and tax appropriations when trying to estimate the total amount available for subsidizing the cost of uncompensated care.

Recent Legislation

The State Children’s Health Insurance Program. The State Children’s Health Insurance Program (CHIP), Title XXI of the Social Security Act, provides block grants to states for health insurance to children in low-income families.⁵⁴ When enacted in 1997, the legislation included \$20.3 billion in federal funds. States can access these funds in proportion to each state’s share of children living in families below 200 percent of the federal poverty line (FPL). These are matching funds; that is, states must spend their own funds in order to obtain the federal money. However, the program’s federal match is higher (65 to 85%) than that of the Medicaid program.

⁵² Association of American Medical Colleges, unpublished data for 1996.

⁵³ L. Fagnani and J. Tolbert, *The Dependence of Safety Net Hospitals*.

⁵⁴ Except where otherwise noted, this description of CHIP is taken from J. Holahan, C. Uccello, and J. Feder, *Children’s Health Insurance: The Difference Policy Choices Make*, The Kaiser Project on Incremental Health Reform (Washington, D.C.: The Henry J. Kaiser Family Foundation, October 1999).

States were given two broad options for implementing CHIP. They could cover low-income children either through an expansion of Medicaid eligibility or under separate state programs, with each state defining its own eligibility criteria. In the latter case, the states could, within federal guidelines, define eligibility based on age, income and assets, residency, disability status, and duration of coverage. Within certain guidelines, states could also define the benefits, premiums, and cost-sharing requirements for CHIP enrollees. By February 2000, all 50 states, the District of Columbia, and Puerto Rico had established programs under CHIP. While a few jurisdictions adopted one approach or the other, many states elected to use a combination of Medicaid expansions and separate state programs.⁵⁵

CHIP is aimed at children in families with incomes up to 200 percent of the FPL who are not otherwise eligible for Medicaid. However, states have some flexibility to establish higher or lower eligibility standards. In 30 states, children with family incomes up to 200 percent of the FPL are eligible under either a Medicaid expansion or a state-designed program. Six of these states have established even higher income limits.⁵⁶

CHIP plans are expected to provide fairly broad benefits. Typically, preexisting Medicaid benefits are used for plans with Medicaid expansions. States may use other “benchmark” health plans in designing their benefit packages. Under Title XXI, these “benchmark” plans may include the Federal Employee Health Benefits Plan (FEHBP), health plans for state employees, or the HMO in the state with the largest commercial enrollment.

During consideration of the CHIP legislation, substantial concern arose that this new plan would simply substitute for other preexisting coverage, a situation known as “crowd out.” That is, children already covered under Medicaid or an employer-based plan might elect to drop this coverage in favor of enrolling in CHIP. Under this circumstance, CHIP would not achieve any net increase in coverage but simply replace existing private coverage with a public plan. The legislation, therefore, requires states to develop plans to limit crowd out. Most states have accomplished this by establishing waiting periods (requiring that a child be uninsured for three or more months before becoming eligible); screening for Medicaid eligibility; or charging premiums to discourage families from dropping existing coverage. While these strategies may curtail crowd out, they clearly also limit the number of poor children who can enroll in CHIP. For example, children who

⁵⁵ National Governors’ Association and National Conference of State Legislatures, *State Children’s Health Insurance Program, 1999 Annual Report*.

⁵⁶ *Ibid.*

temporarily lose their coverage due to a short gap in their parents' employment generally would not be eligible for CHIP benefits.

By the end of 2000, about 3.3 million children had enrolled in CHIP plans, providing crucial benefits to previously uninsured children.⁵⁷ Yet, it has been estimated that at least an additional 2 million children are both uninsured and live in a family with an income low enough to qualify for CHIP coverage.⁵⁸ Many reasons have been cited for the relatively low CHIP enrollment, including parents' failure to recognize their children may be eligible, complex enrollment forms and procedures, language barriers, and unwillingness of low-income working families to go to welfare offices to apply for benefits. A number of proposals have been made to increase enrollment, such as increasing public awareness, simplifying and streamlining enrollment procedures, and establishing more enrollment sites.

The Health Insurance Portability and Accountability Act of 1996. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) initiated a new federal-state partnership in the regulation of private health insurance.⁵⁹ HIPAA is an incremental reform, intended primarily to lower some of the barriers certain individuals and families face in acquiring health insurance coverage. Although early estimates suggested that as many as 25 million people could be helped in maintaining continuous coverage, there has not been any rigorous evaluation of the impact of this legislation.

Prior to enactment of this legislation, the federal government had largely avoided any involvement in the direct regulation of health insurance and had deferred to the historic role played by the states. The notable exception was the Employee Retirement Income Security Act (ERISA) of 1974. The major provisions of this legislation dealt with retirement income issues. However, it also preempted state regulation of self-funded, employer-based health insurance benefits. These plans provide coverage to about 48 million workers and their dependents. As a result, there was minimal regulation of these plans.

⁵⁷ U. S. Department of Health and Human Services, "HHS Fact Sheet," DHHS, Washington, D.C., February 2, 2001.

⁵⁸ Kaiser Commission on Medicaid and the Uninsured, *Key Facts: Health Coverage for Low-Income Children* (Washington, D.C.: The Henry J. Kaiser Foundation, June 1999).

⁵⁹ This description of HIPAA is taken from K. Pollitz et al., "The Health Insurance Portability and Accountability Act of 1996 (HIPAA): Early Experience with 'New Federalism' in Health Insurance Regulation" (unpublished manuscript submitted for publication), Georgetown University, Washington, D.C., March 2000.

HIPAA established certain minimum protections for consumers in all health plans, including ERISA plans, while maintaining states' abilities to enforce state laws that exceed the federal minimums. HIPAA addresses the key problem of "job lock," the situation of people afraid to change jobs because, by switching employers, they would face a period of preexisting condition exclusions imposed by a new health plan. HIPAA limited the scope and duration of such provisions, and—for people who maintain continuous coverage—limited repeated impositions of such clauses. HIPAA also included nondiscrimination provisions that prevented employers from limiting eligibility for health benefits based on health status. It required all health insurance, including both group and individual policies, to be guaranteed renewable. Finally, HIPAA guaranteed access to individual health insurance for those who lose group health coverage, were continuously covered for the preceding 18 months, and who meet certain other criteria.

HIPAA required states to enact legislation to implement HIPAA within a specific time period. The federal government was authorized to step in and regulate HIPAA insurance standards in states that failed to act on a timely basis or who failed to enact the required minimum standards. Three states have notified the Health Care Financing Administration (HCFA) of their legislatures' failure to act. HCFA is now directly enforcing HIPAA group and individual market protections in Missouri and Rhode Island, and individual market provisions in California. HCFA is also considering whether direct federal regulation is warranted in two other states, Michigan and Massachusetts.

As a practical matter, HIPAA has probably had minimal impact on either the availability of individual market health insurance coverage or on the numbers of uninsured persons in this country. In all fairness, it was not intended to. It probably has significantly reduced the use of preexisting condition exclusions in group health plans, providing coverage for services that previously had been uninsured. It also extended its protections to persons covered under self-funded, large group health plans. Finally, it established a new role for the federal government in the regulation of private health insurance.

Temporary Assistance for Needy Families (TANF). Prior to the enactment of the Temporary Assistance for Needy Families (TANF) legislation, eligibility for Medicaid was generally linked to the receipt of cash benefits under one or more state or federal programs. As previously described, states were required to provide Medicaid eligibility to low-income families with children who were receiving benefits under the Aid to Families with Dependent Children (AFDC) program, and to certain other populations. Nearly

two-thirds (65.7%) of Medicaid beneficiaries in 1997 were individuals eligible on the basis of AFDC.⁶⁰

The legislation creating the TANF program was not intended to reform health care. Rather, its objective was welfare reform. Specifically, its goals were to give states the incentives and flexibility to (1) aid families so that children could be cared for in their homes, (2) end dependence on government benefits by promoting job preparation, work, and marriage, (3) prevent and reduce out-of-wedlock pregnancies, and (4) encourage maintenance of two person families.⁶⁰ The AFDC cash program was replaced with block grants to states to provide cash benefits to needy families that included either minor children or a pregnant woman. States were explicitly prohibited from using federal funds to provide cash benefits to unwed mothers under age 18 (unless in school and living in the home of an adult relative), aliens entering the U.S. after August 22, 1996 (except under certain state options), and persons convicted of a drug related felony or fraudulent misrepresentations to obtain food stamps, SSI, TANF, or Medicaid benefits. In addition, TANF established job preparation and work requirements for individuals to keep their eligibility for TANF benefits.

The TANF legislation recognized that, by repealing AFDC, it would have a major impact on eligibility for Medicaid. However, rather than creating a new definition of Medicaid eligibility based on receipt of TANF benefits, the legislation simply stated that repeal of the AFDC program would have no effect on individuals' eligibility for Medicaid. In general, those who would have been eligible for AFDC under the rules that applied on July 16, 1996 would continue to be eligible to enroll and receive benefits under Medicaid.

In spite of its intention to leave Medicaid eligibility essentially intact, TANF created significant problems. County welfare officials, who had previously done the majority of the work in qualifying individuals under AFDC, were unsure of their continuing obligations and were overwhelmed with implementing TANF. Immigrants, including those with permanent resident visas, were uncertain whether use of Medicaid benefits would affect their visa status or eligibility for citizenship. As a result, Medicaid enrollment dropped by 7.1 percent from 1996 to 1998. While some of this drop may be related to the health of the economy and low unemployment rates, most observers believe that the "delinking" of welfare and Medicaid eligibility was a prime contributing factor.

⁶⁰ U.S. Health Care Financing Administration, "Medicare and Medicaid Statistical Supplement, 1999," *Health Care Financing Review*, Washington, D.C., 1999, p. 314.

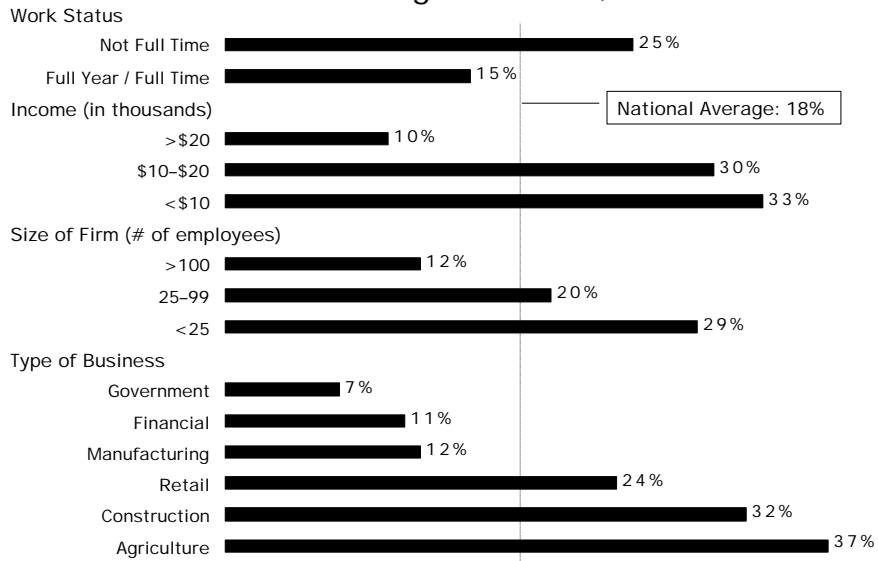
A number of measures are under way to improve the Medicaid eligibility process. The TANF legislation earmarked \$500 million to assist states in improving and simplifying their eligibility systems, and to support eligibility outreach services. Availability of these funds has been extended. Many states have begun efforts to both simplify their eligibility systems and to coordinate Medicaid and CHIP eligibility determinations.⁶¹ Since 1990, many hospitals and federally qualified community health centers have assisted welfare agencies by performing the initial processing of Medicaid applications. A number of hospitals have expanded these programs in an effort to cope with the growing numbers of uninsured requesting services.⁶² Recently, HCFA directed states to review their eligibility processes to assure that all individuals eligible for Medicaid are enrolled and that no one was improperly denied Medicaid as a result of the implementation of TANF. States are required to develop plans for contacting people and reinstating their coverage if appropriate.⁶³

⁶¹ National Governors' Association and National Conference of State Legislatures, *State Children's Health Insurance Program, 1999 Annual Report*.

⁶² L. Fagnani and J. Tolbert, *The Dependence of Safety Net Hospitals*.

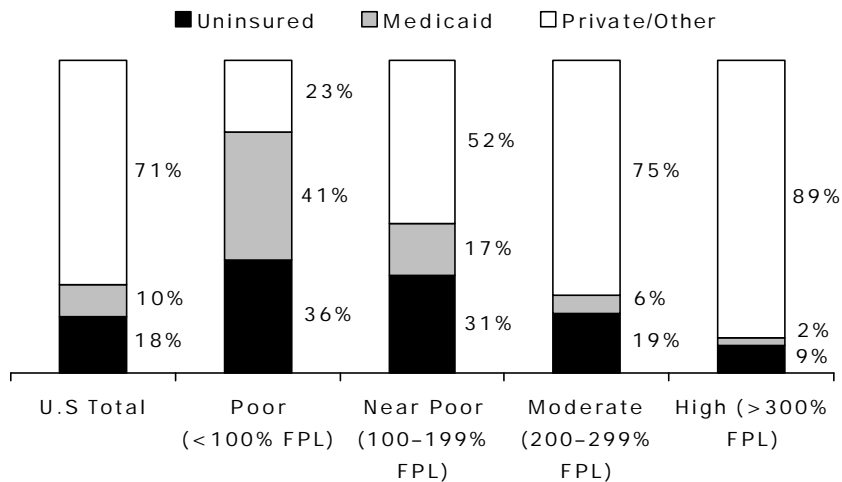
⁶³ U.S. Health Care Financing Administration, "State Medicaid Director Letter," April 7, 2000.

Figure 1
Risk of Being Uninsured, 1998



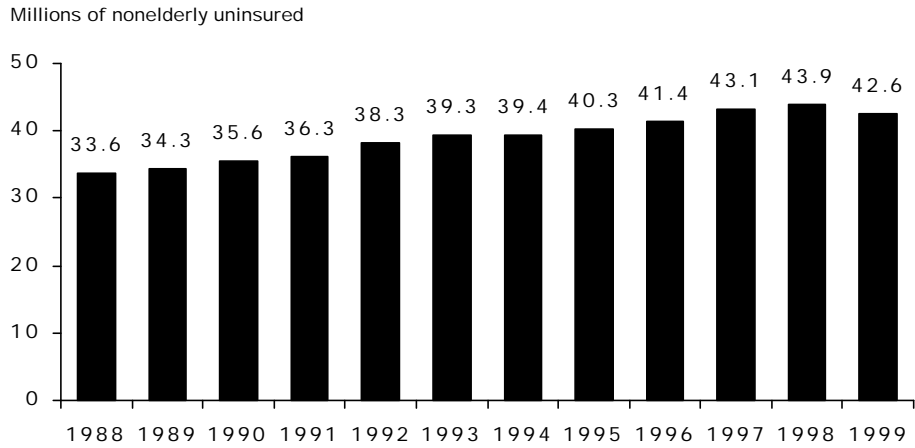
Source: Calculated from data in *Uninsured in America: A Chart Book*, 2nd ed., Kaiser Commission on Medicaid and the Uninsured, March 2000.

Figure 2
Health Insurance Coverage by Poverty Level, 1998



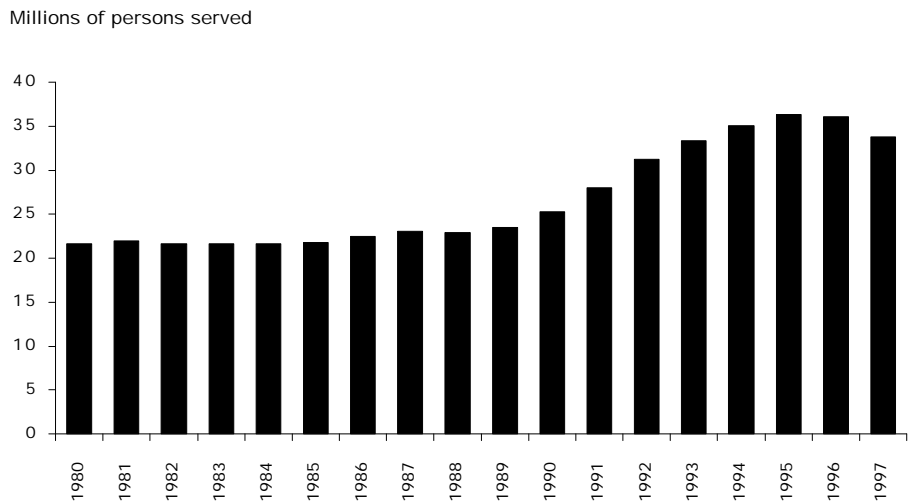
Source: *Uninsured in America: A Chart Book*, 2nd ed., Kaiser Commission on Medicaid and the Uninsured, March 2000.

Figure 3
Growth in the Number of Uninsured Americans,
1988-1999



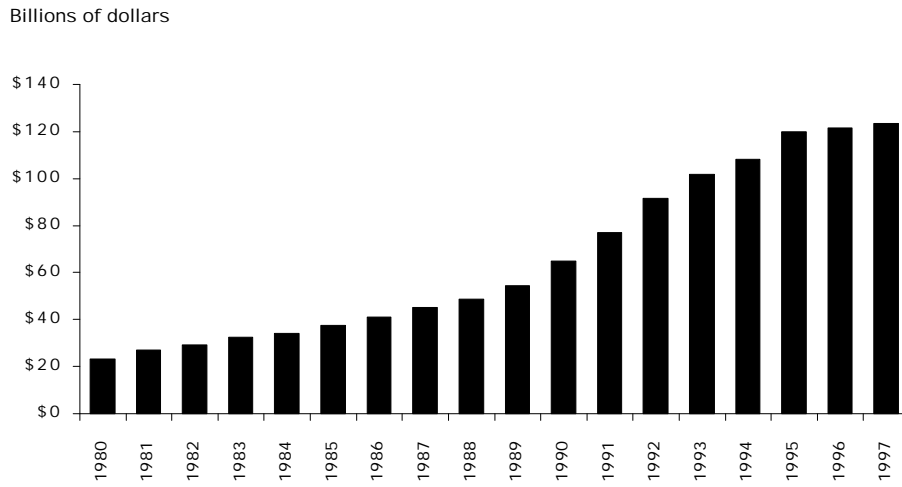
Source: Employee Benefit Research Institute, EBRI Notes, 1999 and 2000. Based on Current Population Surveys.

Figure 4
Number of Persons Served in Medicaid, 1980-1997



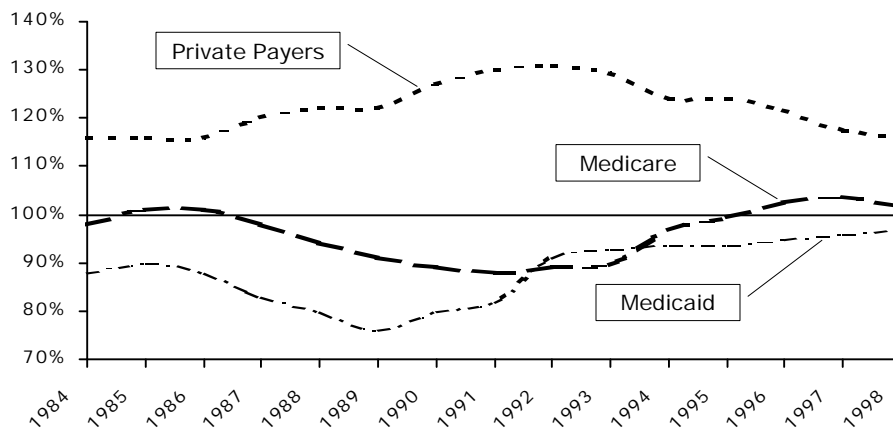
Source: Medicare and Medicaid Statistical Supplement, 1999.

Figure 5
 Medicaid Payments to Providers, 1980-1997



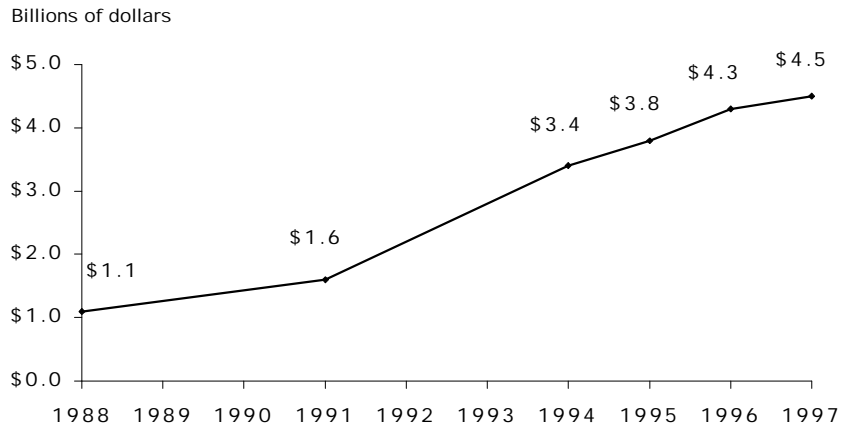
Source: Medicare and Medicaid Statistical Supplement, 1999.

Figure 6
 Hospital Payment-to-Cost Ratios by Payer, 1984-1998



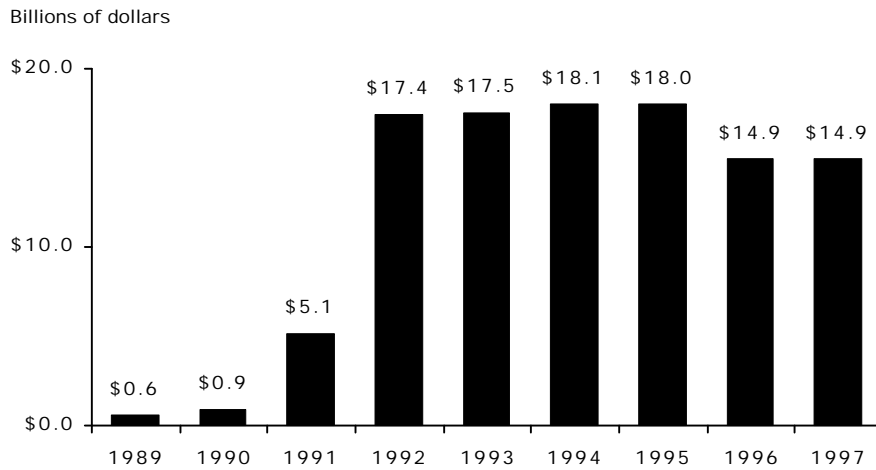
Source: MedPAC, unpublished data, April 2000.

Figure 7
Medicare Disproportionate Share Hospital Payments, 1988-1997



Source: L. Fagnani and J. Tolbert, *The Dependence of Safety Net Hospitals and Health Systems on the Medicare and Medicaid Disproportionate Share Payment Programs* (New York: The Commonwealth Fund, November 1999).

Figure 8
Medicaid Disproportionate Share Payments, 1989-1997



Source: L. Fagnani and J. Tolbert, *The Dependence of Safety Net Hospitals and Health Systems on the Medicare and Medicaid Disproportionate Share Payment Programs* (New York: The Commonwealth Fund, November 1999).

III. FINDINGS

Finding 1. Charity care as a proportion of all hospital care has been growing as the number of people without health insurance increases. The amount of free care academic health centers provide to the uninsured is increasing faster than such care provided by other types of hospitals.

From 1991 to 1996, the number of uninsured increased by 14 percent, from 36.3 to 41.4 million individuals. As might be expected, the volume of care hospitals provided to the uninsured also increased during this period. In communities served by academic health centers,⁶⁴ uncompensated care increased from 6.26 percent of gross patient revenues in 1991 to 6.51 percent in 1996. (Uncompensated care is defined as the sum of bad debt, contractual allowances, and charity care.) This relatively modest increase was due entirely to a rapid increase in the amount of charity care. While bad debt in these hospitals actually declined as a percentage of gross patient revenues, from 3.8 percent in 1991 to 3.1 percent in 1996, the level of charity care increased by over 40 percent, from 2.4 percent of gross revenues in 1991 to 3.4 percent in 1996.

Uncompensated care is generally a higher percentage of gross patient revenue in public hospitals than in private hospitals. However, within categories of ownership, the level of teaching activity is clearly related to the amount of uncompensated care provided. Figure 9 displays the level of uncompensated care by ownership and type of institution for 1996. Among private institutions, uncompensated care as a percent of gross patient revenues is about twice as high in AHCs as in all other types of private hospitals. Among public institutions, AHCs and other major teaching hospitals have the highest levels of uncompensated care.

Over time, AHCs have been carrying an increasing share of the total amount of charity care. They accounted for nearly 40 percent of the total amount of charity care provided in communities served by AHCs in 1991. Private AHCs provided 11.1 percent and public AHCs, nearly 30 percent of the charity care. By 1996, these proportions had increased to 13.5 and 30.7 percent respectively, for an aggregate of more than 44.2 percent of the total charity care provided in their communities (Figure 10).

⁶⁴In this report, the term "academic health center" refers to the 125 institutions that include a medical school, faculty practice plan, and their closely affiliated hospitals. Except where otherwise noted, the term "major teaching hospital" refers to those hospitals that have at least one resident for every four beds and are not academic health centers.

Finding 2. Competition is changing the patterns of care for the poor. In markets with high managed care penetration, care for the uninsured is becoming more concentrated within the provider community. That is, institutions that provide significant amounts of care to uninsured patients are seeing an increase in such cases, while other facilities are experiencing a decrease. This pattern has a strong regional component. Among nine states studied, the increase in concentration of uninsured cases was greatest in California, Florida, and Washington.

Historically, hospitals funded their charity care through cross-subsidies, the higher charges paid by insured patients. However, as competition has increased, the ability of institutions to continue to make these cross-subsidies available may be threatened.

Some hospitals, particularly those that are privately owned or are located in middle- or upper-income communities, may try to develop policies that curtail the amount of charity care they provide. Although anti-dumping legislation prohibits hospitals from turning away patients who are in life-threatening circumstances, there are a variety of more subtle actions a hospital can take to limit its exposure to uninsured patients. For example, a hospital can close or downgrade its emergency room. It can eliminate services, such as burn, trauma, or AIDS units that might be thought to attract non-paying patients. Hospitals may also elect to transfer stabilized, non-paying patients to other institutions. Research by the Association of American Medical Colleges (AAMC) has shown that charity cases are more likely to be transferred to major teaching hospitals than patients with insurance.⁶⁵

A number of hospitals do not have the flexibility to redirect their missions. Public institutions are generally required to make their services available to all patients, regardless of ability to pay. Private institutions, including many private AHCs, happen to be located in low-income areas and, thus, end up serving a significant number of uninsured patients simply because of their proximity to populations most likely to be poor and uninsured.

An analysis by researchers at Georgetown University confirms that increasing competition is associated with an increase in the concentration of uninsured cases within hospital markets. Using discharge data from nine states for 1991, 1994, and 1996, two

⁶⁵ S. Wyatt, "Transfer Patients and Teaching Hospitals," in *Meeting the Needs of Communities: How Medical Schools and Teaching Hospitals Ensure Access to Clinical Services*, Association of American Medical Colleges, Washington, D.C., October 1998.

measures of market concentration were estimated: one measure representing the concentration of uninsured care admissions and one representing the concentration of all admissions. These measures are based on the Herfindahl Index of market concentration. The share of uninsured cases and total admissions of each urban hospital in the nine states was calculated. For example, if there were 1,000 admissions in a metropolitan statistical area/primary metropolitan statistical area (MSA/PMSA) during a year, and a hospital in that market had 100 admissions, the hospital's market share would be 0.10. Then, for each MSA/PMSA in the sample, the concentration of total discharges was calculated as the square of an individual hospital's market shares, summed across all hospitals in the MSA/PMSA. The relative concentration of uninsured care was then defined as the ratio of the index of concentration of uninsured care to the index of concentration for all admissions. Thus, if the index for uninsured cases was higher than the index for all admissions, then uninsured cases would be, on a relative basis, more concentrated in that market. The relative concentration of uninsured care across markets was estimated as the average of the values for each individual market, weighted by the number of total admissions within each market. Finally, markets were divided into two groups, high and low competition, based on the level of HMO penetration. The split was chosen to give each group approximately the same number of AHCs.

The average concentration of charity cases across all markets remained relatively constant from 1991 to 1996 (Figure 11). During each of the three years studied, charity care was slightly more than twice as concentrated as total admissions. The average of the ratios ranged from a high of 2.023 in 1994 to a low of 2.012 in 1996. However, when these MSA/PMSAs are divided into high and low competition markets based on HMO penetration, there is a strong relationship between the level of relative concentration and changes in this relative concentration over time. In 1991, the relative concentration of charity cases was higher in high competition markets than in low competition markets; the averages of the ratios were 2.244 and 1.812 respectively. Over time, the difference between these types of markets increased, with the ratio rising in high competition markets and falling in low competition markets. In 1996, the ratio of relative concentration was 2.747 in high competition markets but only 1.328 in low competition markets.

Further exploration of these ratios suggests a strong, regional effect of competition on the relative concentration of charity care. Charity care has become more concentrated within a large majority of the MSA/PMSAs in California, Florida, and Washington (see Table 1). Within these three states, the concentration of charity cases is up in all of the largest MSAs: Los Angeles, San Francisco, Miami, and Seattle. The relative concentration is down in most markets in New York State (including New York City), Pennsylvania

(including Philadelphia), and Illinois (including Chicago). Wisconsin and New Jersey have mixed results, with relative concentration up in some areas and down in others. While the relative concentration in most Massachusetts markets is up, it is down in the largest market, Boston, and thus down overall for the state.

Table 1
Number of Markets with Increases and Decreases in
Relative Concentration of Charity Care from 1991 to 1996, by State

	Markets with Increasing or Constant Concentration	Markets with Decreasing Concentration	Total
California	20	5	25
Florida*	17	2	19
Illinois	2	8	10
Massachusetts	5	1	6
New Jersey	6	2	8
New York	4	8	12
Pennsylvania	4	10	14
Washington	9	0	9
Wisconsin	8	5	13

* Comparison for Florida is for 1994 and 1996

Source: Georgetown University analysis of state discharge data.

Clearly, the issue of the impact of competition on the relative concentration of charity care is complex and deserves further examination. What will happen in individual markets is likely to be a function of many factors, including changes in the intensity of competition, consolidation in the hospital market (closures and mergers), availability of care from public facilities, changes in states' eligibility criteria for Medicaid, and changes in hospitals' financial status both within and among markets. Nevertheless, the trends should give policymakers concerns about the future ability of safety net institutions to continue to carry an increasing share of charity care.

Finding 3. Academic health centers are important sources of care for uninsured patients in their communities. From 1991 to 1996, their share of care for the uninsured grew, in part because of the increased concentration of uninsured patients within AHCs in markets with high managed care penetration.

Academic health centers are large institutions, often located in the central cores of the biggest U.S. cities. In addition, many AHCs are publicly owned. Thus, it is not surprising that these institutions are major sources of care for the uninsured in their communities.

In 1996, AHCs accounted for more than one quarter (27.9%) of inpatient admissions for uninsured patients in their communities. This is more than nearly twice the share that AHCs have for all beds (13.3%), and nearly twice their share of admissions (15.9%). In general, public AHCs' share of total uninsured admissions is much larger than that of private AHCs in communities served by both. In 1996, public AHCs accounted for 24.5 percent of total uninsured admissions in their markets, but only 7.6 percent of total admissions; private AHCs accounted for 11.4 percent of uninsured admissions and 14.2 percent of total admissions.

The share of charity care (uninsured patients) provided by AHCs has been increasing, growing from 20.4 percent in 1991 to 27.9 percent in 1996. This growth has generally been the result of the changing patterns of charity care in high managed care markets. The share of charity care provided by both public and private AHCs in less competitive markets remained relatively constant over this five-year period (Figure 12).

However, the shares provided by AHCs in competitive markets have significantly increased. Public AHCs' share of charity care jumped from 23.2 to 36.4 percent in markets with high levels of managed care. The share for private AHCs also rose, from 8.2 percent in 1991 to 13.8 percent in 1996. By 1996, private AHCs in competitive markets provided a higher share of total charity care than their share of total admissions, 13.8 to 12.6 percent respectively.

While the share of total charity care provided by public hospitals has been increasing in competitive markets, their share of Medicaid cases has been declining, from 24.3 percent of total Medicaid cases in 1991 to only 17.0 percent in 1996. Thus, to the extent that Medicaid DSH support is dependent on the number of Medicaid admissions, these hospitals have been losing a significant source of subsidy while the need for such support has increased.

Finding 4. Providing substantial amounts of care to uninsured patients has a negative effect on the margins of all hospitals, including academic health centers.

Hospitals finance the care they provide to uninsured patients from insurance payments they receive for covered patients, tax appropriations from state and local governments, and various other sources. Given a stable demand for charity care, hospitals have been able to manage their revenues and expenses to stay financially sound. However, periods of growing demand for charity care can increasingly strain a hospital's financial stability.

Using discharge data from nine states and Medicare cost reports, researchers at Georgetown University used variance and linear regression models to analyze the relationship between the level of charity care and hospital margins in 1991, 1994, and 1996. The measure of hospital margins used was the total margin, calculated from the Medicare cost reports. The load of charity care was defined as the proportion of admissions to a hospital that were categorized as self-pay or charity admissions. Hospitals in the nine states were categorized into four levels of charity care: less than 2 percent, 2 percent to less than 4 percent, 4 percent to less than 6 percent, and 6 percent or greater. Hospitals were further classified into eight types depending on their involvement in graduate medical education, ownership status, size, and location (urban vs. rural). Preliminary analysis found no significant interaction effects between the level of charity care, hospital type, and year, and these variables' impact on total margins.

During the period studied, average hospital total margins significantly increased ($p < 0.01$), from 1.84 percent in 1991 to 3.70 percent in 1996. There also were significant differences in total margins across types of hospitals. Over the three years, for-profit hospitals had the highest average margin (4.44%), followed by private AHCs (3.91%), large, urban non-teaching hospitals (3.55%), and rural hospitals (3.24%). Public AHCs and other public major teaching hospitals had the lowest average margins, 1.52 and -1.83 percent respectively. The average total margins of public institutions were not statistically different from zero.

All types of hospitals with charity care caseloads of less than 6.0 percent showed no statistical relationship between their level of charity care and margins. However, those hospitals with charity care caseloads that exceeded 6 percent had margins 1.2 percentage points lower than other hospitals. The impact of charity care on hospital margins increased over time. The average margins for hospitals with charity caseloads less than 6 percent consistently increased over time. The average margin for hospitals with high charity caseloads was not only consistently lower, but actually declined somewhat from 1994 to 1996. Based on regression analysis, the estimated threshold effect of high levels of charity care on hospitals' margins increased over time, from an average differential of 0.85 percentage points in 1991 to 1.80 percentage points in 1996 (Figure 13).

Public academic health centers and public major teaching hospitals are more likely than other types of hospitals to have charity care caseloads that exceed 6 percent. This is, of course, largely due to their missions as public institutions to provide such care. Among the institutions studied in this analysis, 12 out of 16 public AHCs and 6 of 7 public major teaching hospitals had charity caseloads that exceeded 6 percent in 1996. On the other hand, there were over 300 other hospitals that also provided high levels of charity care.

The relationship between charity care caseloads and hospital margins raises concerns on two levels. On the first level, policymakers should be aware of the implications of increasing charity care on individual hospitals' long range financial stability and develop policies to limit the impact. On a second level, policymakers should be concerned over the potential responses that hospitals could make to these financial pressures. If some hospitals establish policies that directly or indirectly restrict access for uninsured patients, the responsibility for charity care will become more concentrated in fewer institutions. Over the long run, increasing concentration of charity care could result in a downward spiral in the financial status of safety net institutions.

Finding 5. Faculty practice plans are also providing an increasing amount of charity care, but without the subsidies from Medicare and Medicaid that are available to hospitals providing a disproportionate amount of care to the poor and uninsured.

Faculty practice plans (FPPs) are an integral component of AHCs. These plans are the organizational structure through which medical school faculty provide both the inpatient and outpatient physician services that are central to the research, educational, and specialty care missions of AHCs. FPPs are an important revenue source not only for the salaries and benefits of clinical faculty but also for medical schools. According to the most recent data available, FPPs provided an average of nearly \$15 million dollars to their affiliated medical schools, universities, and hospitals in fiscal year 1998.⁶⁶

FPPs also provide a significant and growing amount of care to the poor and medically indigent. Of the plans surveyed by the AAMC, FPPs provided an average of more than \$17 million in charity care in 1998; the median plan provided about \$6 million in charity care. On an inflation-adjusted basis, the median amount of charity care provided by FPPs grew by more than one-third (35.0%) from 1995 to 1998 (Figure 14).

As with other types of health care providers, FPPs finance their charity care through revenues from paying patients. However, their patient revenues have not kept pace with the growing demand for charity care. Median total net patient revenues remained nearly constant on an inflation-adjusted basis, growing by only 0.5 percent from 1995 to 1998.

⁶⁶ K. G. Serrin, S. Larkins, and G. R. D'Antuono, *GFP Practice Plan Profiles Report: Report of Fiscal Year 1998 Data* (Washington, D.C.: Association of American Medical Colleges, 1999).

FPPs do not receive the financial consideration from government for their clinical services that hospitals do. AHC hospitals are eligible for significant payment adjustments from Medicare and Medicaid to support the cost of their care to the poor and uninsured. Medicare and Medicaid disproportionate share policies provide substantial funding for hospitals with an unusually high volume of care to poor Medicare and Medicaid patients. Yet, neither public plan offers comparable support to physicians and faculty practice plans. In fact, Medicare and Medicaid payments for physician services have been falling. On an inflation-adjusted basis, FPP Medicare revenues fell by nearly 10 percent (9.8%) from 1995 to 1998; Medicaid patient revenues were down 15.2 percent.

The drop in Medicare payments to FPPs is due to a combination of policies. First, beginning in 1991, Medicare implemented the resource-based relative value scale (RB RVS) for the physician work component of physician payments. This new reimbursement policy resulted in major drops in Medicare payment rates for physician specialists. As AHCs tend to have a relatively high density of specialists to support their specialty care and educational missions, FPPs faced a decrease in Medicare payments. Second, beginning in 1998, the RB RVS concept was extended to the overhead component of physician payments. Although still in the earliest phase of implementation, this policy is expected to further reduce payments for specialty care, again putting pressure on FPP Medicare revenues. Finally, Medicare has implemented new rules restricting the circumstances under which teaching physicians may bill for services. Thus, while AHC hospitals providing disproportionate amounts of care to the poor continue to receive additional support from Medicare and Medicaid, the revenues of FPPs from the public plans have been falling.

Finding 6. Medicare disproportionate share payments are not efficiently targeted to provide additional support to those safety net hospitals that treat a disproportionate share of uninsured patients.

When first considered, the Medicare disproportionate share payment adjustment (DSH), implemented in 1986, was intended to compensate hospitals for the higher costs associated with treating low-income patients. As noted by MedPAC, the intent behind this adjustment has evolved over the past 10 years. “[T]he adjustment has increasingly been viewed as serving the broader purpose of protecting access to care for Medicare and low-income populations by assisting the hospitals they use.” These hospitals, providing substantial amounts of care to the poor, have difficulty attracting privately insured patients. Without some form of public support, these institutions might be forced to curtail their services to the poor.

If the Medicare adjustment is intended to subsidize hospitals with large numbers of uninsured patients or substantial levels of uncompensated care, one would expect that the DSH payment adjustment would be higher for hospitals with higher volumes of self-pay or charity patients. In fact, similar levels of DSH payments go to hospitals showing great variation in their volume of charity patients.

To examine whether Medicare DSH payments are appropriately targeted to hospitals with significant burdens of non-paying patients, an analysis at Georgetown University combined 1996 discharge data from nine states with Medicare cost report data. The discharge data were used to determine the proportion of admissions to each hospital that were categorized as self-pay or charity cases. Medicare cost report data were used to calculate the ratio of DSH payments to regular DRG payments. While not exactly equal to the DSH payment adjustment, this ratio is a measure of the value of the subsidy this payment adjustment provided to each hospital. The sample was then limited to hospitals with 50 or more beds to eliminate the effects of small numbers of discharges on the observed ratios. Hospitals were grouped by level of DSH payments, and the average proportion of charity and self-pay patients within each group was calculated.

There is a weak relationship between the level of DSH payments and the proportion of charity care and self-pay admissions. The proportion of charity and self-pay discharges in this sample is positively correlated to the ratio of DSH to regular DRG payments ($r = 0.3396$). On average, hospitals receiving relatively high DSH payments per case (greater than 45%) have the highest average proportion of charity and self-pay admissions (11.1%). Hospitals that receive no DSH payments have, on average, the lowest number of charity and self-pay discharges.

However, the middle range of this distribution suggests why the correlation is as low as it is. Across a fairly wide range of DSH payment adjustments, there is very little difference in the average level of charity and self-pay admissions. For example, hospitals with DSH adjustments of from 5 to 10 percent have virtually the same load of charity and self-pay patients as hospitals with DSH adjustments of 25 to 30 percent (5.0 and 5.1 percent respectively). Stated simply, hospitals that provide the same levels of care to charity and self-pay patients may receive very different levels of subsidy from Medicare.

Beyond the averages displayed in Figure 15, the data show that there are wide variations in the proportion of charity and self-pay patients within categories of DSH payment adjustments. For example, there are a significant number of hospitals with high DSH payment rates that provide relatively little care to charity and self-pay patients. Ten

percent of the hospitals in this sample with DSH payment adjustments between 15 and 25 percent provide less than 1 percent of their care to charity patients. Nearly 15 percent of hospitals with DSH payment rates greater than 25 percent have a caseload of charity cases that is less than 2 percent of their total discharges.

Clearly, the poor relationship between the DSH payment adjustment and charity care is related to the basic structure of the formula for determining the adjustment. The formula is based on the amount of care provided to Medicaid and low-income Medicare patients, and explicitly excludes the amount of care provided to charity patients. However, if the goal of the Medicare DSH payment policy is to provide higher Medicare payments to hospitals with providing more charity care as a means of protecting access for low-income beneficiaries, the policy clearly fails or is, at least, inefficiently targeted. There are a number of hospitals with high DSH payments that provide relatively little charity care. At the same time, there are hospitals with significant charity care burdens that receive little or no DSH payments from Medicare.

MedPAC has noted a number of additional problems with the existing policy. First, hospitals are not treated equally under the formulae. For example, small urban and many rural hospitals must provide extraordinary amounts of care to the poor before qualifying for a relatively modest payment adjustment. Large urban hospitals have much lower eligibility thresholds, and can receive much larger adjustments. Second, the eligibility criteria create a payment notch around the eligibility thresholds. Hospitals just above the threshold may have DSH payment adjustments of at least 2.5 percent while hospitals just below the thresholds receive nothing. Finally, the existing Medicare DSH eligibility criteria are based, in part, on the proportion of a hospital's days that are for Medicaid patients. States' eligibility requirements for Medicaid vary significantly. Thus, hospitals in different states may treat the same number of patients below the federal poverty level (FPL), but have very different proportions of Medicaid patients and thus different DSH adjustments under Medicare.

While DSH payments are not efficiently targeted to hospitals with significant levels of charity care, these payments are related to hospitals' cost per case. Coleman et al. estimated a wide variety of regression models of hospitals' cost per case.⁶⁷ In each of the models estimated, the Medicare DSH payment adjustment was significantly and positively related to hospitals' cost per case. That is, in spite of the flaws in the policy's basic design,

⁶⁷ K. Coleman and A. Dobson, "Estimating Provider Training, Stand-By Capacity, and Clinical Research Costs Using Regression Analysis," unpublished report for The Commonwealth Fund, April 1999.

the fact remains that, all else being equal, hospitals with higher costs receive high DSH adjustments.

Finding 7. The Medicaid disproportionate share payments represent an important source of funding for AHCs and safety net hospitals. However, these funds are inequitably distributed and poorly targeted. In addition, there are wide variations in how these funds are used. In several states, these funds are primarily used to support state-owned institutions, including state mental hospitals, rather than being used to support acute care hospitals that provide care to the poor and uninsured.

In many states, the Medicaid DSH program has made significant contributions to the support of institutions that provide significant amounts of care to the poor and uninsured. In 1996, Medicaid DSH payments were the difference between a 13 percent negative margin on Medicaid patients in public hospitals, and the 6 percent positive margin actually realized.⁶⁸ As previously noted, states have used these funds, in part, to significantly increase provider payments. Higher Medicaid payments have, in turn, increased the access of Medicaid beneficiaries to inpatient hospital care, particularly in for-profit hospitals.

In spite of these benefits, the Medicaid DSH program has several problems that suggest that these funds are not being equitably distributed, and are not efficiently targeted to support care to the poor and uninsured.

First, there are large inequities in how these funds are distributed among states. The level of DSH funding is clearly related to the size of a state's Medicaid programs. Large states (California, New York, and Texas) tend to have the highest levels of DSH funding, while small states tend to have the lowest. However, legislation in 1991 and 1997 explicitly capped the DSH allocations among states, seeking to curb some of the major abuses of the program while containing its growth. Thus, states that created their Medicaid DSH programs prior to 1991 have relatively large allocations while states that acted somewhat more slowly have not been able to obtain the same benefit of additional federal funds.

After taking the need for such funding into account based on the relative size of a state's Medicaid program or the number of uninsured individuals, DSH spending appears to have little relationship to actual need. In addition, Medicaid DSH payments are only

⁶⁸ L. Fagnani and J. Tolbert, *The Dependence of Safety Net Hospitals*.

made to institutions for treating individuals who are qualified for Medicaid. The wide variations in eligibility criteria among states increases the inequities of using Medicaid as a general mechanism for supporting hospitals that provide charity care.

A recent analysis of the Medicaid DSH program examined the variations in payments among states.⁶⁹ At the low extreme, the total amount of Medicaid DSH spending in six states was less than \$1 per Medicaid and uninsured individual. At the other extreme, five states had DSH spending greater than \$500 per Medicaid and uninsured individual. Using Medicare DSH payments as an alternative measure of “need” reveals similar disparities. In five states, Medicaid DSH payments are more than 10 times the amount of Medicare DSH payments in the state. In 10 states, the amount of Medicaid DSH is less than the amount of Medicare DSH paid to hospitals within the state.

In addition to the wide disparities in the amount of DSH funding among states, there also are major differences in how states use these funds. Some states use these funds principally to support state-owned mental institutions. Prior to the establishment of Medicaid DSH programs, states were required to use state funds to support these institutions as Medicaid does not cover inpatient psychiatric care for adults. Nevertheless in 1997, nine states paid more than 50 percent of their total Medicaid DSH allotment to state mental hospitals. Overall, 20 percent of total DSH spending in 1997, approximately \$3 billion, was used to support these types of institutions.⁷⁰ The BBA limited the proportion of DSH spending that could be paid to mental hospitals to 33 percent of a state’s DSH allotment. Even under this limit, these payments represent a significant diversion of funds that could otherwise be used to support acute care providers who treat the poor and uninsured.

Moreover, some states have simply retained a portion of their Medicaid DSH allocations. The net amount gained by a state can be calculated by summing the total revenues (provider taxes, intergovernmental transfers, state funds, and federal matching payments) and subtracting total payments made to providers. A recent survey of 40 states suggested that the total net gains to states, principally federal matching funds, amounted to about \$8 billion in 1997.⁷¹ Approximately 15 percent of these gains, \$1.2 billion, was not paid out to providers but retained by the states for other purposes. Most of the retained funds (\$1 billion) were concentrated in four states (California, Massachusetts, Missouri,

⁶⁹ T. A. Coughlin, L. Ku and J. Kim, “Reforming the Medicaid Disproportionate Share Hospital Program in the 1990s,” Discussion Paper #99-14, The Urban Institute, Washington, D.C., January 2000.

⁷⁰ Ibid.

⁷¹ Ibid.

and Texas). It is not clear how these states have used these funds. At least one state, California, has used some of this money to provide additional support for graduate medical education in state-owned AHCs.

Finding 8. Direct funds from state and local governments are a vital resource for financing indigent care. While publicly owned AHCs and major teaching hospitals provide much more care to the poor and uninsured than private hospitals, this additional cost is generally financed through direct subsidies from state and local governments.

Publicly owned hospitals provide a much greater amount of care to poor and uninsured patients than do private institutions. For example, charity care in public AHCs was 13 percent of gross patient revenues in 1996, while the figure for private AHCs was only 4.1 percent. Taking on this greater fiscal burden is consistent with public institutions' mission to provide care to all in their communities, without regard to a patient's ability to pay or insurance status.

On the surface, these differences would seem to imply that public AHCs are financing a much larger portion of charity care through cross subsidies than their private counterparts. However, as a matter of practice, the amount of expenses for charity care absorbed by AHCs and other major teaching hospitals, and ultimately financed through higher payments from paying patients, is virtually the same across all classes of ownership. The difference is compensated for by state and local government tax appropriations.

Figure 16 displays the amount of uncompensated care provided by AHCs and other major teaching hospitals, by type of ownership, from 1992 through 1996.⁷² The amount of uncompensated care is then divided into two components: the amount of tax appropriations received from state and local governments, and the amount of uncompensated care that must be absorbed by the hospital. As shown, the amount of uncompensated care AHCs and major teaching hospitals must absorb is very similar across all classes of ownership. From 1992 to 1996, the average amount of uncompensated care (expressed as a percentage of total operating expenses) that major teaching hospitals must absorb ranged from 3.3 to 4.6 percent for municipally owned hospitals, from 3.3 to 4.3 percent for state-owned hospitals, and from 4.8 to 5.1 percent for private, not-for-profit

⁷² E. Valente and K. G. Serrin, "Uncompensated Care in Major Teaching Hospitals and Faculty Practice Plans," in *Meeting the Needs of Communities: How Medical Schools and Teaching Hospitals Ensure Access to Clinical Services* (Washington, D.C.: Association of American Medical Colleges, October 1998).

hospitals. After controlling for tax appropriations, the cost of uncompensated care that is borne by the hospital is actually somewhat higher for private than for public institutions.

It must be noted that state and local government tax appropriations are not simply for indigent care programs. In some cases, these funds are provided to support educational, public health, or even research programs. Nevertheless, these funds represent an important source of subsidy, and, as a result, in aggregate all types of major teaching hospitals are absorbing the costs of charity care on a roughly equal basis.

Finding 9. Academic health centers provide a disproportionate amount of some types of specialized services to the poor and uninsured.

Academic health centers provide a disproportionate share of specialized care for poor and uninsured populations in their communities. Ethnic minorities, Medicaid patients, uninsured patients, and very poor patients are more likely to receive specialty care from AHCs.

A recent study examining patterns of care for procedures predominantly performed in AHCs and other teaching hospitals found that underserved populations were more likely to have received a broad range of specialty procedures in major teaching hospitals.⁷³ The study showed that procedures that were predominantly performed in AHCs and other major teaching hospitals accounted for 15 percent of all hospitalizations among underserved patients, but only 10 percent of hospitalizations in all other groups of patients. This finding suggests that non-teaching hospitals may be avoiding these patients and steering them to AHCs and other safety net institutions for care. Also, minority and poor patients also may wait longer to seek care. Thus, they may be sicker and need more specialized services when they eventually seek treatment. Finally, the finding may reflect the higher use by poor patients of particular teaching hospital services, such as burn care and trauma services.

The care of patients with AIDS provides an additional example of how poor patients requiring specialty care may be channeled into AHCs. A study conducted at Georgetown University examined patterns of care in 38 cities for a variety of specialized services.⁷⁴ In these communities, AHCs represented 5.8 percent of hospitals and accounted

⁷³ R. Levin, "Procedures Primarily Performed in Major Teaching Hospitals," in *Meeting the Needs of Communities: How Medical Schools and Teaching Hospitals Ensure Access to Clinical Services* (Washington, D.C.: Association of American Medical Colleges, October 1998).

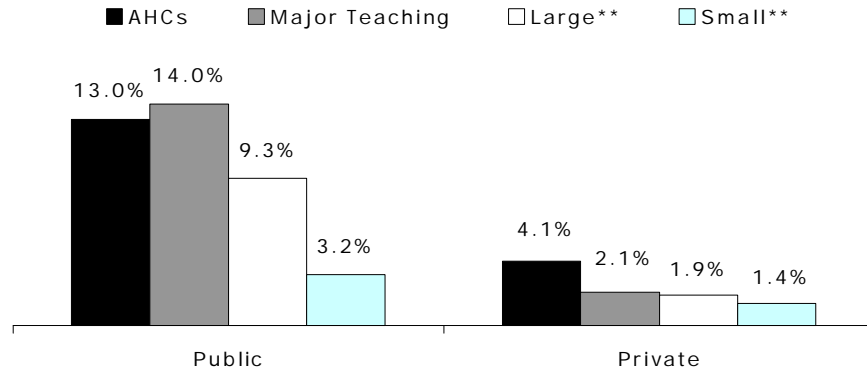
⁷⁴ J. A. Reuter, *Patterns of Specialty Care: Academic Health Centers and the Patient Care Mission* (New York: The Commonwealth Fund, 1999).

for just 13.3 percent of hospital beds. Despite their small numbers, AHCs provided over one-quarter (26.4%) of all inpatient AIDS care in these communities. The proportion of AIDS cases treated by AHCs varied substantially by type of insurance. AHCs provided care for 35.7 percent of all Medicaid AIDS cases and 33.8 percent of all care for uninsured AIDS patients. On the other hand, only 3.3 percent of AIDS cases insured by an HMO were treated in an AHC (Figure 17).

AHCs also are the primary providers of care for trauma cases and high-risk infants who are either uninsured or covered by Medicaid. AHCs provide treatment for 35.8 percent of Medicaid trauma cases and 35.6 percent of uninsured trauma cases. They provide care for 25.3 percent of Medicaid high-risk infants and 25.8 percent of uninsured high-risk infants.

The concentration of poor and uninsured patients requiring specialty care in AHCs is due, in part, to the role that many AHCs—and public AHCs in particular—have accepted in providing care to the poor. In the 38 cities studied, public AHCs treated 17.1 percent of all uninsured cases and 10.4 percent of Medicaid cases. Private AHCs treated 5.1 of uninsured and 7.6 percent of Medicaid cases. However, the concentration of poor and uninsured specialty cases in AHCs clearly goes beyond the relative concentration of poor patients in these institutions. While AHCs provide care for one out of every five who are poor or uninsured, they treat one out of every three AIDS and trauma cases, and one out of four high-risk infants.

Figure 9
 Uncompensated Care* as a Percentage of Gross Patient Revenues, by Ownership and Type of Hospital, 1996

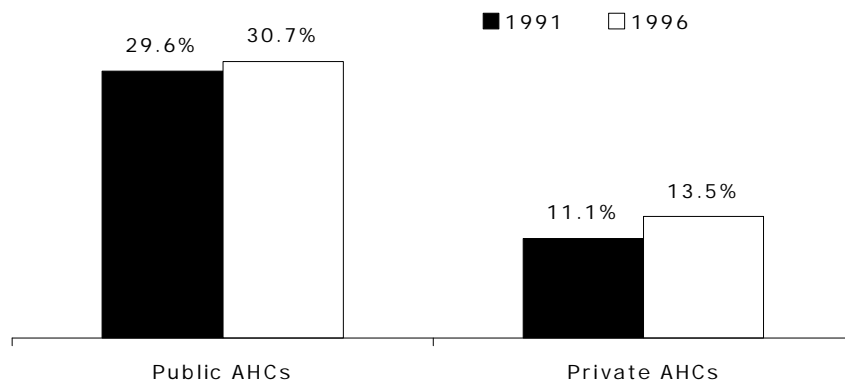


* Bad debt plus charity care.

** Includes minor teaching and nonteaching hospitals.

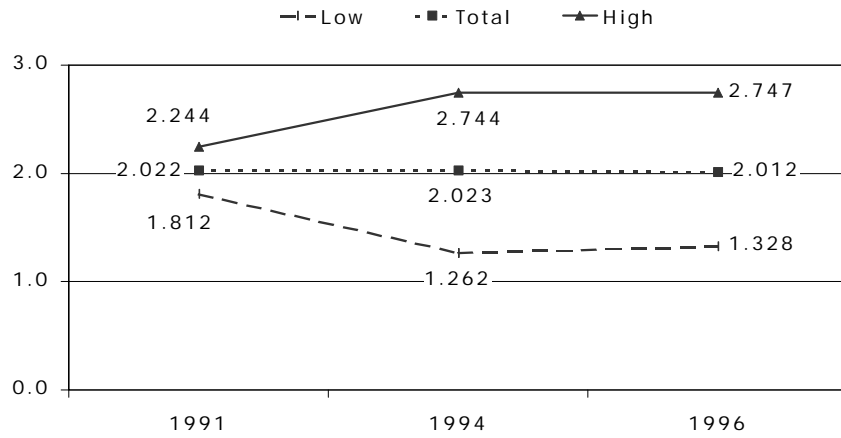
Source: Georgetown University analysis of data summaries of the American Hospital Association 1996 Annual Survey of Hospitals provided by AHA.

Figure 10
 Share of Total Charity Care Provided by Public and Private AHCs in Their Communities, 1991 and 1996



Source: Georgetown University analysis of data summaries of the American Hospital Association 1991 and 1996 Annual Surveys of Hospitals provided by AHA.

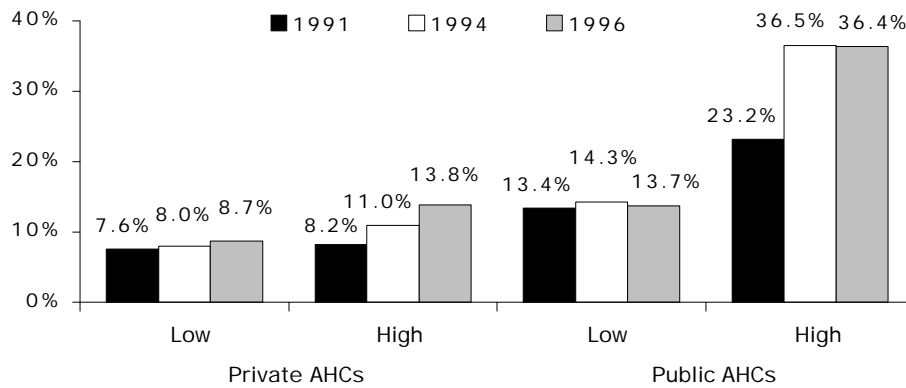
Figure 11
 Relative Concentration of Uninsured Patients,*
 Total and by Level of Competition, 1991, 1994, and 1996



* Self-pay plus free care cases.

Source: Georgetown University analysis of 1991, 1994, and 1996 State discharge data.

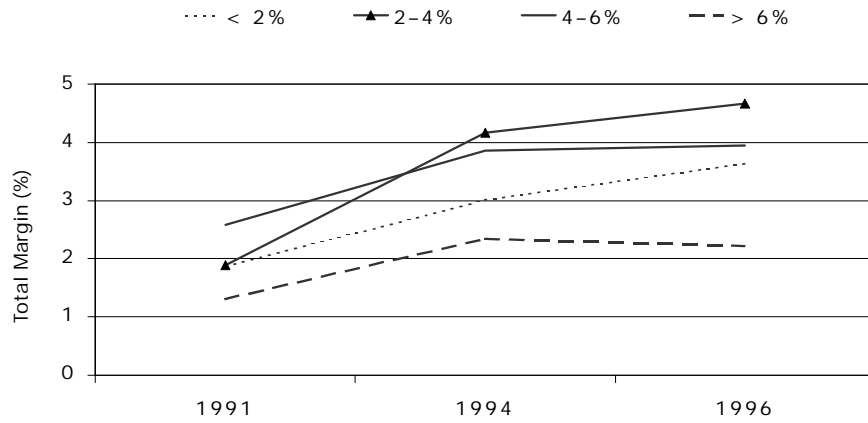
Figure 12
 Share of Uninsured Patients* Served by AHCs in Their
 Markets, by Ownership and Level of Competition,
 1991, 1994, and 1996



* Self-pay plus free care cases.

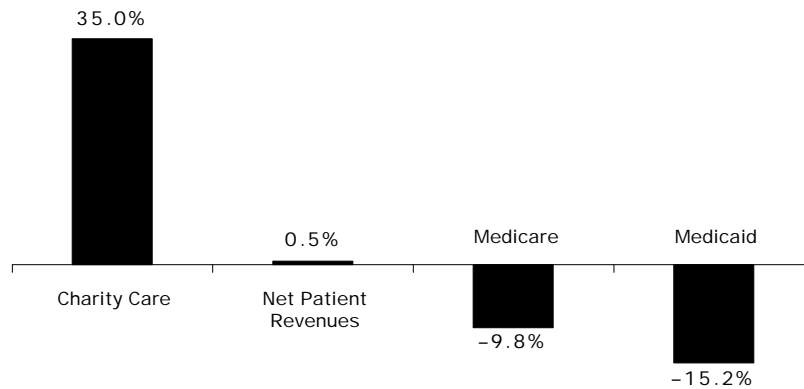
Source: Georgetown University analysis of 1991, 1994, and 1996 State discharge data.

Figure 13
 Average Total Margin by Percent of Admissions That Are Self-Pay/Charity, 1991, 1994, and 1996



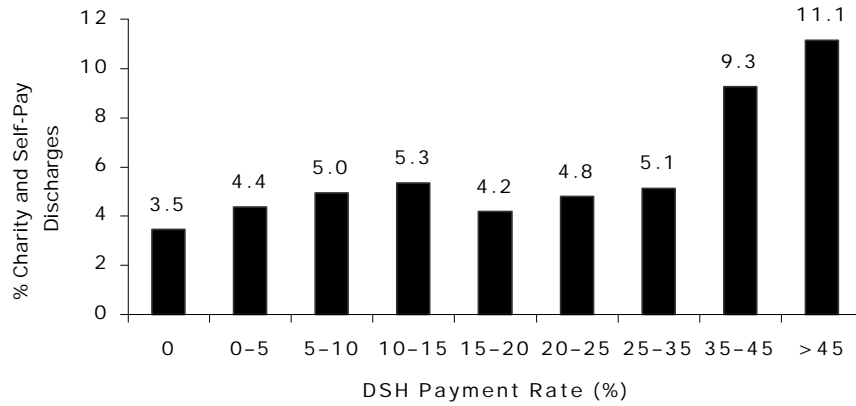
Source: Georgetown University analysis of Medicare Cost Report and State discharge data.

Figure 14
 Change in Inflation-Adjusted Charity Care and Patient Revenues for Faculty Practice Plans, 1995 to 1998 (median values)



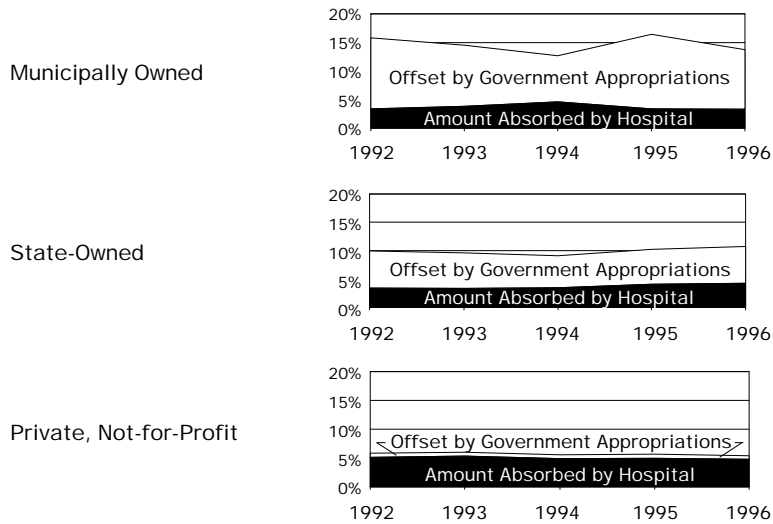
Source: Association of American Medical Colleges analysis of FY 1995 and FY 1998 GFP survey of faculty practice plans. Analysis based on cohort of plans reporting data for both periods.

Figure 15
 Distribution of Percentage of Self-Pay Patients
 by Medicare DSH Payment Rate



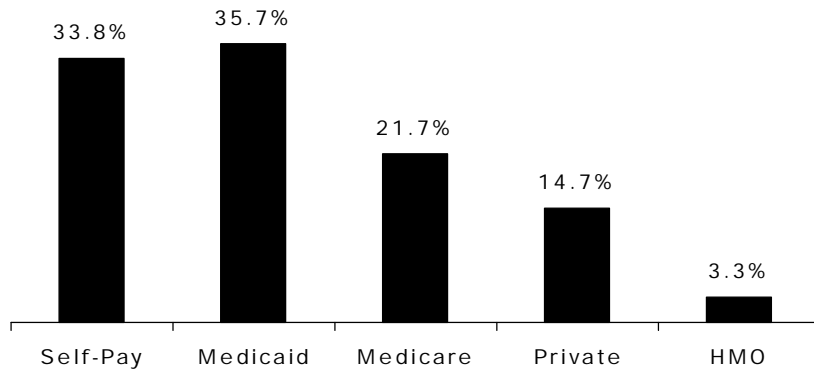
Source: Georgetown University analysis of Medicare Cost Report and State discharge data.

Figure 16
 Uncompensated Care Costs in Major Teaching Hospitals
 as a Percentage of Operating Expenses (mean values)



Source: Association of American Medical Colleges.

Figure 17
Percent of AIDS Cases Treated in AHCs,
by Type of Insurance Coverage



Source: Georgetown University analysis of State discharge data.

IV. PRINCIPLES AND CONCLUSIONS

The Task Force's review of the status of health care for the poor and uninsured at the current time leads to certain principles and conclusions that should be used to guide AHCs and policymakers in the development of policies to address the issues raised in this report.

1. The provision of care to the uninsured is a social benefit, whose costs should be shared broadly across all society.

Society clearly benefits by having access to necessary and appropriate health care. The economy benefits through the availability of a healthy workforce. A healthy population limits the spread of epidemics, and limits the resources that must be expended on acute care medical services.

A large majority of our society finances its health care through participation in private, employer-based health insurance plans, but a significant number of individuals either cannot or do not participate in such plans. In some cases, they work for employers who do not offer such a benefit, or they may not be able to afford to purchase such coverage.

Public policies must address the issue of financing the care for the poor and uninsured. In view of long-standing trends, it seems clear that this problem may well get worse before it gets better. A guiding principle in the development of solutions should be the recognition that the cost of assuring availability of care ought to be shared across the entire society.

2. Increasing the number of persons covered by both public and private health insurance is the most appropriate way of reducing the financial burden on providers caring for the uninsured.

The most direct method of reducing the stresses placed on providers who give care to the poor and uninsured is to increase the proportion of the population that is insured. This approach offers additional important benefits. Patients would be able to obtain care from all providers. With reduced financial barriers, they would be more likely to seek care earlier in the course of an illness and thus be less likely to require expensive inpatient services. Finally, the issue of how to share the costs of such coverage would be resolved by developing policies to provide insurance premium subsidies for low-income individuals.

3. As long as some Americans remain uninsured, all participants in the health care system, including providers, insurers, and employers, should continue to meet their obligations to assure the poor and uninsured access to needed care. Academic health centers must continue to carry out their historic mission to provide such care.

Historically, health care providers, both institutions and individuals, have performed the social function of shifting resources to finance care for the poor and uninsured. Ultimately, these resources have come from governments (federal, state, and local) and payers (both public and private). In the absence of significant expansions of coverage, all of the existing contributors must continue to ensure that providers have the resources necessary to cover the costs of caring for the poor and uninsured. Governments will need to maintain their contributions. Public and private payers, too, must maintain their responsibilities for assuring that safety net institutions have adequate funds to fulfill their social missions.

4. Policies need to be developed that provide support for care to the poor and uninsured while allowing providers to compete on an equal basis for insured patients.

In this country, charity care has been financed through three principal mechanisms: explicit support from state and local governments, targeted subsidies from Medicare and Medicaid, and higher charges to paying patients. However, the adequacy of this hybrid approach in the future is questionable.

Increasingly, our health care system is characterized by, and is being transformed by, competitive forces. Competition provides a variety of benefits. First, and most importantly, it can lead to real reductions in both the cost of care and the rate at which costs rise over time. In addition, competition may also lead to improvements in the quality of care. However, institutions that are engaged in social missions, including education, research, specialty care, or provision of care to the poor and uninsured, are disadvantaged in competitive markets. In the absence of explicit subsidies to finance their social missions, these institutions try to recover the additional costs of caring for the poor and uninsured by charging their paying patients higher fees—making their care more expensive. As payers seek to control their own costs, they are negotiating discounts and directing their beneficiaries to lower-cost providers. While perfectly rational from the perspective of payers, this form of competition can reduce the financing available to support a hospital's social missions.

It is certainly appropriate for these providers to compete in the market for insured patients, but they will not be able to do so fairly as long as they must finance care for the uninsured and underinsured through high charges for paying patients. This care needs to be financed through some other mechanism to allow AHCs and safety net institutions to compete on a level playing field.

5. Public support for indigent care should be targeted to those providers that deliver the greatest amounts of such care.

The growing number of uninsured individuals is placing greater financial demands on those institutions that provide significant amounts of charity care. This trend is accelerated by the increasing concentration of these patients in competitive markets. Thus, it is imperative that funds intended to support these institutions are targeted to those who actually bear the brunt of providing such care.

Unlike their community competitors, AHCs and many other safety net institutions do not have the same flexibility to reduce their volume of charity care. In some cases, this lack of flexibility is due to their ownership status. Public AHCs and hospitals have an explicit mandate to provide care to all persons, regardless of their ability to pay. In other cases, the lack of flexibility is because of a hospital's location. Many AHCs are located in the central cores of our largest cities. Appropriately targeted policies will need to reflect these institutions' social and financial commitments to their mission.

V. RECOMMENDATIONS

Based on the findings and principles described above, the Task Force has identified five recommendations regarding the financing and provision of care for the poor and uninsured. These recommendations fall into three broad categories: health insurance coverage; targeting of existing subsidies to providers, including AHCs, who care for significant numbers of the poor and uninsured; and research and educational issues that need to be addressed to improve the quality and effectiveness of care for these patients.

Recommendation 1. As first priority, the long-term trend of ever increasing numbers of uninsured persons must be reversed.

The stresses and strains created by the large number of uninsured in this country are not unique to academic health centers but infect all aspects of our health care system. Clearly, patients who either are unable to obtain or delay in seeking needed care suffer the most. Academic health centers, other safety net hospitals, community health centers, free clinics, physicians, and other indigent care providers must struggle to find the means to cover the real costs of uncompensated and free care while trying to participate in an increasingly competitive market. The fact that the number of uninsured has increased over past years makes finding solutions to this problem all the more critical.

It is unacceptable that, in a country as wealthy as ours, 18 percent of the population lacks health insurance. The numbers of uninsured have increased even during a period of unprecedented economic expansion, although the most recent census figures show a slight decline, from 43.9 million to 42.6 million. Whether this is a one-year interruption or the reversal of the trend, the question remains: What will happen when the economy has a downturn? Progress must be made. And the time to act is now. The Task Force recognizes that it is unlikely that any serious attempt will be made to reconsider national health care reform and universal coverage. Nevertheless, opportunities exist for progress.

- a. Federal and state governments should adopt policies that will maximize the number of eligible persons who are actually enrolled and covered under existing public insurance programs, including Medicaid and the Children's Health Insurance Program (CHIP).

A large population currently eligible for both Medicaid and CHIP benefits are not enrolled. Half of the 4 million children who could be receiving CHIP benefits are not; similarly, many children who qualify for Medicaid are not enrolled. Although

implementation of welfare reform was not intended to alter eligibility for Medicaid, confusion over the actual policies, and severing the eligibility link between welfare and Medicaid have resulted in a significant falloff in Medicaid enrollment, from a high of 12.5 percent of the nonelderly population in 1994 to only 10.4 percent in 1998.

A number of proposals have been made to boost enrollment in these programs. These include: simplifying eligibility forms, aligning Medicaid and CHIP eligibility rules, improving outreach, and stepping up efforts to enlist the assistance of agencies serving poor children to identify those eligible for benefits. Since 1990, federal statute requires states to place enrollment workers in hospitals receiving disproportionate share payments (DSH) and in Federally Qualified Health Centers, a process known as "outstationing." Many AHCs and safety net providers have established linkages with state and county agencies or increased their own efforts to enroll eligible children. However, about one-quarter of DSH hospitals do not participate in an outstationing program.

The Task Force believes that these proposals should be supported and expanded. In addition, the Task Force calls on AHCs to provide leadership in their own communities by creating model eligibility programs that other providers could replicate and by working with local agencies to enhance the coordination of eligibility processes across multiple settings.

- b. Congress and the Administration should continue to expand the availability of health insurance coverage through incremental reforms.

A wide variety of opportunities exist for expanding health care coverage through incremental reforms, such as providing premium support to low-wage workers and increasing the availability of private health insurance that is not employer-based. In addition, eligibility criteria for existing public insurance programs could be expanded. For example, the CHIP program could be enhanced to provide coverage to parents of eligible children or to restore benefits to pregnant women and children who are legal immigrants. Alternatively, the complex eligibility requirements for Medicaid could be amended simply to cover all individuals below 100 percent of the federal poverty line.

The Task Force does not endorse one approach over any other. Each of these potential policies should be considered, and, if appropriate, enacted and implemented. However, the Task Force strongly believes that this is the time for action, while the economy remains healthy and budget surpluses are available.

- c. The federal government should encourage AHCs to experiment with innovations in providing care to poor and uninsured populations, including demonstration programs involving new methods of reimbursement and organization of services.

It is well known that free care, *per se*, for uninsured patients does not exist, since resources must somehow be provided, usually by shifting costs against other sources of revenue. In some cases, specific state or local programs are available to pay for services provided to indigent patients who are otherwise ineligible for public insurance programs such as Medicaid or Medicare. In addition, the traditional mode of providing care to uninsured patients primarily through the emergency department or public clinics may not be optimal in terms of continuity and timeliness. Thus, finding innovative ways to care for uninsured and poor patients in the most cost-effective manner possible should be a policy goal. These fresh approaches, which should emphasize preventive care, could include the use of community health centers, outreach programs, coordination of information systems among hospitals, or use of mobile units. The Task Force does not endorse one method of providing care over any other, but feels strongly that AHCs should be able to try out various approaches without putting themselves at any added financial risk over that which currently exists. A program of grants or the institution of necessary waivers on the use of public funds should be developed to encourage AHCs to engage in such experiments.

Recommendation 2. The Medicare disproportionate share payments regulations should be amended to channel this support to the institutions most involved in providing care to the poor and uninsured.

- a. The formula for the Medicare disproportionate payment adjustment should be based on each institution's volume of uncompensated care as well as care provided to poor patients who are covered by Medicaid, other indigent care programs, and Medicare. These subsidies should be targeted to those hospitals with the largest shares of low-income patients.

As described in the "Findings" section of this report, Medicare disproportionate share payments (DSH) are not efficiently targeted to support those institutions that provide the greatest amount of care to the poor and uninsured. Hospitals that treat a similar volume of charity cases may have a wide range of DSH adjustment factors. This variation is largely due to two factors: the differing thresholds that hospitals must exceed in order to qualify for DSH payments under Medicare, and the differing formulae that are used to determine the size of the adjustment for different types of hospitals.

MedPAC has developed and recommended several amendments to Medicare's DSH policies. In general, the Task Force supports MedPAC's proposals and recommends that legislation be adopted to implement them.

Under these recommendations, a single formula would be used for determining a hospital's low-income patient share. In addition, the formula should be amended to reflect a much broader definition of low-income patients. Whereas the current formula considers only the proportion of patient days attributable to Medicaid and low-income Medicare patients, the proposed definition would reflect the total amount of care rendered to all poor patients, including Medicaid beneficiaries, low-income Medicare patients, patients covered under CHIP, patients covered under other indigent care programs, and uncompensated care. This broad definition, and the inclusion of uncompensated care, would address many of the problems created by differences in eligibility criteria among states and localities.

In its original proposal, MedPAC suggested that a minimum eligibility threshold for Medicare DSH payments should be set that would qualify between 50 and 60 percent of all hospitals for Medicare DSH payments. In its most recent report, MedPAC has recommended that the threshold be set to qualify the larger number of hospitals, 60 percent, for Medicare DSH payments.

While supporting MedPAC's recommendations, the Task Force is concerned about how the broad expansion in the number of hospitals that would qualify for DSH payments under this proposal would impact hospitals now receiving such payments. Under current law, only 38 percent of hospitals qualify for DSH payments, 51 percent of urban hospitals and 20 percent of rural hospitals. Expanding eligibility to 60 percent of all institutions would add more than 1,000 hospitals. Given that these amendments are proposed to be implemented in a budget neutral way, this expansion would have a significant impact on the level of funds provided to each hospital as compared to current policy. According to MedPAC's own analysis, the major shifts in support would reduce DSH funding to urban hospitals, AHCs, and major teaching hospitals. In fact, as the threshold is increased from 50 to 60 percent, hospitals with the lowest margins actually receive less support.

The Task Force recommends that Congress not enact MedPAC's proposals in a budget neutral manner. As discussed, hospitals in the highest quartile of charity care have the lowest margins, and thus the greatest need for any subsidy. In many urban communities, charity care is becoming much more concentrated in a smaller number of

institutions. Thus, the value of the subsidy should not be diluted to finance an expansion of the benefit to more hospitals. Congress should adjust the proposed formula so that, in aggregate, urban hospitals receive the same total support as under existing law.

- b. Medicare payments to Medicare+Choice plans should be determined without regard to Medicare disproportionate share payments. As with Medicare support for graduate medical education, disproportionate share payments should be carved out of the Medicare+Choice premiums and made directly to the institutions providing care to Medicare+Choice enrollees who qualify for such payments under traditional Medicare.

In a previous report,⁷⁵ the Task Force adopted the principle that a goal of public policy should be to “level the playing field.” That is, AHCs and other providers who carry out valued social missions should be able to compete in the market on the basis of both price and quality, without the need to cross-subsidize their social missions from patient revenues. Building on this principle, the Task Force recommended that payments for the direct and indirect costs of graduate medical education should be handled separately from the ongoing price negotiations between health plans and providers. With regard to Medicare payments to managed care plans, the Task Force recommended that the premiums should be determined without regard to amounts Medicare pays for the direct and indirect costs of graduate medical education (GME). Instead of channeling the GME funds through health plans, the Task Force recommended that teaching hospitals receive additional GME payments directly, based on the number of Medicare managed care enrollees it admitted. The Balanced Budget Act (BBA) adopted this policy when it established Medicare+Choice plans.

The Task Force believes that this policy should be extended to include Medicare DSH payments. By leaving DSH funds in the premium calculations, the current policy creates an opportunity for these funds to be diverted from their purpose of supporting institutions that serve the poor and uninsured. Medicare+Choice plans are expected to negotiate prices with providers as a means of controlling their own costs, consistent with the general goal of assuring high quality care for their members. There is no incentive for these plans to pass the DSH funds on to providers, in the form of higher payments, to support the social missions of assuring access to care for poor and uninsured patients.

⁷⁵ The Commonwealth Fund Task Force on Academic Health Centers, *Leveling the Playing Field: Financing the Missions of Academic Health Centers* (New York: The Commonwealth Fund, 1997).

- c. Medicare's system of higher payments to providers of disproportionate amounts of care to the poor and uninsured should be extended to cover a broader array of services, including those provided in hospital outpatient departments and clinics and by faculty practice plans.

In general, federal and state subsidies for institutions that provide care to the poor and uninsured are targeted to hospitals and are paid for inpatient services. No payment adjustment is allowed for either physician services or those provided in hospital outpatient departments. According to current law, outpatient services are still paid under a modified cost-based reimbursement system. Higher costs associated with the treatment of poor Medicare patients can be partially recovered. However, no recognition is given to the cost of care in the outpatient department that is uncompensated. The situation has been even worse with respect to physician services. Physicians are paid according to the resource-based relative value scale (RB RVS). Under this system, physicians in faculty practice plans are paid the same amount for each service as community physicians, with no recognition of the additional time that may be required to treat poor and uninsured patients.

The BBA, as amended by the Balanced Budget Refinement Act, provides for implementation of a prospective payment system for services provided in hospital outpatient departments, effective in fiscal year 2001. The initial details of this system have only recently been released. At this time, it does not include any adjustments for the provision of care to the uninsured.

The Task Force recommends that Medicare's system of payment adjustments to providers with high levels of care to poor and uninsured patients should be extended to include a broad array of services, including those provided in hospital outpatient departments and by physicians in faculty practice plans (FPPs). The pending implementation of an outpatient perspective payment system clearly provides the opportunity for effecting such a change with respect to hospital outpatient departments. For FPPs, the problem would still remain.

The Task Force's recommendation would have several beneficial effects. First, it would eliminate the current economic incentives to prefer expensive inpatient care to less costly outpatient care. Second, as shown in Finding 5, FPPs provide a significant and growing amount of care for the poor and uninsured. The FPPs' volume of this care is likely to be highly correlated with the amount of such care rendered by their hospital partners. While some AHC hospitals and FPPs are under common ownership, nearly half

of AHC hospitals are under separate ownership from the medical school, and more than 40 percent of FPPs are separately incorporated from their schools. Thus for most schools, subsidies to the hospital do not necessarily result in support (either directly or indirectly) for all elements of an AHC. By extending DSH subsidies directly to FPPs, Medicare would provide conforming payment adjustments to all components of AHCs that bear a significant share of the total costs of caring for poor and uninsured patients.

Recommendation 3. The Medicaid disproportionate share program should be reformed to target these funds to acute care hospitals and other organizations that provide care to the poor and uninsured.

The Medicaid disproportionate share program provides major benefits to many AHCs and safety net institutions, but, as discussed in Finding 6, a significant portion of these funds are being diverted for other purposes. Many states have used this resource to shift support for state psychiatric institutions from state to federal funds. In addition, over \$1 billion is being retained by states and is not used to pay the costs of providing care to the poor and uninsured.

The Task Force recommends that this program be amended to target this money more accurately to the institutions providing the care these funds are intended to support. Specifically, the Task Force believes that this reform should have six objectives:

- First and foremost, any reform must recognize the benefits of this program to many states, and should ensure that the integrity of the program is maintained.
- Second, DSH funds should be distributed based on the relative magnitude of a hospital's Medicaid and uncompensated caseloads.
- Third, the use of these funds to support long-term psychiatric hospitals should be sharply reduced. Currently, states are permitted to spend up to 33 percent of their DSH funds on these institutions.
- Fourth, states should be prohibited from retaining an excessive amount of DSH funds. The program should allow states to retain a small proportion of these funds for administrative purposes. However, this proportion should be no greater than the overall ratio of Medicaid program administrative costs to total program costs.

- Fifth, greater equity in the use of federal funds should be established among states. Under current law, states can increase their DSH programs at the rate of inflation, subject to a ceiling of 12 percent of a state's total annual Medicaid costs. States with small DSH programs are not permitted to increase the relative size of their DSH programs. Some limit is both reasonable and appropriate. However, current policy simply rewards the programs that acted quickly and most aggressively, without regard to a state's real needs for such funds.
- Sixth, children's hospitals should not be substantially disadvantaged by changes in the method of distributing DSH funds.

The Task Force recognizes that these reforms may be politically difficult and would increase federal Medicaid spending. However, it is important to consider the context in which this recommendation is made. If the number of uninsured people in this country continues to increase, the financial burden on institutions committed to serving the uninsured will also increase. In markets where the responsibility of caring for this population is becoming more concentrated, the fiscal strain on individual institutions will grow even faster than the growth in the numbers of uninsured. To exacerbate the situation, acute care hospitals are still expected to compete in the market for managed care and other insured patients. If properly targeted, Medicaid DSH programs would be a very efficient means of getting these institutions the support they need.

Recommendation 4. The federal government should increase support for studies designed to improve the quality of care provided to the uninsured and to members of racial and ethnic minorities.

Clear differences exist in the patterns of care provided to persons who are poor, uninsured, or members of racial and ethnic minorities. In some cases, these differences have been attributed to lack of insurance, because uninsured individuals may delay seeking care and fail to comply with recommended treatments. Other studies have shown that, even after controlling for insurance status, racial and ethnic minorities may receive different care than white patients with similar symptoms and conditions.

In a previous report, the Task Force made recommendations for increasing National Institutes of Health (NIH) support for clinical research, training of clinical researchers, and health services research.⁷⁶ Within these broad categories, it is clear that

⁷⁶ The Commonwealth Task Force on Academic Health Centers, *From Bench to Bedside: Preserving the Research Mission of Academic Health Centers* (New York: The Commonwealth Fund, April 1999).

specific attention should be paid to the appropriateness and quality of care provided to poor and minority patients, and to the implications of treating patients who have inferior access to care.

The Task Force recommends that specific funding should be provided to support clinical research designed to increase our understanding of why these differences in patterns of care exist, to determine whether or not these differences reflect appropriate variations in care, and to enhance the quality of care to these individuals. Raising the quality of care will not only improve patients' health, but also reduce the waste of medical resources. Given the substantial proportion of our population who are either uninsured or members of a racial or ethnic minority, it is imperative to develop new and improved approaches for serving these groups.

Recommendation 5. AHCs should ensure that medical students and residents have appropriate training and experience in providing care to the poor, uninsured, and racial and ethnic minorities. The goal of these activities should be to reduce the disparities in health care use and outcomes for these populations.

As the leaders in medical education, AHCs should ensure that all students and residents have appropriate experience providing care to a wide variety of patients, including different racial and ethnic groups, individuals at all points of the economic spectrum, and both insured and uninsured patients. Poor and uninsured patients can present special challenges for physicians. They may seek care at a relatively late date in the illness and have difficulty following a course of treatment. Even if insured, they may not have adequate coverage or money to purchase prescription medications or other medical supplies. Language, too, may present a significant barrier.

High quality medical education should offer adequate opportunities to physicians-in-training, to care for such patients in order to recognize their unique problems and to develop strategies for overcoming the obstacles to effective treatment. Many AHCs already place students in sites where they can gain the necessary experience. The objective of these experiences should be to reduce the disparities that now arise when poor and uneducated patients receive treatment.

While all students and trainees should have significant exposure to the problems of caring for these populations, the Task Force wishes to emphasize that these activities must be part of a structured educational program, and not simply a device to use students and residents as cheap sources of medical labor to provide services to needy populations.

RELATED PUBLICATIONS

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Policy Reports

#390 *Health Care at the Cutting Edge: The Role of Academic Health Centers in the Provision of Specialty Care* (July 2000). This policy report of The Commonwealth Fund Task Force on Academic Health Centers identifies the specialty care mission of academic health centers (AHCs), shows how AHCs are the main providers and initial developers of many rare procedures and treatments, and reports that AHCs provide a disproportionate share of specialty services to poor and uninsured patients.

#312 *From Bench To Bedside: Preserving the Research Mission of Academic Health Centers* (April 1999). This policy report of The Commonwealth Fund Task Force on Academic Health Centers is intended to provide a resource for future policy development and management related to research mission of academic health centers. It also examines how recent changes in the health care market and public policies may hamper the ability of academic health centers to conduct research as effectively as they have in the past.

#231 *Leveling the Playing Field: Financing the Missions of Academic Health Centers* (May 1997). This policy report of the Task Force on Academic Health Centers reviews the pressures academic health centers face due to market forces and how these pressures affect their ability to carry out their academic and indigent care missions. The report discusses the need for public action to support these missions and presents a set of policy recommendations related to financing them.

Papers, Studies, and Reports

#408 *Managing Academic Health Centers: Meeting the Challenges of the New Health Care World* (October 2000). This report of The Commonwealth Fund Task Force on Academic Health Centers describes strategies undertaken by the nation's academic health centers (AHCs) to improve management of their patient care and research missions in the face of continuing tumult in the U.S. health care system.

#330 *New Approaches to Academic Health Center Affiliations: Public Hospitals and the Department of Veterans Affairs* (April 1999). Jo Ivey Boufford, Larry Gage, Kenneth W. Kizer, Luis R. Marcos, John H. Short, and Katherine E. Garrett. This issue brief summarizes a panel discussion regarding new approaches to academic health center affiliations that took place at New York University's Robert F. Wagner Graduate School of Public Service.

#307 *Patterns of Specialty Care: Academic Health Centers and the Patient Care Mission* (January 1999). James A. Reuter, Georgetown University. The author defines the specialty care mission, presents an initial qualitative evaluation of patterns of this care in academic health centers, major teaching hospitals, and non-teaching hospitals, and attempts to identify measures for tracking future changes in the provision of specialty care.

#265 *Key Issues in Community Hospital and Academic Medical Center Consolidations* (April 1998). David Altman, The Lewin Group. In an effort to inform community hospital leaders of the issues involved in hospital acquisitions and mergers, the author developed this primer to explain the motivations and principles involved in consolidations, to assess consolidation options and the critical points that must be addressed, and to provide lessons derived from institutions that have recently consolidated.

Published Articles

A Tale of Two Systems: The Changing Academic Health Center (May/June 2000). David Blumenthal and Nigel Edwards. *Health Affairs*, vol. 19, no. 3. Copies are available from *Health Affairs*, 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#381 *Trends in Specialized Surgical Procedures at Teaching and Nonteaching Hospitals* (January/February 2000). Rebecca Levin, Ernest Moy, and Paul F. Griner. *Health Affairs*, vol. 19, no. 1. This article examines how the risks and high costs associated with the large number of complex surgical procedures performed by major teaching hospitals have serious implications for the perceived efficiency of these institutions.

#337 *Market Forces and Un-sponsored Research in Academic Health Centers* (March 24/31, 1999). Joel S. Weissman, Demet Saglam, Eric G. Campbell, Nancyanne Causino, and David Blumenthal. *The Journal of the American Medical Association*, vol. 281, no. 12. This article looks at how increased competitive pressures on academic health centers may result in reduced discretionary funds from patient care revenues to support un-sponsored research, including institutionally funded and faculty-supported activities.

#291 *New Bottles for Vintage Wines: The Changing Management of Medical School Faculty and Reforming the Structure and Management of Academic Medical Centers: Case Studies of Ten Institutions* (June and July 1998). Paul F. Griner and David Blumenthal. *Academic Medicine*, vol. 73, nos. 6 and 7. In the first article, the authors offer a comprehensive review of innovative practices to reform faculty responsibilities. Among the changes they describe are appointment letters that detail explicitly the roles and responsibilities of faculty members, annual performance reviews, promotions tied to performance, and enhanced communication with administrators. In the second article, the authors explore changes instituted by medical schools to improve their efficiency. Reforms highlighted include designing strategic plans for individual departments, streamlining and consolidating departments, improving teaching programs, and exploring new sources of revenue.

#339 *Relationship Between Market Competition and the Activities and Attitudes of Medical School Faculty* (July 1997). Eric G. Campbell, Joel S. Weissman, and David Blumenthal. *Journal of the American Medical Association*, vol. 278, no. 3. The authors argue that increased competitiveness of health care markets may hinder the capacity of academic health centers to conduct clinical research and foster the careers of young clinical faculty.

#338 *Relationship Between National Institutes of Health Research Awards to U.S. Medical Schools and Managed Care Market Penetration* (July 1997). Ernest Moy, Anthony J. Mazzaschi, Rebecca J. Levin, David A. Blake, and Paul F. Griner. *Journal of the American Medical Association*, vol. 278, no. 3. The authors provide evidence of an inverse relationship between growth in NIH awards during the past decade and managed care penetration among U.S. medical schools.