September 28, 1984 Statement on Uncompensated Care and the Teaching Hospital

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## ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Uncompensated Care and the Teaching Hospital

Presented to the
Subcommittee on Health, Finance Committee, U.S. Senate

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The Association of American Medical Colleges is pleased that the Subcommittee on Health of the Senate Finance Committee is continuing to study health care for the economically disadvantaged. As the hospitals of our nation confront and adapt to a more traditional commercial marketplace, we must give adequate attention and respond to both the health care needs of our poorer citizens and the financial needs of the hospitals and health professionals who care for them.

Because of the long and distinguished history of hospitals such as Bellevue Hospital Center in New York, Cook County Hospital in Chicago, and Los Angeles County Hospital, many people perceive the non-Federal members of the Association's Council of Teaching Hospitals (COTH) as "charity care teaching hospitals." Charity care and medical education are assumed by some to be necessarily interdependent objectives of major medical centers. There is some validity to this perception. First, in 1980, non-Federal COTH members, which comprise 6% of the nation's community hospitals and 18% of their admissions, incurred 35% of the bad debts and 47% of the charity care. Secondly, many municipally-sponsored "charity" hospitals historically have had difficulty recruiting an adequate number of physicians. To provide appropriate and necessary medical services to their patients, those hospitals have often affiliated with local medical schools to obtain the professional medical services which are provided by residents training under faculty supervision. These affiliation arrangements have benefitted both the patients receiving care and the physicians receiving supervised training. Thirdly, when states and municipalities have authorized appropriated funds to help finance hospitals with disproportionate charity care populations, the funding has sometimes been given

an educational label to either increase its political acceptability or to channel it to particular hospitals. These three relationships between teaching hospitals and charity care have left many in our nation with the stereotypical view that the terms "teaching hospital" and "charity care hospital" are synonomous.

This perception is not completely accurate, and its perpetuation can hamper appropriate discussions of the options for addressing uncompensated care. It should be noted that the uncompensated care burden of COTH members is bimodal: some COTH members, both publicly owned and not-for-profit, provide vast amounts of uncompensated care but many provide an amount comparable to non-teaching, non-profit hospitals. Secondly, it must be recognized that medical students and residents can be trained without charity care patients. Therefore, if the issue of uncompensated care is to receive the attention it deserves at this hearing, we must separate the issues of uncompensated care and medical education wherever possible and address them separately. The balance of this statement will focus primarily on financial and organizational impacts of providing necessary care to patients who do not pay for it.

At the outset, several observations should be made to help ensure a common frame of reference. First, major amounts of uncompensated care are presently being provided by the nation's hospitals. The expenses necessary for this care -- staff, supplies, facilities, and equipment -- are already in the present hospital system. While the financing of those services is a "hodge-podge" of cost shifting, philanthrophy, lost earnings and appropriations, hospitals currently are able to provide massive amounts of uncompensated care. What is most at risk in the re-structured environments is that the self-focused cost containment efforts of individual third party payers and self-insured employers

will silently squeeze the present level of funding for uncompensated care out of the system.

This is related to a second observation: the increases in the price consciousness of buyers of hospital services places hospitals with large uncompensated care burdens at a significant and growing disadvantage. In the absence of a comprehensive entitlement program for financing health services of the poor and medically indigent, hospitals have historically set their prices to subsidize uncompensated care with funds from their paying patients. In a marketplace of price sensitive consumers, hospitals which attempt this cost shifting to underwrite uncompensated care will be at a disadvantage. Their necessarily higher prices will make them less attractive to paying patients, and, as paying patients choose cheaper hospitals without the uncompensated care "surcharge," the financial problem of the hospital with a major uncompensated care burden will get worse and worse.

This leads directly to the third observation: the increasingly competitive marketplace for hospital services is forcing hospitals to balance the costs of uncompensated care for current patients with the hospital's fiduciary responsibility to remain viable in order to serve future generations of patients. It is a major ethical dilemma when a hospital finds that adequately serving its present community may preclude its ability to exist in the future.

Finally, the AAMC must note that teaching hospitals have historically filled special missions as a consequence of their location. Teaching hospitals are primarily in metropolitan areas; the largest are generally in inner city neighborhoods. In response to the hospital's location and the area's shortage of

health personnel, teaching hospitals have often established large clinics and primary care services to meet neighborhood needs, even at a financial loss. The teaching hospital's area-wide programs for burn, trauma, high risk maternity, alcohol and drug abuse, and intensive psychiatric care may also attract patients unable to pay for their care. As a result, many public and private teaching hospitals are major providers of uncompensated care.

The bottom-line conclusion of these observations is clear: uncompensated care is a major problem in a competitive environment because uncompensated care is unevenly distributed across hospitals. This uneven distribution in a competitive market handicaps hospitals serving the indigent and medically indigent and benefits hospitals with primarily paying patients.

AAMC Actions

During the past year, the Administrative Board of the Council of Teaching Hospitals and the AAMC Executive Council have been engaged in a strategic planning effort for the Association's hospital activities. After a thorough review, it has been determined that one of the most important issues presently facing COTH is the future financing of uncompensated care. Association efforts are now giving added emphasis to this issue. The first step in developing efforts in the area of uncompensated care has been an attempt to review the research about uncompensated care patients. To date, the staff review has identified seven primary concentrations of uncompensated care:

- o obstetrical and pediatric patients,
- o chronically ill patients repeatedly admitted,

- o patients awaiting placement in a less than acute care setting,
- o patients admitted for catastrophic medical services such as burn or trauma care,
- o uninsured patients including the unemployed and illegal aliens,
- o patients who have abused drugs and alcohol, and
- o insured patients unable to pay copayments and deductibles.

In individual teaching hospitals, the mix of these seven types of patients varies substantially. Nevertheless, the finding that uncompensated care patients can be categorized suggests that focused responses can be developed to assist these patients.

To maintain present levels of assistance for these types of patients, the AAMC has continually lobbied Congress to retain adequate funding for the Medicaid program. The AAMC opposed the three year reduction in Medicare funding enacted in 1981 and opposed the unsuccessful efforts to extend those reductions this year. The Association also actively supported this year's successful effort to expand Medicaid coverage for first time pregnant women, pregnant women in households where the primary wage earner is unemployed, and children under five.

The second step in developing efforts in the area of uncompensated care has been to review and follow the growing body of research seeking to identify the characteristics of hospitals with atypical burdens of uncompensated care.

Initial findings indicate that the most heavily burdened hospitals are publicly sponsored hospitals in metropolitan areas and not-for-profit hospitals in decaying inner city neighborhoods. Once again this suggests the possibility of developing categorical or focused solutions.

A number of alternative solutions are presently being tried and the Association is reviewing carefully their impact on COTH members. The all payer approved charge systems in New Jersey and Maryland have assisted COTH members with atypical uncompensated care burdens. The enthusiasm for this approach is not uniform throughout the Association membership. The recent experience in which Blue Cross of Maryland developed a preferred provider program giving patients financial incentives to use suburban hospitals with little uncompensated care rather than downtown hospitals with substantial uncompensated care costs included in approved rates may weaken the enthusiasm of those who support this approach.

Because of the recent Maryland experience, members and staff are giving increased attention to the "revenue pools" established in New York and Florida to help finance uncompensated care. These "revenue pools" are a much more recent development and their intended and unintended consequences are too recent to fully assess. In an equally preliminary way, members and staff are watching the developments in California and Arizona to see what lessons may be learned from those approaches.

The AAMC does not yet have a clear, concise, and carefully focused plan for ameliorating the problem of uncompensated care. The AAMC applauds the effort of this

Subcommittee and the initiative of its chairman to highlight this serious problem and is eager to work cooperatively with others having a major interest in solving this problem.