The Financial Condition of Urban Hospitals

The National Association of Urban Hospitals

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Introduction

The National Association of Urban Hospitals (NAUH) is a coalition of private, urban hospitals located throughout the country that treat a significant number of patients who are poor and elderly. After recent reports that suggest that urban hospitals are thriving in today's health care environment – a conclusion that flies in the face of current financial challenges facing NAUH hospitals – we decided to take a closer look at the data on which these conclusions were based.

The perception that urban hospitals are doing well today poses three major challenges for NAUH members. First, it perpetuates the illusion that these hospitals will be able to continue serving their communities, as they do today, without any additional federal support. Second, it leaves them vulnerable to additional cuts from government policy-makers who may not understand the gravity of the financial threats they currently face. And third, it makes it too easy to overlook the very basic reality that without important changes in federal reimbursement policy, major parts of today's urban health care safety net may not survive to serve their communities tomorrow.

This report is divided into three sections. First, we offer an overview of critical changes in health care reimbursement practices over the past two decades. Next, we present the findings of NAUH's analysis of basic data that defines the relative health of the hospital industry as a whole and of specific types of hospitals – and especially, of urban safety-net hospitals. Finally, we outline the case for why these findings should be of enormous concern to federal health care policy-makers.

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Background

The financial challenges that face urban safety-net hospitals today can be traced back to changes in health care reimbursement that began in 1983 and have continued to the present day. Those changes include the abandonment of cost-based reimbursement in favor of prospective payment systems; the movement from fee-for-service to managed care; the repeal of the Medicaid Boren Amendment; and fundamental changes in the health insurance industry.

Collectively, these changes unquestionably have helped reduce the growth of health care expenditures for the public, for employers, and for government. They also have had a significant impact on health care providers – and especially on urban hospitals that care for large numbers of elderly, poor, and uninsured patients.

The Movement from Cost-Based to Prospective Payment

In 1983, government began moving away from cost-based reimbursement in favor of prospective payment. This change has had a profound impact on hospitals that care for large numbers of low-income patients because it marked a significant reduction in government contribution to the costs of caring for low-income patients. This has forced hospitals that care for large numbers of low-income patients to make due with significantly less resources in order to survive.

The Movement from Fee-For-Service to Managed Care

The second major change in health care reimbursement in recent years is the dramatic movement from fee-for-service to managed care, mostly through the growth of HMOs. Generally speaking, managed care plans pay hospitals less for services than traditional fee-for-service insurers, which means that in many cases, hospitals today are receiving less money to provide the same services to the same patients.

Market forces compound this problem for hospitals that care for large numbers of low-income and uninsured patients. Individual hospitals negotiate rates with individual managed care plans, but if hospitals with large numbers of low-income patients attempt to create a rate structure that reflects all of the under- or uncompensated care they provide, they risk becoming too expensive to managed care insurers. These hospitals lose their ability to negotiate competitive agreements for managed care contracts and their patients. Instead, they must lower their rates to remain competitive with hospitals that care for fewer low-income patients. This may be good for managed care

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organizations, which keep their costs low, but it can be disastrous for hospitals that treat large numbers of low-income patients.

The Repeal of the Medicaid Boren Amendment

Until 1997, health care providers enjoyed protection from inadequate Medicaid rates through the Boren Amendment, which required states to ensure that their Medicaid payments covered the reasonable costs of inpatient services provided in an economical and efficient manner. The repeal of the Boren Amendment in 1997, however, has enabled states to lower their rates below this commonsense threshold. In recent years, more and more states are taking advantage of this opportunity to reduce their health-care expenditures – but they are doing so at the expense of the very providers that serve the most poor and uninsured patients.

The Growing Competitiveness of the Health Insurance Industry

The fourth major force that has altered the economics of the health care industry in recent years is the growing competitiveness of the health insurance market. Employers pay for most health insurance, and these employers have placed great pressure on health insurers to hold down their insurance premiums. In response to this pressure, insurers have developed new health insurance products that are designed to keep premiums low and competitively priced. Often, though, these lower costs come at the expense of health care providers such as hospitals, in the form of lower payment rates.

The added pressure that this places on all hospitals can be seen in the reduction of generosity of private insurance payments to hospitals. According to MedPAC (Medicare Payment Advisory Commission),[1] private insurers paid hospitals $1.215 for every dollar of patient costs they incurred in 1996. Just four years later, in 2000, that figure had fallen to just $1.125 for every dollar of patient costs incurred. So excess revenues over expenses associated with private insurance dropped by more than 40 percent during this period.

Generally speaking, health care payers now only pay for costs associated with caring for the people they insure. This is a particular problem for safety-net hospitals that often must negotiate rates with insurers that do not factor in the cost of the care that they provide to low-income patients.

When you add to this that Medicare generally covers costs on a dollar-for-dollar basis and Medicaid pays less than costs, safety-net hospitals have become the payer, or insurer, of last resort. Other health care payers have largely abandoned their commitment

[1] MedPAC. *"A Data Book on Hospital Financial Performance."* March 2002.

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to care for the poor, leaving hospitals to use their own resources to pay for this care. While Medicare and Medicaid have attempted to assist hospitals through their disproportionate share programs, these programs do not come close to providing the revenue needed to cover the costs of treating the poor.

Conclusion

These four major changes – the shift from cost-based to prospective payment, the growth of managed care, the repeal of the Medicaid Boren Amendment, and the growing competitiveness of the health insurance industry – have had an undeniable effect on health care providers. As the three major health care payers – Medicare, Medicaid, and private insurers – have stepped back from their commitment to helping hospitals cover the costs of caring for the poor and uninsured, they have left those hospitals to find other ways to cover those costs. Some of those hospitals – urban safety-net hospitals, for example – face much larger responsibilities for caring for the poor and the uninsured. As we will see in the next section, the financial burden of caring for large numbers of poor and uninsured is having a disproportionately large impact on a specific group of hospitals: the nation's urban hospitals.

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Findings

In recent years, some studies of hospital financial health have focused solely on hospital Medicare margins. These studies conclude that the Medicare margins of urban hospitals are adequate and suggest that urban hospitals, therefore, are in sound financial condition. NAUH believes that this approach – using Medicare margins as a proxy for financial health – is incorrect and could lead to erroneous public policy.

Any single payer's margin, judged alone, is insufficient to describe the overall financial state of an institution. Institutions all have different payer mixes, each with their own margin. Ultimately, it is the combination of each payer's proportional contributions to overall margin that determines a hospital's overall financial health.

Consequently, NAUH believes that the best way – really, the only valid way – to measure a facility's financial well-being is to look at its overall total and operating margins, not the margin of any of its individual payers. These are the margins that factor in the totality of an institution's payer mix, the market forces in its geographic area, and the institution's negotiating leverage with insurers. Because only overall margin shows the broad perspective of a hospital's financial health, only overall total and operating margins should be used to draw conclusions about that financial health.

Methodology

In preparing this analysis, NAUH used data from the Centers for Medicare and Medicaid Services' (CMS) hospital data set for PPS XVI, which is the national data set for prospectively-paid hospitals for 1999. (This dataset contained 4,907 records.) The following records were eliminated:

- All hospitals that were not general short-term or pediatric hospitals. (This eliminated 834 records.)
- All records that did not provide revenue data or did not include a full year's worth of data. (This eliminated another 395 records.)
- Hospitals with extremely high or low total margins to eliminate potential outliers. (0.25 percent of the records were eliminated on both tails. This eliminated another 18 records.)

We ended up with a data set of 3,660 records.

Using this data, we calculated total margins and operating margins in the following manner:

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- Total Margin

  Total patient revenues minus contractual allowances plus other income minus total operating expenses minus all other expenses and dividing that result by the result of total patient revenue minus contractual allowances plus other income.

- Operating Margin

  Total patient revenues minus contractual allowances minus operating expenses and dividing that result by the result of total patient revenues minus contractual allowances.

Our Analysis of Hospital Total Margin

Total margin is a measure of hospital performance when incorporating *all* sources of income, not just patient care revenues. These additional revenues generally include, but are not limited to, investment income, parking garage income, gift shop revenue, and philanthropic contributions.

Margin itself can be interpreted in the following manner: a margin of 1.25 percent means that a hospital's excess revenues over expenses are 1.25 percent of its revenues. A negative margin means that a hospital's revenues did not cover its expenses.

Please note that all data used in the following analysis comes from CMS's PPS XVI database, as outlined in the methodology section of this report. Also, note that we provide the size of the sample for each particular comparison. Those sample sizes are shown inside the parentheses next to the resulting margin calculation.

The following table shows total margin for hospitals nation-wide in 1999.

Table One
Total Margin 1999

Non-Urban Hospitals	4.85% (1,692)
Urban Hospitals	3.47% (1,968)

As Table One illustrates, urban hospitals have lower total margins than non-urban hospitals – in fact, their margins are a considerable 28.5 percent lower.

Table Two illustrates the effect of Medicaid patient loads on hospital total margin.

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Table Two
Total Margin 1999 - Medicaid Payer Mix as % of days

	<15%	≥15%
Non-Urban Hospitals	4.66% (1,245)	5.21% (447)
Urban Hospitals	4.30% (1,237)	2.48% (731)

As Table Two illustrates, urban hospitals with over 15 percent Medicaid fare much worse than other urban hospitals. This category also experiences much lower margins than non-urban hospitals. In fact, the total margin of urban hospitals that serve fifteen percent or more Medicaid patients is less than half the total margin of non-urban hospitals that serve a similar proportion of Medicaid patients.

Table Three shows the effect of Medicare payer mix on total margins.

Table Three
Total Margin 1999 - Medicare Payer Mix as % of Days

	<45%	≥45%
Non-Urban Hospitals	4.71% (254)	4.87% (1,438)
Urban Hospitals	3.48% (823)	3.45% (1,145)

Medicare payer mix does not have the same effect on total margin as Medicaid.

Table Four shows the effect of removing children's hospitals and public hospitals on total margins.

Table Four
Total Margin 1999 - Effect of Public & Children's Hospitals

	All Hospitals	Without Public & Children's
Non-Urban Hospitals	4.85% (1,692)	5.37% (1,003)
Urban Hospitals	3.47% (1,968)	3.54% (1,706)

As Table Four demonstrates, there is virtually no difference in the margins for urban hospitals when pediatric and public hospitals are eliminated from the computations.

As these four tables illustrate, urban hospitals consistently have lower total margins than their non-urban counterparts. Worse, the more Medicaid patients they serve, the wider the disparity grows between the two groups.

Our Analysis of Hospital Operating Margin

A hospital *operating* margin is a more important measure of a provider's financial strength because it measures the financial strength of a hospital's core activity – patient

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care. Operating margin quantifies how patient revenues and patient activity contribute to the overall financial health of an institution. If an institution's operating margin is negative, it is losing money on its core patient activities and it must use non-patient-care income sources (such as its investments) to compensate for these losses.

Table Five shows the operating margin for all hospitals nation-wide.

Table Five
Operating Margin 1999

Non-Urban Hospitals	-1.10% (1,692)
Urban Hospitals	-4.64% (1,968)

As Table Five illustrates, hospitals in the U.S. today are not covering their operating expenses with patient care income alone; to the contrary, they are losing money on patient care. Instead, they are relying on non-patient care income sources to break even. This table also shows that the operating margins of urban hospitals are more than three times lower than non-urban providers.

Table Six shows what happens to hospital operating margins as the proportion of Medicaid patients that they serve increases.

Table Six
Operating Margin 1999 - Medicaid Payer Mix as % of Days

	<15%	**≥15%**
Non-Urban Hospitals	-1.38% (1,245)	-0.57% (447)
Urban Hospitals	-2.01% (1,237)	-7.84% (731)

As this table illustrates, serving greater numbers of Medicaid patients has a devastating effect on urban hospitals. Under this measure, the spread between urban and non-urban grows to a point where urban hospitals perform more than thirteen times worse than non-urban hospitals. The operating margin noted above, -7.84 percent, means that for every dollar these urban hospitals receive in revenues, they lose almost eight cents.

Urban hospitals that treat large numbers of Medicaid patients must rely on their investments and other non-patient care income to fund large losses. With the recent downturn in the financial markets, these hospitals will find it increasingly difficult to fund these kinds of operating losses with their investments.

All industries should be expected to break even financially from their operations. No industry can survive if year after year its operations are not self-funding. If an industry does not do so on a consistent basis, that industry will be weakened and may have trouble surviving in its current form. From the results shown here, we fear for the future stability of health care – in particular at urban hospitals treating the largest numbers of the poor.

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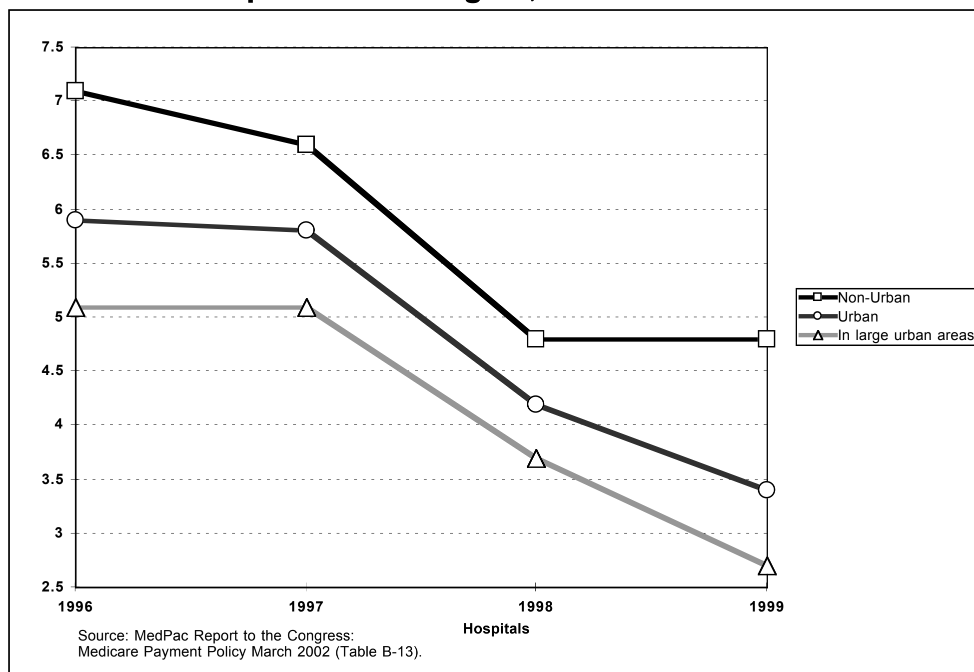
Data for 1999 Is Representative of Trends for Past Several Years

All previous data in this section have involved data for 1999. This data is very typical of hospital performance in recent years. According to MedPAC,[2] urban hospitals have consistently performed worse than non-urban hospitals when measuring total margins, and 1999 is not an aberration.

Chart One illustrates the differences in total margin among three different groups of hospitals over a four-year period.

Chart One: Hospital Total Margins, 1996 to 1999



These results are consistent with our results using 1999 data. As this chart shows, urban hospitals have been consistently performing worse than non-urban providers. This chart also shows that urban hospitals in large urban areas are the urban hospitals that have the lowest margins.

[2] MedPAC. *"Report to Congress: Medicare Payment Policy."* Table B-13. March 2002.

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An Indication That Urban Hospitals Are Cash-Starved

Table Seven[3] shows that urban hospitals are behaving differently than non-urban hospitals.

Table Seven
Comparison of Growth in Operating Expenses Per Patient Day

	Growth 1996-1999
Urban Hospitals	14.8%
Non-Urban Hospitals	21.4%

At non-urban hospitals, operating costs per patient day grew forty-four percent more than at urban hospitals during this four-year period. This is a significant difference in behavior between these two groups. This suggests that urban hospitals may be cash-starved.

[3] For 1996 data, we used CMS's PPS XIII dataset. For 1999 data, we used CMS's PPS XVI.

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The Case for Helping Urban Hospitals

The federal government has a vested interest in preserving the health care safety net. It is, itself, the country's most important health care payer, funding 100 percent of Medicare and more than half of Medicaid. It counts on the financial health of the hospital industry to ensure the availability of providers to serve those whom it insures through Medicare and Medicaid.

The federal government has responded to this challenge in a number of ways. Through its Medicare and Medicaid disproportionate share programs, for example, it provides supplemental funding to hospitals that care for especially large numbers of poor, elderly, and uninsured people. Its medical education program provides similar supplemental funds.

At the same time, however, a number of federal actions have had a clear and damaging effect on the financial health of the hospital industry. The federal government was a leader in the shift from cost-based reimbursement to prospective payment systems; it has been a leader in the continued movement towards increasing use of managed care; and it was responsible for the repeal of the Boren Amendment.

All of these policy changes represent individual moves that are part of a series of moves designed to balance the needs of many important interests. The federal government wants to ensure access to care for the poor and elderly; it wants to encourage health care providers to operate in an economical and efficient manner; it wants to encourage the development and maintenance of healthy hospital and health insurance industries; it wants to preserve the health care safety net; and it wants to keep federal spending on health care at a reasonable level that increases only within the bounds of normal inflationary growth.

All of these factors put the economics of the health care industry on a constantly moving pendulum. As NAUH's analysis of hospital industry finances has demonstrated, the financial health of the hospital industry today is, at best, precarious. The pendulum has clearly moved in one direction – away from access to care and towards cost containment.

Within the hospital industry, moreover, one group appears to be in particular financial trouble: urban hospitals. According to every commonly used measure of hospitals' financial health, urban hospitals fare worse than their non-urban counterparts. By some of those measures, they fare dramatically worse. And those urban hospitals that treat large numbers of low-income patients fare the worst.

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All of this speaks to the need to adjust selected federal health care policies and practices. Without such adjustment, the pendulum may continue swinging in one direction and, in doing so, threaten the future viability of a critical part of the health care safety net.

By their very nature, urban hospitals treat a significant number of elderly, poor, and uninsured patients. Without these hospitals, many of these patients would have little or no access to quality health care services.

But as this report has demonstrated, the policy and regulatory framework of the health care industry today is causing enormous financial damage to America's urban hospitals. With carefully chosen policy changes, however, this damage can be undone and urban hospitals can continue serving their elderly, poor, and uninsured patients without further jeopardizing the loss of this valuable resource for their entire community with every new inpatient admission.

The National Association of Urban Hospitals looks forward to participating in the public dialogue regarding the policy and regulatory changes that are so clearly needed.

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For further information about the views expressed in this document or the data presented here, please contact Ellen Kugler, Esq., executive director of the National Association of Urban Hospitals, at 703-444-0989.

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