Minnesota Department of Health

Uncompensated Care in Minnesota

Report to the Minnesota Legislature

January, 2000

MINNESOTA MDH DEPARTMENT OF HEALTH

Health Policy and Systems Compliance Division
Health Economics Program
121 East Seventh Place
St. Paul, Minnesota 55101
(651) 282-6367
www.health.state.mn.us

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Executive Summary

Uncompensated care has long been an issue of concern for policy makers, legislators, health care providers, advocacy groups, and others. The reality of the voluntary insurance system established in the United States is that certain individuals will not have health insurance coverage. In addition, many individuals, while having coverage for high cost, catastrophic care, may have high copays and deductibles and may experience gaps in scope of covered services. As these uninsured and underinsured individuals seek care from health care providers around the state, they are often unable to pay for the cost of care, resulting in "uncompensated care" being provided to these individuals.

Policymakers and legislators in the state of Minnesota have shown increasing concern about uncompensated care. The 1999 Legislature directed the Minnesota Department of Health to develop definitions of bad debt and charity care, to collect data on the users of uncompensated care, and to recommend ways to address the uncompensated care problem. As a means of drawing a broad array of perspectives for input to this report, and as an attempt to see if consensus existed on approaches to best address uncompensated care, the Commissioner of Health convened a task force to help examine the issue.

In August, MDH initiated the first of a series of meetings of the Minnesota Task Force on Uncompensated Care. The task force was comprised of members representing hospitals, physician clinics, health plans, consumers, advocacy groups, counties, and governmental entities. The task force's charge was to assist the Commissioner with her legislative mandate as well as to attempt to develop consensus on an approach for reducing uncompensated care. The task force gave careful consideration to the evidence and issues related to uncompensated care and reported findings and recommendations to the Commissioner of Health via a report.

This report to the Legislature draws on the work of the task force, as well as on independent work by the Minnesota Department of Health. It presents a series of findings that draw on the work of the task force. In addition, this report provides the Legislature with a uniform statewide definition of charity care and bad debt, and lays out issues for future consideration around the development of policy on uncompensated care.

Findings

The Department used three methods to derive its findings on the issue of uncompensated care:

First, analysis of available provider data was used to study development of uncompensated care trends over time. In this context, significant efforts were undertaken to establish better information on the demographics of uncompensated care patients and the type of services that constitute uncompensated care and the settings where care occurs. Second, the Department conducted extensive interviews with stakeholders in the community to better understand the scope of the problem. Third, the Department consulted the work of the uncompensated care task force. Following are the Department's general findings on the problem of uncompensated care:

- **Uniform definitions of bad debt and charity care should be implemented**. The Department believes it is crucial, moving forward, that specific statewide standards for data collection around uncompensated care be implemented so that the state is able to better understand the scope of the charity care problem in the state.

- **Uncompensated care is a function of a lack of health insurance coverage**. The problem of uncompensated care is really a symptom of a larger problem: the lack of health insurance coverage for some segments of our population.

- **Given the voluntary nature of the U.S. health care system, we are unlikely to completely eliminate the need for provision of uncompensated care**. Because individuals can voluntarily choose to participate in the health insurance system, it is likely that some segment of the population will choose not to do so. As a result, there will likely always be some residual uncompensated care in Minnesota.

- **Minnesota's aggregate burden of uncompensated care is below national averages**. Primarily because Minnesota's uninsurance rate is considerably below the national average, the aggregate burden of uncompensated care in the state is considerably below national averages.

- **The burden of uncompensated care continues to be distributed unevenly among Minnesota providers**. In spite of our low aggregate levels of uncompensated care, certain providers bear a large share of overall uncompensated care provision. In particular, community clinics, and large hospitals that function as regional trauma centers, tend to bear a large share of the uncompensated care burden.

- **The continued evolution of Minnesota's health care marketplace, with its increased emphasis on cost containment, means that the ability of providers of uncompensated care to finance this care is increasingly limited**. Traditionally, providers of uncompensated care have financed the provision of this care by building some of the costs of uncompensated care into rates charged to payers. In today's cost conscious environment, the ability of these providers to continue to finance uncompensated care in this fashion has become limited.

- **Financial burdens from uncompensated care are not restricted to large providers**. While much attention has been focused on uncompensated care provided by large hospitals, it is important to remember that smaller providers frequently bear a burden of uncompensated care (relative to their overall expenses) that is similar, if not higher, than that of some larger providers.

Recommendations to the Legislature

Last year, in its February 1999 report to the Legislature, the Department of Health presented information on the extent of uncompensated care incurred in the state and discussed options for reducing the need for uncompensated care.

The Department pointed out that aggregated data on uncompensated care have been available for longitudinal research, but found that disaggregating uncompensated care into its components of charity care and bad debt resulted in unreliable information. Through conversations with stakeholders and providers, the Department found varying uses of the terms of charity care and bad debt, and different implementation of otherwise similar definitions of charity care and bad debt. The February 1999 report concluded therefore, that in order to adequately assess the level of charity care and bad debt, a uniform definition of each category is required.

Following the report's finding and based on concerns about financing charity care without adequate definitions, the Legislature charged the Department of Health with developing a uniform definition that would allow for a clear distinction of charity care from bad debt. In particular, the Legislature directed the Department to:

> "... determine a definition for charity care and bad debt that distinguishes these two terms for inpatient and ambulatory care. The commissioner shall use these definitions as a basis for collecting data on uncompensated care in hospitals, surgical centers, and health care clinics located in Minnesota." (Minn. Laws, 1999, Chapter 245, Article 4, Sec. 105)

In response to the 1999 legislative charge and in the absence of existing state-wide uniform guidelines, the Department's main recommendation is to adopt the following definition of charity care and bad debt in order to standardize the collection and reporting of both accounts within the health care industry. The benefits of the definition recommended here are twofold:

- First, the definition with explicit income standards for charity care will allow for a clear documentation and reporting of provider-specific charity care and bad debt. The application of uniform methods of data collection and reporting will better resolve the issue of data validity.

- Second, because the proposed statewide uniform definition is used only for the ***reporting*** of charity care and bad debt, the definition still allows individual providers and hospitals to develop and apply individual, community-based charity care policies to fit the needs of their communities. Therefore, at the same time that reported figures are collected in comparable form, provider organizations retain their individual determination of how to distribute charity care resources to the community.

It is important to note that this definition is **only for reporting purposes** to the Department of Health. Nothing in the application of this definition for reporting purposes prevents individual providers in the community from delivering charity care at levels that meet the needs of individual communities.

Definition of Charity Care and Bad Debt[1]

Assumptions

The classification of medical care into the categories of charity care or bad debt is based on the following assumptions:

- A patient seeking care has the ability and willingness to pay, until and unless information is obtained that indicates the patient's inability to pay;

- The determination of a patient's eligibility for charity care (free care or discounted care) is made upon admission or at the time of treatment. If the positive determination of eligibility for charity care is not made upon admission or at the time of treatment, the determination must be made before the account is turned over to a third party for collection purposes. Providers may use third-party collection agencies for the purposes of collecting information in order to determine a patient's charity care status, but may not count as charity care any patients subsequently turned over for collections to a third-party agency.

- Figures reported in a statewide system will be cost-based. A formula for adjusting charge-based figures to a cost basis is included with this definition.

Charity Care

Charity care is the cost to the provider organization for rendering free or discounted care to persons who cannot afford to pay, who are not eligible for public programs, and for which the provider did not expect payment.

To be reported to the state as charity care:

a) a bill/claim must be generated and recorded by the provider;

b) a hospital-specific policy on the provision of charity care must be available and communicated to the public;

c) the provider must have made a reasonable effort to identify a third party payor, encourage the patient to enroll in public programs, and should, to the extent possible, aid the patient in the enrollment process;

d) the patient must meet the organization's criteria for charity care, which must be consistent with its mission and financial ability and with the statewide income standards, which are as follows:

Full Charity Care:

Care to patients with incomes at or below 150 percent of the Federal Poverty Guideline (FPG) will be eligible to be reported as full charity care. Free care provided to a Minnesota resident whose family income is equal or below the charity care income standard will be considered charity care. There will be no patient asset determination necessary for the application of these standards.

Discounted Charity Care / Sliding Fee Schedule:

The provider's share of the discounted charges for medical care to individuals with family income below 275 percent of FPG qualifies for classification as charity care. The use of following sliding fee schedule is suggested:

Income as Percent of FPG	Percent Charges Paid by Patient	Corresponding Charity Care
151-200%	20%	80%
201-225%	40%	60%
226-250%	60%	40%
251-275%	80%	20%

The following additional points are intended to clarify the definition of charity care:

- Charity care may include services which the provider is obligated to render independently of the ability to collect.

- Charity care may include care provided to low-income patients who meet the state-wide income standards and have partial coverage (e.g. no fault care insurance, secondary Medical Assistance or Medicare) but are unable to pay the remainder of their medical bills.
- Charity care may include care provided to low-income patients who may qualify for a public health insurance program and meet the state-wide eligibility criteria for charity care, but who do not complete the application process for public insurance despite the provider's best efforts.
- Charity care **does not** include contractual allowances - the difference between gross charges and payments received under contractual arrangements with insurance companies and payors.
- Charity care **does not** include bad debt.
- Charity care **does not** include what may be perceived as underpayments from public health insurance programs.
- Charity care **does not** include cases which are paid through a charitable contribution, through a third party or provider-related foundation.
- Charity care **does not** include unreimbursed costs of basic or clinical research and of professional education and training.
- Charity care **does not** include professional courtesy discounts.
- Charity care **does not** include community service or outreach activities.

Bad Debt

Provider organizations presume the patient is able and willing to pay until and unless information is obtained indicating the patient's inability to pay.

Care for which there was an expectation of payment and no available information on the patient's inability to pay but for which the patient is unwilling to pay is defined and classified as bad debt.

- Bad debt includes any unpaid patient responsibility, such as deductibles, co- insurance, co-payments and non-covered services.
- Bad debt includes that portion of the payment on a sliding-fee scale that an individual was assigned to pay but has not.

Next Steps and Considerations Around Uncompensated Care

In its report to the Commissioner, the task force provided a series of recommendations on ways to increase access to public sector health insurance programs, to monitor developments in the private market, and ways to finance uncompensated care in Minnesota.

The Department of Health believes that uncompensated care is a significant policy issue that touches on many aspects of our health care system. The recommendations provided by the task force will serve as a starting point for discussions within the Administration on the issue of access and uncompensated care. In preparation for the 2002-2003 biennial budget, the Department of Health will work closely with the Minnesota Department of Human Services and the Ventura Administration's Health Policy Council to prioritize the recommendations provided to the Commissioner by the task force for possible inclusion in the next biennial budget.

In addition to examining the task force recommendations, the Department feels it is also important to consider a number of other issues as the state moves forward on policy around uncompensated care. The following topics need additional exploration:

- A key area for further exploration is to better understand the state's role in the area of uncompensated care. It is clear there is an important role for the state, but it is not as clear how that role should be distinguished from that of the private health care sector, the federal government and local governments. The private health care system in this state is, by and large, not-for-profit and hospitals are nearly all tax exempt. There is a relationship between this status and the return of community benefits, including charity care, and the Department believes an exploration of the interplay between these roles would be useful in guiding policy development in this area.

- The task force report to the Commissioner correctly noted that the problem of uncompensated care in Minnesota was one of distribution. The Department believes this issue should be further examined, to guide policy as to whether this distributional problem is best addressed through new funds or through better use of existing resources within the health care system.

The Department of Health intends to explore these areas in more detail in the coming months, as it moves forward working with other state agencies and stakeholders to develop initiatives for the 2002-2003 biennial budget.

Introduction

Uncompensated care (UC) has long been an issue of concern for policy makers, legislators, health care providers, advocacy groups, and others. The reality of the voluntary insurance system established in the United States is that certain individuals will not have health insurance coverage. In addition, many individuals, while having coverage for high cost, catastrophic care, may have high copays and deductibles on their health insurance and experience gaps in the scope of covered services. As these uninsured and underinsured individuals seek care from health care providers around the state, they are often unable to pay for the cost of care, resulting in "uncompensated care" being provided to these individuals.

Policymakers and legislators in the state of Minnesota have shown increasing concern over the issue of uncompensated care. The 1998 Legislature directed the Minnesota Department of Health to report back on the levels of uncompensated care in Minnesota and to provide options to reduce the burden of uncompensated care for Minnesota's health care providers. That report, "Uncompensated Care in Minnesota," was released in February 1999 and documented the extent of the uncompensated care problem in Minnesota. The uncompensated care report also presented the Legislature with a variety of options and potential policy tools for reducing the burden to providers.

While finding general agreement among stakeholders interviewed for the February 1999 study that uncompensated care was a problem in Minnesota, the Department also discovered that there were a variety of opinions regarding the extent of the problem and over what constituted the best approach to addressing uncompensated care. The Commissioner concluded that a task force of stakeholders would be helpful in sharpening the understanding of the problem and in building consensus around possible solutions. In response to the Department's February 1999 report, the 1999 Legislature directed MDH to develop definitions of bad debt and charity care, to provide information to better describe the demographics of uncompensated care patients, and to recommend ways to address the uncompensated care problem.

In August, MDH initiated the first of a series of meetings of the Minnesota Task Force on Uncompensated Care. The task force was comprised of members representing hospitals, physician clinics, health plans, consumers, advocacy groups, counties, and governmental entities, and was chaired by David S. Doth, Commissioner of the Minneapolis Department of Health and Family Support. The task force's charge was to assist the Commissioner with her legislative mandate as well as to attempt to develop consensus on an approach for reducing uncompensated care. The task force gave careful consideration to the evidence and issues related to uncompensated care and reported findings and recommendations to the Commissioner of Health a final report. That report is included as an appendix to this report.

This report to the Legislature draws on the work of the task force, as well as independent work of the Minnesota Department of Health. The findings and policy development principles developed by the task force will be valuable tools as the Department and the Administration move forward on the matter of uncompensated care and other health policy issues.

This report presents in the following section a review of the legislative history, legislative actions taken and point to the work by the Department of Health on the issue of uncompensated care. Then we will discuss findings from the Department's work on uncompensated care which will be followed by recommendations to the Legislature on definitions for bad debt and charity care and the discussions of next steps and considerations around policy development to reduce the burden of uncompensated care.

History

The 1998 Legislature directed MDH to report on the problem of uncompensated care and to suggest options for reducing the need for uncompensated care and ways in which to finance it. Legislators' interest was prompted by the concerns of large hospitals and community clinics, both of which experienced continued increases in the burden of uncompensated care in both relative and absolute terms. Metro-based hospital providers also expressed concern that they were experiencing an increased flow of patients from counties outside of the Twin Cities metro area. The Department was charged with

- documenting the extent of uncompensated care,
- discussing the feasibility of and evaluating options for financing uncompensated care (which included the option of reducing the need for uncompensated care through improving insurance access),
- evaluating approaches used by other states, and
- describing alternative approaches to encourage health care coverage.

In the resulting uncompensated care report, which was released in February 1999, the Commissioner indicated her intention to convene a workgroup of stakeholders to address outstanding data and policy concerns.

Also in 1999, the Legislature, working with the Department's report, chose to approach uncompensated care from three directions. First, the Legislature appropriated $10 million on a one-time basis to certain disproportionate share hospitals to help offset uncompensated care costs. Second, the Legislature adopted a number of policy changes targeted at easing some elements of the enrollment process for Minnesota's public health insurance programs and at reducing some of the barriers to enrollment in these programs. Finally, the Legislature directed MDH to report back, by January, 2000, on the demographics of the populations receiving uncompensated care, problem and develop recommendations for reducing uncompensated care through public program enrollment and simplification of the application process. In addition, the Department was charged with refining existing data collection mechanisms through the development of specific and uniform definitions of charity care and bad debt.

Task Force Convened

In August, the Commissioner of Health convened the task force on uncompensated care. The charge of the group was two-fold. First, consistent with the Commissioner's letter in the February 1999 report, the Commissioner asked the group that use the report as a starting point to explore whether there was consensus on the approaches that should be used to lessen the uncompensated care burden. Second, the task force was asked to provide input on the Department's legislative mandates, both on definitions of bad debt and charity care and on ways in which to encourage greater enrollment in public and private health insurance coverage.

The task force meetings were held to provide a forum for key stakeholders to discuss and debate various potential approaches to uncompensated care. Because the problem of uncompensated care can be ultimately attributed to a lack of health insurance coverage, the Department asked that the task force give special attention to mechanisms that promote improved access to public and private health insurance, which could then be used in the development of policy proposals for possible inclusion in the Governor's 2002-2003 biennial budget. In addition, the Commissioner asked the task force to consider the roles that various stakeholders play in the provision of uncompensated care and to consider how those roles should be altered, if at all.

The task force met seven times during the fall of 1999. Members of the task force are listed in the Appendix to this report. The task force provided recommendations via a report to the Commissioner of Health in December 1999. That report is included as an attachment to this report.

Overview of Findings on Uncompensated Care Problem

In this section of the report, we present findings on the issue of uncompensated care. The Department used three methods to derive its findings on the issue of uncompensated care:

First, analysis of available provider data was used to study the development of uncompensated care trends over time. In this context, significant efforts were undertaken to establish better information on the demographics of the uncompensated care population and the type and setting of care where uncompensated care occurs. Second, the Commissioner conducted extensive interviews with stakeholders in the community to gain a better understanding of the scope of the problem. Third, the Department drew upon the work of the uncompensated care task force, an advisory group convened by the Department in August 1999.

In general, many of the findings of this report echo those of the Department's February 1999 report. For example:

- We confirm the finding in the February 1999 report that approximately 1% to 2% of overall health care spending in the state is for uncompensated care. This amounts to well over $200 million in uncompensated care at hospitals, clinics, and among other health care providers.
- Again, there are positive signs, such as a continued reduction in hospital-based uncompensated care since the implementation of MinnesotaCare, the continued stability of the comparatively low level of uninsurance in the state, and the fact that Minnesota's level of uncompensated care is considerably below the national average.
- This report again underscores, however, that the burden of uncompensated care is unevenly distributed and that the impact of uncompensated care is felt differentially across the state.
- Finally, many of the findings continue to be clouded by an inability to distinguish adequately between charity care and bad debt. As a result, the Department has placed strong emphasis in this report on developing a uniform definition of charity care and bad debt and in setting forth guidelines for consistent application of that definition.

General Findings on the Problem of Uncompensated Care

- **Uniform definitions of bad debt and charity care should be implemented**. It is important, as the discussion moves forward on uncompensated care that uniform definitions of bad debt and charity care be applied. This will allow not only the development of consistent estimates of the size of the charity care problem, but also ensure that any estimates of the distribution of the burden of care among facilities is done on a uniform and consistent basis.

This report contains a recommended definition of charity care and bad debt to be used as a starting point in discussions. The Department intends to move forward on the implementation and use of this definition in its data collection activities under the Health Care Cost Information System.

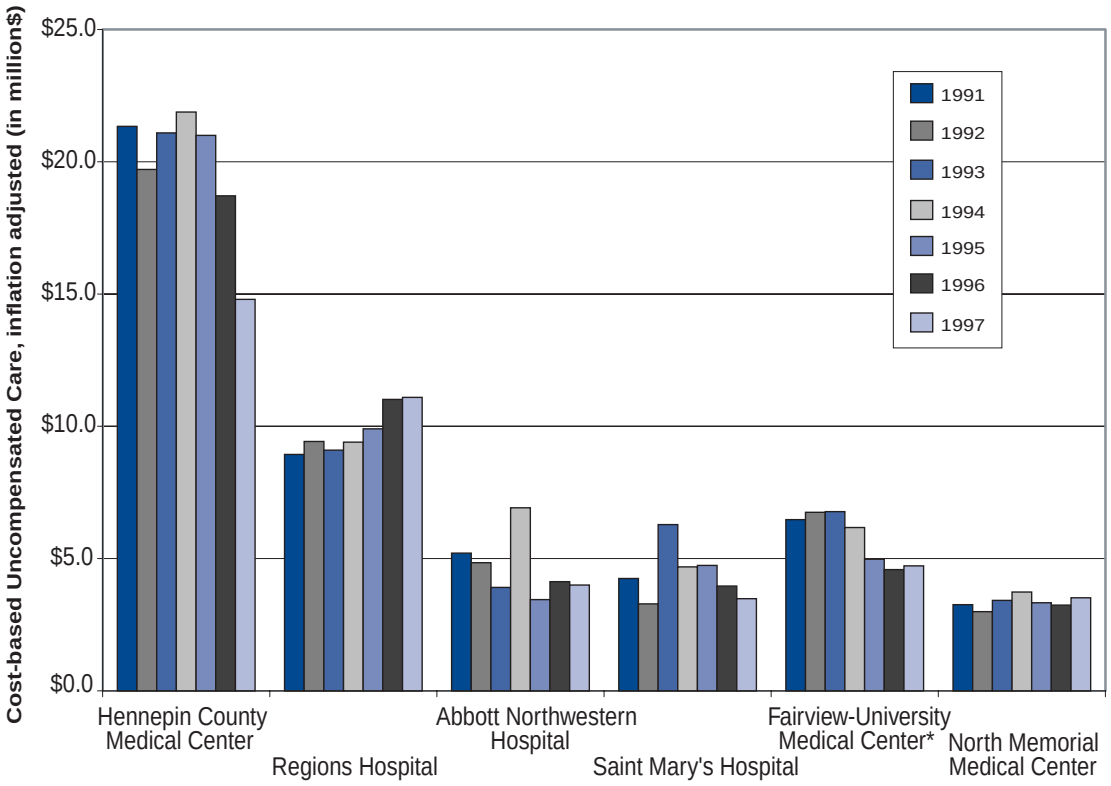
- **Uncompensated care is a function of a lack of health insurance coverage**. Nationally, Minnesota is recognized as a state with comparably high levels of insurance coverage, both through private insurance as well as through the availability of public programs. Minnesota's high levels of insurance coverage likely explain its moderate levels of uncompensated care compared to the nation. However, in spite of the relatively low numbers of uninsured, Minnesota still has at least 250,000 residents without health coverage[2] and a sizeable number of Minnesotans who, while having some level of coverage, face large out-of-pocket expenses due to less-than-comprehensive policies. In addition, it is important to note that many of the gains made in health insurance coverage over the past several years result from the tight labor market, which has led to an increase in employer-sponsored coverage. The possibility of an economic downturn brings the prospect of reduced employer coverage. Finally, it is well established that people without coverage, or without adequate coverage, often delay seeking treatment and present with more symptoms than those with adequate coverage.

- **Given the voluntary nature of the U.S. health care system, we are unlikely to completely eliminate the need for provision of uncompensated care**. Consequently, potential solutions to the uncompensated care problem will always need to include the existence of a functioning safety-net system that is available to provide care for those for whom health insurance, whether privately or publicly funded, remains unaffordable or for those who choose not to participate in the health insurance market.

- **Minnesota's aggregate burden of uncompensated care is below national averages**. Relative to national averages, uncompensated care is a smaller percentage of Minnesota's hospital expenses. Much of this relates to Minnesota's relatively low rate of uninsurance, and data indicate that uncompensated care in Minnesota (adjusted for inflation, and put on a cost-basis) has declined relative to national figures since the implementation of MinnesotaCare.

- **The burden of uncompensated care continues to be distributed unevenly among Minnesota providers**. One of the primary findings of MDH's February 1999 report on uncompensated care was that, while Minnesota's overall level of uncompensated care was below the national average, the provision of uncompensated care was unevenly distributed among providers, with a disproportionate burden falling on relatively few hospital and clinic-based providers. Recent data on uncompensated care underscore this fact: According to preliminary data for 1998, ten hospitals provided 64 percent of all uncompensated care in the state. Two hospitals alone account for about 32 percent. Similarly, for physician clinics, the most recent data (1997) show that ten clinics, with $51 million of uncompensated care, account for 66 percent of the total uncompensated care incurred in physician clinics. In addition to the mentioned provider groups, community clinics see a disproportionate number of uninsured which results in significant levels of uncompensated care.

Figure 1: Uncompensated Care Trends for Minnesota Hospitals with the Highest Level of Uncompensated Care (Cost-based, inflation-adjusted)



Source: Minnesota Department of Health, Health Care Cost Information System as of January 2000.

Notes: 1) Hospitals shown have a share of 51 percent of the total hospital-based uncompensated care.

2) Data shown for Fairview-University Medical Center prior to 1997 are the sum of data pertaining to University Medical Center and Fairview-Riverside Medical Center.

- **The continued evolution of Minnesota's health care marketplace, with its increased emphasis on cost containment, means that the ability of providers of uncompensated care to finance this care is increasingly limited**. Traditionally, providers of uncompensated care have financed a portion of that care through charging somewhat higher rates to private and public payers. As cost containment in the health care marketplace has become more aggressive, the ability of providers to build in these additional costs is diminished.

- **The financial burden of uncompensated care is not restricted to large providers**. For some smaller hospitals and clinics, the relative burden (as measured by uncompensated care as a percent of operating expenses) exceeds that of large providers. In addition, smaller providers are often further disadvantaged because they rely on fewer payers. Oftentimes, the federal government is a significant payer for these institutions; thus, the effects of provisions of the Balanced Budget Act will likely further compromise smaller providers' abilities to make uncompensated care available to their communities.

Figure 2: Estimated Aggregate Minnesota Uncompensated Care (in millions) and as a Percent of Total Expenditures

	Charge-Based (1996 values in brackets)	Cost Based
Clinics		
Uncompensated Care	**$ 76.9** ($ 71.8)	-
Uncompensated Care as a Percent of Expenses	2.2 %	
Hospitals		
Uncompensated Care	**$ 134.5** ($ 130.5)	**$ 81.7** ($ 81.2)
Uncompensated Care as a Percent of Expenses	2.7 %	1.7 %
Community Clinics (NHCN)		
Uncompensated Care	**$ 3.1** ($ 4.1)	**$ 3.0** ($ 3.6)
Uncompensated Care as a Percent of Expenses	11.1 %	10.7 %
Clinics in the MN Primary Care Association		
Uncompensated Care	($ 3.9)	-
Uncompensated Care as a Percent of Expenses	(17.2 %)	
MN Assocation of Community Mental Health Programs		
Uncompensated Care	**$ 5.7** ($5.0)	-
Uncompensated Care as a Percent of Expenses	14.6%	
Other Provider Groups**	currently undetermined	
Total Minnesota Uncompensated Care (above provider groups)	**$ 224.1 ($ 215.3)**	**$ 171.2 ($ 165.5)**
	2.6%	**2.0%**

Source: MDH, Health Care Cost Information System with adjustments, January 1999; Provider Financial and Statistical Report, January 2000; Neighborhood Health Care Network/Community Clinic Reporting System, January 1999; Minnesota Primary Care Association, January 2000; Minnesota Mental Health Association, January 2000.

* Uncompensated Care is defined as the sum of charity care and bad debt

** Included in this table are only those provider groups that have data collection systems in place which allow for accurate identification of uncompensated care per MDH definitions

Note: A share of the growth reported by the MN Primary Care Association and the MN Association of Community Mental Health Programs is due to increased compliance with reporting.

Demographics of the Uncompensated Care Population

The Legislature also requested the Department develop information "...on the types of care provided, the settings in which the care is provided, and if known, the most common reasons why the care is uncompensated." (Minn. Laws, 1999, Chapter 245, Article 1, Sec. 3, Subd. 2). In response, the Department of Health has worked with providers in the community to develop information to better describe the demographics of the population receiving uncompensated care at Minnesota's hospitals and community clinics. Preliminary information of some providers with a large uncompensated care burden is contained in the Appendices of this report.

Recommendations to the Legislature

In its February 1999 report to the Legislature, the Department of Health presented information on the extent of uncompensated care incurred in the state and discussed options for reducing the need for uncompensated care.

The Department pointed out that aggregated data on uncompensated care have been available for longitudinal research, but found that disaggregating uncompensated care into its components of charity care and bad debt resulted in unreliable information. Through conversations with stakeholders and providers, the Department found varying uses of the terms of charity care and bad debt and different implementation of otherwise similar definitions of charity care and bad debt. The February 1999 report concluded therefore, that in order to adequately assess the level of charity care and bad debt, a uniform definition of each category is required.

Following the report's finding and based on concerns about financing charity care without adequate definitions, the Legislature charged the Department of Health with developing a uniform definition that would allow for a clear distinction of charity care from bad debt. In particular, the Legislature directed the Department to:

> "... determine a definition for charity care and bad debt that distinguishes these two terms for inpatient and ambulatory care. The commissioner shall use these definitions as a basis for collecting data on uncompensated care in hospitals, surgical centers, and health care clinics located in Minnesota." (Minn. Laws, 1999, Chapter245, Article 4, Sec. 105)

In response to the 1999 legislative charge and in the absence of existing state-wide uniform guidelines, the Department's main recommendation is to adopt the following definition of charity care and bad debt in order to standardize the collection and reporting of both accounts within the health care industry. The benefits of the definition recommended here are twofold:

- First, the definition with explicit income standards for charity care will allow for a clear documentation and reporting of provider-specific charity care and bad debt. The application of uniform methods of data collection and reporting will better resolve the issue of data validity.

- Second, because the proposed statewide uniform definition is used only for **reporting** of charity care and bad debt, the proposed definition still allows individual providers and hospitals to develop and apply individual, community-based charity care policies to fit the needs of their communities. Therefore, at the same time that reported figures are collected in comparable form, provider organizations retain their individual determination of how to distribute charity care resources to the community.

It is important to note that this definition is **only for reporting purposes** to the Department of Health. Nothing in the application of this definition for reporting purposes prevents individual providers in the community from delivering charity care at levels that meet the needs of individual communities.

Definition of Charity Care and Bad Debt[1]

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The classification of medical care into the categories of charity care or bad debt is based on the following assumptions:

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- Figures reported in a statewide system will be cost-based. A formula for adjusting charge-based figures to a cost basis is included with this definition.

Charity Care

Charity care is the cost to the provider organization for rendering free or discounted care to persons who cannot afford to pay, who are not eligible for public programs, and for which the provider did not expect payment.

To be reported to the state as charity care:

a) a bill/claim must be generated and recorded by the provider;

b) a provider-specific policy on the provision of charity care must be available and communicated to the public;

c) the provider must have made a reasonable effort to identify a third party payor, encourage the patient to enroll in public programs, and should, to the extent possible, aid the patient in the enrollment process;

d) the patient must meet the organization's criteria for charity care, which must be consistent with its mission and financial ability and with the statewide income standards, that are stated as follows:

Full Charity Care:

Care to patients with incomes at or below 150 percent of the Federal Poverty Guideline (FPG) will be eligible to be reported as full charity care. Free care provided to a Minnesota resident whose family income is equal or below the charity care income standard will be considered charity care. There will be no patient asset determination necessary for the application of these standards.

Discounted Charity Care / Sliding Fee Schedule:

The provider's share of the discounted charges for medical care to individuals with family income below 275 percent of FPG qualifies for classification as charity care. The use of following sliding fee schedule is suggested:

Income as Percent of FPG	Percent Charges Paid by Patient	Corresponding Charity Care
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251-275%	80%	20%

The following additional points are intended to clarify the definition of charity care:

- Charity care may include services which the provider is obligated to render independently of the ability to collect.
- Charity care may include care provided to low-income patients who meet the state wide income standards and have partial coverage (e.g. no fault care insurance, secondary Medical Assistance or Medicare) but are unable to pay the remainder of their medical bills.
- Charity care may include care provided to low-income patients who may qualify for a public health insurance program and meet the state wide eligibility criteria for charity care, but who do not complete the application process for public insurance despite the provider's best efforts.
- Charity care **does not** include contractual allowances - the difference between gross charges and payments received under contractual arrangements with insurance companies and payors.
- Charity care **does not** include bad debt.
- Charity care **does not** include what may be perceived as underpayments for operating public programs.
- Charity care **does not** include cases which are paid through a charitable contribution, through a third party or provider related foundation.
- Charity care **does not** include unreimbursed costs of basic or clinical research and of professional education and training.
- Charity care **does not** include professional courtesy discounts.
- Charity care **does not** include community service or outreach activities.

Bad Debt

Provider organizations presume the patient is able and willing to pay until and unless information is obtained indicating the patient's inability to pay.

Care for which there was an expectation of payment and no available information on the patient's inability to pay but for which the patient is unwilling to pay is defined and classified as bad debt.

- Bad debt includes any unpaid patient responsibility, such as deductibles, co-insurance, co-payments and non-covered services.
- Bad debt includes that portion of the payment on a sliding-fee scale that an individual was assigned to pay but has not.

Adjusting Charge-Based Figures to Cost-Based Figures

As mentioned in the assumptions section of this definition, all figures reported on bad debt and charity care will be reported on a cost basis. Because there is no current system that gives specific costs for each given service, a proxy will be used to standardize the reporting of charity care and bad debt to a cost basis. This proxy was developed by the American Hospital Association, and is widely used as a proxy for costs currently:

$$Cost\ of\ Care = Patient\ Charges \times \frac{Total\ Operating\ Expense}{(Gross\ Patient\ Revenue + Other\ Operating\ Revenue)}$$

Next Steps and Considerations Around Uncompensated Care

In its report to the Commissioner, the task force provided a series of recommendations on ways to increase access to public sector health insurance programs, to monitor developments in the private market, and ways to finance uncompensated care in Minnesota.

The Department of Health believes that uncompensated care is a significant policy issue that touches on many aspects of our health care system. The recommendations provided by the task force will serve as a starting point for discussions within the Administration on the issue of access and uncompensated care. In preparation for the 2002-2003 biennial budget, the Department of Health will work closely with the Minnesota Department of Human Services and the Ventura Administration's Health Policy Council to prioritize the recommendations provided to the Commissioner by the task force for possible inclusion in the next biennial budget.

In addition to examining the task force recommendations, the Department feels it is also important to consider a number of other issues as we move forward developing policy around uncompensated care. The following topics need additional exploration:

- A key area for further exploration is to better understand the state's role in the area of uncompensated care. It is clear there is an important role for the state, but it is not as clear how that role should be distinguished from that of the private health care sector, the federal government and local governments. The private health care system in this state is, by and large, not for profit and hospitals are nearly all tax exempt. There is a relationship between this status and the return of community benefits, including charity care, and the Department believes an exploration of the interplay between these roles would be useful in guiding policy development in this area.

- The task force report to the Commissioner correctly noted that the problem of uncompensated care in Minnesota was one of distribution. The Department believes this issue should be further examined, to guide policy as to whether this distributional problem is best addressed through new funds or through better use of existing resources within the health care system.

The Department of Health intends to explore these areas in more detail in the coming months, as it moves forward working with other state agencies and stakeholders to develop initiatives for the 2002-2003 biennial budget.

Attachments

CHAPTER 245

Article 1, Sec. 3, Subd. 2. Health Systems and Special Populations.

UNCOMPENSATED CARE

The commissioner shall study and report to the legislature by January 15, 2000, with:

(1) statistical information on the amount of uncompensated healthcare provided in Minnesota, the types of care provided, the settings in which the care is provided, and, if known, the most common reasons why the care is uncompensated; and

(2) recommendations for reducing the level of uncompensated care, including, but not limited to, methods to enroll eligible persons in public health care programs through simplification of the application process and other efforts.

Article 4, Sec. 105.

CHARITY CARE DATA COLLECTION

The commissioner of health shall determine a definition for charity care and bad debt that distinguishes these two terms for inpatient and ambulatory care. The commissioner shall use these definitions as a basis for collecting data on uncompensated care in hospitals, surgical centers, and health care clinics located in Minnesota.

Members of the Uncompensated Care Task Force Convened by the Commissioner of Health

Jan Malcolm	Commissioner, Minnesota Department of Health
Julie Brunner	Deputy Commissioner, Minnesota Department of Health (alternate for Ms. Malcolm)
David S. Doth	Task Force Chair, Commissioner, Minneapolis Department of Health and Family Support
Lynn Abrahamsen	Executive Director, Neighborhood Health Care Network
Rose Arnold	Chair, Association of Minnesota Counties
David Edwards	Fiscal Services Director, Metropolitan Health Plan
Terry Finzen	CEO & President, Regions Hospital
Greg Kluegherz	CFO, Regions Hospital (alternate to Mr. Finzen)
Robert Fulton	Director, St. Paul/Ramsey County Department of Public Health
Susan Haigh	Commissioner, Ramsey County Board
Jim Koppel	Director, Children's Defense Fund
Peter McLaughlin	Commissioner, Hennepin County District 4
Brock Nelson	CEO, Children's Hospital
Maureen O'Connell	Managing Attorney, Legal Services Advocacy Project
Bruce Rueben	President, Minnesota Hospital and Healthcare Partnership
Jim Schulte	Administrator, Redwood Falls Municipal Hospital
Jeffrey Scrivner, MD	Medical Director, Northland Medical Clinic
Ghita Worcester	VP of Public Affairs and Development, UCare
Michael Scandrett	Executive Director, Council of Minnesota Health Plans

Uncompensated Care in Minnesota Hospitals, 1997

ID	Hospital Name	City	County	RCB	MSA	Uncompensated Care (cost-based)	Charity Care (cost-based)	Bad Debt (cost-based	Uncompensated Care as a % of Expenses
4	Riverwood HealthCare Center	Aitkin	Aitkin	2	R	74,472	1,803	72,669	1.01%
84	Mercy Hospital	Coon Rapids	Anoka	4	U	1,543,673	1,030,316	513,357	1.36%
164	Unity Hospital	Fridley	Anoka	4	U	1,375,774	399,952	975,822	1.52%
147	St. Mary's Regional Health Center	Detroit Lakes	Becker	1	R	169,179	28,653	140,526	1.44%
102	North Country Regional Hospital	Bemidji	Beltrami	1	R	479,889	70,998	408,891	1.33%
61	Graceville Health Center	Graceville	Big Stone	5	R	12,912	2,656	10,256	0.83%
108	Ortonville Area Health Services	Ortonville	Big Stone	5	R	65,740	2,558	63,183	1.69%
63	Immanuel-St. Joseph-Mayo Health System	Mankato	Blue Earth	5	R	420,118	89,191	330,927	0.81%
127	New Ulm Medical Center	New Ulm	Brown	5	R	428,765	6,644	422,121	2.39%
129	Sleepy Eye Municipal Hospital	Sleepy Eye	Brown	5	R	5,522	0	5,522	0.22%
130	Springfield Medical Center - Mayo Health	Springfield	Brown	5	R	23,842	3,709	20,133	0.98%
24	Cloquet Community Memorial Hospital	Cloquet	Carlton	2	R	171,078	0	171,078	1.84%
83	Mercy Hospital & Health Care Center	Moose Lake	Carlton	2	R	52,934	0	52,934	0.97%
168	Riverview Medical Center	Waconia	Carver	4	U	197,755	87,037	110,717	0.56%
17	Chippewa County-Montevideo Hospital	Montevideo	Chippewa	5	R	72,445	0	72,445	1.26%
18	Chisago Health Services	Chisago City	Chisago	3	U	261,373	0	261,373	1.25%
122	Rush City Hospital	Rush City	Chisago	3	U	79,842	0	79,842	3.31%
19	Clearwater Health Services	Bagley	Clearwater	1	R	98,535	0	98,535	2.51%
30	Cook County Northshore Hospital	Grand Marais	Cook	2	R	44,479	0	44,479	1.59%
35	Westbrook Health Center	Westbrook	Cottonwood	5	R	4,988	0	4,988	0.57%
176	Windom Area Hospital	Windom	Cottonwood	5	R	57,323	0	57,323	1.09%
31	Cuyuna Regional Medical Center	Crosby	Crow Wing	3	R	160,131	69,769	90,362	1.30%
142	St. Joseph's Medical Center	Brainerd	Crow Wing	3	R	671,438	314,490	356,948	1.48%
42	Fairview Ridges Hospital	Burnsville	Dakota	4	U	1,114,638	162,282	952,356	1.85%
115	Regina Medical Center	Hastings	Dakota	4	U	258,289	44,014	214,274	1.58%
125	Trinity Hospital	Farmington	Dakota	4	U	168,973	44,756	124,217	3.59%
34	Douglas County Hospital	Alexandria	Douglas	3	R	251,692	78,598	173,094	0.81%
162	United Hospital District	Blue Earth	Faribault	5	R	100,503	50,252	50,252	1.20%
56	Harmony Community Hospital	Harmony	Fillmore	6	R	21,341	0	21,341	3.98%
100	Albert Lea Medical Health Center-Mayo He	Albert Lea	Freeborn	6	R	371,302	1,874	369,427	1.52%
15	Cannon Falls Community Hospital	Cannon Falls	Goodhue	6	R	84,726	0	84,726	2.14%
138	Fairview Red Wing Health Services	Red Wing	Goodhue	6	R	331,641	113,414	218,226	1.67%
178	Zumbrota Health Care	Zumbrota	Goodhue	6	R	6,026	0	6,026	0.20%
54	Grant County Health Center	Elbow Lake	Grant	3	R	6,119	0	6,119	0.19%
2	Abbott Northwestern Hospital	Minneapolis	Hennepin	4	U	3,997,013	1,105,846	2,891,168	1.15%
91	Children's Hospitals and Clinics	Minneapolis	Hennepin	4	U	2,132,705	527,979	1,604,726	1.82%
44	Fairview Southdale Hospital	Edina	Hennepin	4	U	2,287,579	464,638	1,822,941	1.40%
185	Fairview-University Medical Center	Minneapolis	Hennepin	4	U	4,721,841	1,131,203	3,590,638	1.04%
59	Hennepin County Medical Center	Minneapolis	Hennepin	4	U	14,797,143	2,894,557	11,902,587	4.82%
86	Methodist Hospital	St. Louis Park	Hennepin	4	U	1,653,149	227,689	1,425,459	0.88%
103	North Memorial Medical Center	Robbinsdale	Hennepin	4	U	3,515,397	585,985	2,929,412	1.60%
184	Phillips Eye Institute	Minneapolis	Hennepin	4	U	53,274	0	53,274	0.38%
183	Vencor Hospital	Golden Valley	Hennepin	4	U	98,662	49,459	49,202	0.75%
160	Tweeten/Lutheran Health Care Center	Spring Grove	Houston	6	U	48,727	0	48,727	5.84%
140	St. Joseph's Area Health Services	Park Rapids	Hubbard	1	R	183,379	10,563	172,817	1.21%
13	Cambridge Medical Center	Cambridge	Isanti	3	U	807,243	249,121	558,122	2.17%
25	Deer River HealthCare Center	Deer River	Itasca	2	R	64,867	0	64,867	1.53%
64	Itasca Medical Center	Grand Rapids	Itasca	2	R	204,173	7,081	197,093	0.92%
104	Northern Itasca Health Care Center	Bigfork	Itasca	2	R	52,446	0	52,446	1.62%
65	Jackson Medical Center	Jackson	Jackson	5	R	25,498	605	24,893	1.06%

ID	Hospital Name	City	County	RCB	MSA	Uncompensated Care (cost-based)	Charity Care (cost-based)	Bad Debt (cost-based	Uncompensated Care as a % of Expenses
67	Kanabec Hospital	Mora	Kanabec	2	R	208,363	33,300	175,063	2.43%
118	Rice Memorial Hospital	Willmar	Kandiyohi	5	R	331,207	11,283	319,923	0.74%
69	Kittson Memorial Healthcare Center	Hallock	Kittson	1	R	39,966	10,815	29,150	1.93%
45	International Falls Memorial Hospital	International Falls	Koochiching	2	R	154,772	12,503	142,269	1.87%
66	Johnson Memorial Health Services	Dawson	Lac Qui Parle	5	R	22,583	6,765	15,818	1.17%
78	Madison Hospital	Madison	Lac Qui Parle	5	R	16,043	0	16,043	0.92%
72	Lake View Memorial Hospital	Two Harbors	Lake	2	R	16,884	0	16,884	0.63%
159	Lakewood Health Center	Baudette	Lake of the Woods	1	R	64,952	21,442	43,511	1.78%
92	Minnesota Valley Health Center	Le Sueur	LeSueur	5	R	17,288	0	17,288	0.88%
32	Divine Providence Health Center	Ivanhoe	Lincoln	5	R	3,586	1,306	2,280	0.25%
58	Hendricks Community Hospital	Hendricks	Lincoln	5	R	21,686	0	21,686	0.94%
1	Tyler Healthcare Center, Inc.	Tyler	Lincoln	5	R	28,920	19,057	9,863	1.08%
156	Tracy Hospital	Tracy	Lyon	5	R	25,121	0	25,121	0.91%
172	Weiner Memorial Medical Center	Marshall	Lyon	5	R	41,479	1,029	40,451	0.36%
79	Mahnomen Health Center	Mahnomen	Mahnomen	1	R	20,334	0	20,334	1.17%
169	North Valley Health Center	Warren	Marshall	1	R	34,693	0	34,693	1.88%
39	Fairmont Community Hospital	Fairmont	Martin	5	R	284,254	680	283,574	1.89%
51	Glencoe Area Health Center	Glencoe	McLeod	5	R	30,956	1,093	29,863	0.31%
62	Hutchinson Area Health Care	Hutchinson	McLeod	5	R	212,069	6,860	205,209	0.94%
80	Meeker County Memorial Hospital	Litchfield	Meeker	5	R	61,918	0	61,918	0.79%
41	Fairview Northland Regional Hospital	Princeton	Mille Lacs	3	R	370,256	51,560	318,696	1.90%
28	Mille Lacs Health System	Onamia	Mille Lacs	3	R	179,404	5,777	173,628	3.03%
136	St. Gabriel's Hospital	Little Falls	Morrison	3	R	279,856	93,373	186,483	1.63%
150	Austin Medical Center - Mayo Health Syst	Austin	Mower	6	R	211,221	60,060	151,161	0.90%
99	Murray County Memorial Hospital	Slayton	Murray	5	R	45,805	0	45,805	1.43%
22	St. Peter Community Hospital and Health	St. Peter	Nicollet	5	R	54,157	3,755	50,402	1.15%
8	Arnold Memorial Health Care Center	Adrian	Nobles	5	R	12,785	0	12,785	1.51%
177	Worthington Regional Hospital	Worthington	Nobles	5	R	234,652	89,296	145,357	1.63%
3	Bridges Medical Services	Ada	Norman	1	R	47,944	304	47,640	2.20%
107	Olmsted Medical Center	Rochester	Olmsted	6	U	280,965	95,158	185,807	1.81%
120	Rochester Methodist Hospital	Rochester	Olmsted	6	U	1,853,266	812,925	1,040,341	1.26%
145	Saint Mary's Hospital	Rochester	Olmsted	6	U	3,481,340	1,237,852	2,243,488	1.09%
71	Lake Region Healthcare Corporation	Fergus Falls	Otter Tail	3	R	98,081	9,832	88,249	0.42%
112	Perham Memorial Hospital	Perham	Otter Tail	3	R	90,861	0	90,861	1.82%
106	Northwest Medical Center	Thief River Falls	Pennington	1	R	108,682	737	107,945	0.83%
48	Lakeside Medical Center, Inc. - Hospital	Pine City	Pine	2	R	34,114	3,261	30,853	2.97%
124	Pine Medical Center	Sandstone	Pine	2	R	49,263	0	49,263	1.74%
113	Pipestone County Medical Center	Pipestone	Pipestone	5	R	78,514	30,226	48,288	1.34%
46	First Care Medical Services	Fosston	Polk	1	U	-50,366	0	-50,366	-
119	Riverview Healthcare Association	Crookston	Polk	1	U	235,454	113,643	121,811	2.23%
50	Glacial Ridge Hospital District	Glenwood	Pope	3	R	15,140	59	15,081	0.35%
93	Minnewaska District Hospital	Starbuck	Pope	3	R	19,918	9,331	10,587	0.95%
16	Children's Hospitals and Clinics	St. Paul	Ramsey	4	U	1,038,093	97,565	940,528	1.51%
49	Gillette Children's Specialty Healthcare	St. Paul	Ramsey	4	U	377,138	83,068	294,070	1.29%
10	HealthEast Bethesda Lutheran Hospital	St. Paul	Ramsey	4	U	86,814	75,728	11,086	0.25%
88	HealthEast Midway Hospital	St. Paul	Ramsey	4	U	306,770	342,153	-35,383	1.40%
180	HealthEast St. John's Hospital	Maplewood	Ramsey	4	U	931,973	470,285	461,688	1.06%
141	HealthEast St. Joseph's Hospital	St. Paul	Ramsey	4	U	1,517,117	982,171	534,946	1.36%
151	Regions Hospital	St. Paul	Ramsey	4	U	11,090,954	9,222,396	1,868,558	5.25%
163	United Hospital Inc.	St. Paul	Ramsey	4	U	2,663,849	840,860	1,822,990	1.14%
98	Redwood Falls Municipal Hospital	Redwood Falls	Redwood	5	R	145,139	68,888	76,251	2.32%
116	Renville County Hospital	Olivia	Renville	5	R	62,252	0	62,252	1.55%
105	Northfield Hospital	Northfield	Rice	6	R	246,646	14,104	232,542	1.82%
117	Rice County District One Hospital	Faribault	Rice	6	R	255,451	76,616	178,836	1.51%
21	Luverne Community Hospital	Luverne	Rock	5	R	71,813	0	71,813	1.03%
121	Roseau Area Hospital and Homes, Inc.	Roseau	Roseau	1	R	115,074	0	115,074	1.67%
114	Queen of Peace Hospital	New Prague	Scott	4	U	88,471	22,370	66,101	0.79%
135	St. Francis Regional Medical Center	Shakopee	Scott	4	U	612,939	48,781	564,158	2.32%
7	Arlington Municipal Hospital	Arlington	Sibley	5	R	48,673	7,110	41,563	1.82%
29	Cook Hospital	Cook	St. Louis	2	U	14,576	0	14,576	0.61%
37	Ely Bloomenson Community Hospital	Ely	St. Louis	2	U	6,278	0	6,278	0.12%
90	Miller-Dwan Medical Center, Inc.	Duluth	St. Louis	2	U	662,078	185,471	476,607	1.40%
143	St. Luke's Hospital	Duluth	St. Louis	2	U	791,308	280,336	510,973	0.97%
148	St. Mary's Medical Center	Duluth	St. Louis	2	U	2,081,419	987,637	1,093,781	1.43%
85	University Medical Center - Mesabi	Hibbing	St. Louis	2	U	336,278	94,476	241,802	1.16%

ID	Hospital Name	City	County	RCB	MSA	Uncompensated Care (cost-based)	Charity Care (cost-based)	Bad Debt (cost-based	Uncompensated Care as a % of Expenses
153	Swift County-Benson Hospital	Benson	Swift	5	R	71,651	34,297	37,355	1.89%
76	Long Prairie Memorial Hospital	Long Prairie	Todd	3	R	36,657	0	36,657	0.74%
174	Wheaton Community Hospital	Wheaton	Traverse	3	R	9,252	0	9,252	0.28%
70	Lake City Hospital	Lake City	Wabasha	6	R	32,029	0	32,029	0.87%
133	St. Elizabeth's Hospital	Wabasha	Wabasha	6	R	86,123	44,061	42,062	1.89%
161	Lakewood Health System	Staples	Wadena	3	R	158,362	25,664	132,697	1.93%
157	Tri-County Hospital	Wadena	Wadena	3	R	103,440	21,360	82,079	0.89%
170	Waseca Area Medical Center - Mayo Health	Waseca	Waseca	5	R	61,822	5,396	56,426	1.31%
82	District Memorial Hospital	Forest Lake	Washington	4	U	199,432	0	199,432	2.67%
74	Lakeview Hospital	Stillwater	Washington	4	U	330,784	44,059	286,724	1.22%
77	Madelia Community Hospital	Madelia	Watonwan	5	R	101,645	36,324	65,322	3.83%
171	St. James Health Services, Inc.	St. James	Watonwan	5	R	44,337	4,397	39,940	1.39%
134	St. Francis Medical Center	Breckenridge	Wilkin	1	R	526,755	183,257	343,498	4.29%
27	Winona Community Memorial Hospital	Winona	Winona	6	R	313,719	0	313,719	1.45%
11	Buffalo Hospital	Buffalo	Wright	3	U	180,816	33,227	147,589	1.19%
94	Monticello Big Lake Comm. Hosp. District	Monticello	Wright	3	U	219,964	12,460	207,505	2.42%
14	Canby Community Health Services	Canby	Yellow Medicine	5	R	2,076	0	2,076	0.06%
53	Granite Falls Municipal Hospital	Granite Falls	Yellow Medicine	5	R	48,687	1,392	47,295	1.02%
			Total Uncompensated Care			**81,535,014**	**27,716,884**	**53,818,131**	**1.65%**
			Total Uncompensated Care in Rural MSAs			**11,203,388**	**1,926,916**	**9,276,473**	**1.32%**
			(in percent)			13.7%	7.0%	17.2%	
			Total Uncompensated Care in RCB 4			**57,160,200**	**20,985,150**	**36,175,050**	**1.38%**
			(in percent)			70.1%	75.7%	67.2%	

Source: Minnesota Department of Health, Health Care Cost Information System, as of January 2000.

Demographic Information on the Uncompensated Care Population

Attachments present some preliminary findings from data that was gathered in cooperation with those community clinic and hospital providers, who bear a significant burden of uncompensated care.

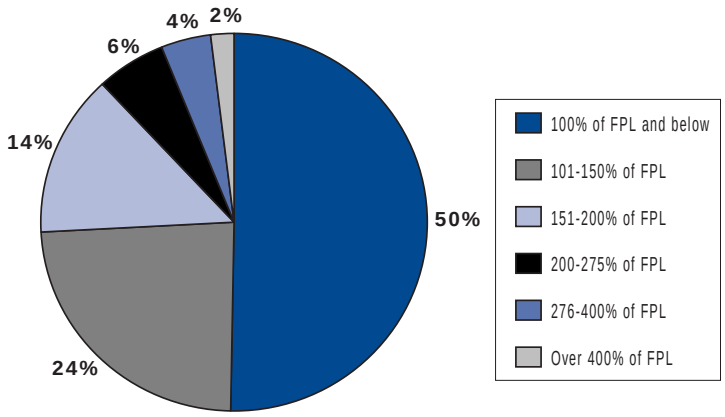
This data was collected from a subset of clinic providers and hospitals in the state who bear a large burden from charity care. Because these providers do not represent all providers in the state who provide charity care, this analysis should be seen as a first step to providing a more complete description of the uncompensated care population in Minnesota.

Community Clinics, Rural Health Centers, and Federally Qualified Health Centers

The information reported below is from data submissions by the Minnesota Primary Care Association and the Neighborhood Health Care Network for calendar year 1998. Since it is not possible, in the case of the clinic reporting system, to identify demographic information of patients who receive charity care and incur bad debt, we are reporting on the uninsured population only. However, clinics have confirmed that the vast share of both charity care and bad debt is attributable to the uninsured. Therefore, reporting on the uninsured largely reflects clinic users who receive charity care and who are responsible for bad debt.

The income distribution of the uninsured who visit the clinic affiliated with the above-mentioned associations reflect that the majority of these patients are poor and are likely eligible for enrollment public programs. Of the uninsured patients, 88 percent have income levels below 200 percent of the Federal Poverty Guideline (FPG). Less than 2 percent of these uninsured patients have income levels above 400 percent of the FPG.

Figure 3: Income Distribution of Uninsured Patients at Community Clinics

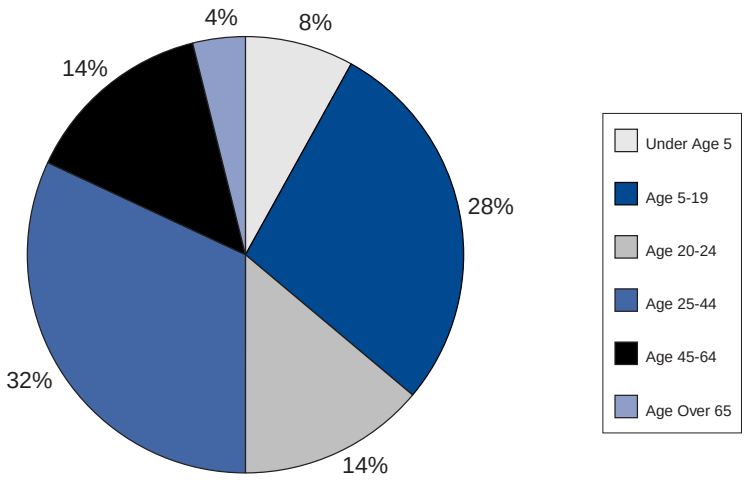


Source: Neighborhood Health Care Network/Community Clinic Reporting System (November 1999); Minnesota Primary Care Association (November 1999)

Comparing the income distribution among uninsured patients against the state-wide income distribution of uninsured reveals that a disproportionate share of the share of lower income individuals among patients is higher than among state-wide numbers of the uninsured.

The majority of the uninsured patients, 63 percent, are female and more than one-third of the uninsured patients are below the age of 20 years. Again, many patients of this age group are potentially eligible for enrollment in Minnesota health insurance programs. Figure 4 shows the age distribution of uninsured patients in community clinics. Approximately half, 49.4 percent, of patients are younger than 25 years.

Figure 4: Age Distribution of Uninsured Patients in Community Clinics

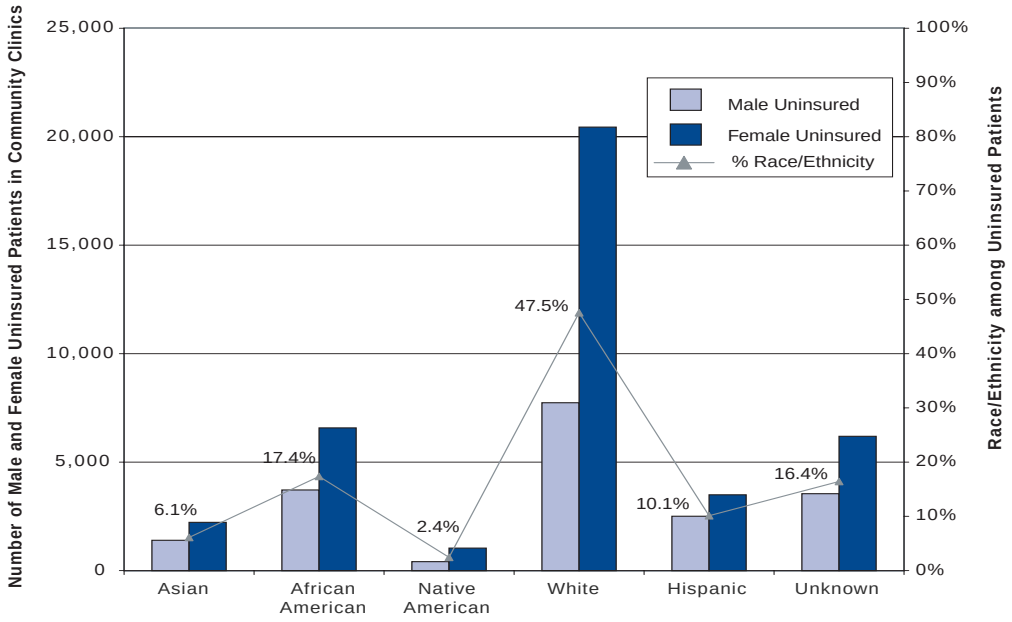


Source: Neighborhood Health Care Network/Community Clinic Reporting System (November 1999); Minnesota Primary Care Association (November 1999)

Finally, information is available on the racial/ethnic makeup of uninsured patients visiting community clinics. The majority of the uninsured patients, 47.5 percent, are white. The next highest race/ethnic category among uninsured patients visiting community clinics are African Americans with 17.4 percent. of total clinic visits. For all racial and ethnic categories, female patients makeup a higher percentage of total visits than male patients.

This distribution deviates from the racial/ethnic makeup of the total population of uninsured which is dominated with 83 percent by the white population.[3] The greater ethnic mix shown at community clinics, appears to be the result of the geographic location of these clinics. Many are located in the ethnically less homogenous urban areas.

Figure 5: Racial/Ethnic Makeup of the Uninsured Patients of Community Clinics



Source: Neighborhood Health Care Network/Community Clinic Reporting System (November 1999); Minnesota Primary Care Association (November 1999)

Further analysis on clinic patient's demographics will include patient flow statistics as well as describing the type of care that resulted in charity care and bad debt.

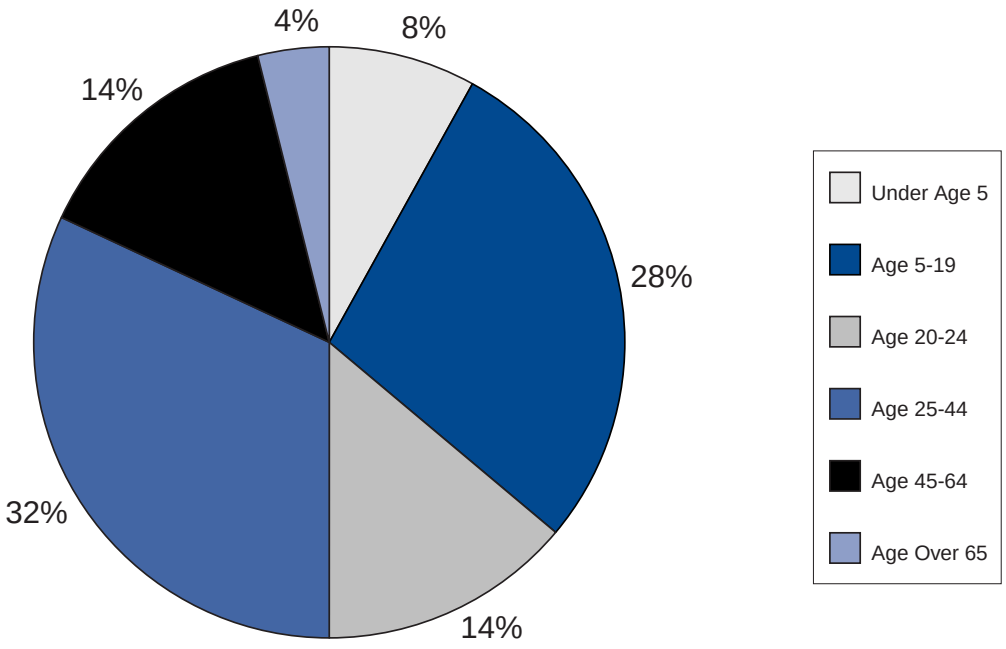
Demographic Information on Hospital Patients

The preliminary analysis reported here, is based on data provided by Hennepin County Medical Center (HCMC) and Regions Hospital only. As noted earlier, this information cannot be assumed to be representative of statewide charity care/bad debt encounters.

However, HCMC and Regions account for 32 percent of the state's uncompensated care expenses. Therefore, the information provides a good indication of patient characteristics observed at urban hospitals for individuals whose care results in charity care and/or bad debt.

Again, the age distribution of the uncompensated care population at these facilities shows that nearly 40% of the encounters for uncompensated care at these facilities was for patients under 20 years of age.

Figure 6: Age Distribution of 1998 Hospital Encounters that Resulted in Charity Care and/or Bad Debt



Source: Hennepin County Medical Center and Regions Hospital, data submission from patient discharges, November, 1999 through January, 2000.

Further data submission from HCMC and Regions Hospital as well as renewed attempts to include other major providers of uncompensated care, will allow for additional analysis on the ethnic mix, patient flows and the description types of care that results in charity care and bad debt.

Endnotes:

1. This definition is adopted from the *Community Benefit Financial Statement Disclosure Guidelines* (Metropolitan Healthcare Council, 1994) with reference to work by the Association of Certified Public Accountants, the Healthcare Financial Management Association and the Minnesota Hospital and Healthcare Partnership.

2. Rate of Insurance (5.2) percent as of University of Minnesota, Division of Health Services Research (1999) *Health care Access Survey.*

3. Health Economics Program analysis of the *Minnesota Health Care Access Survey* by the University of Minnesota, Division of Health Services Research (1999).

Task Force on Uncompensated Care in Minnesota

Report to the Commissioner of Health

December, 1999

Executive Summary

Policymakers and legislators in the state of Minnesota have shown increasing concern over the issue of uncompensated care. The 1998 Legislature directed the Minnesota Department of Health to report back on the levels of uncompensated care in Minnesota and to provide options to reduce the burden of uncompensated care for Minnesota's health care providers. That report "Uncompensated Care in Minnesota" was released in February 1999 and documented the extent of the uncompensated care problem in Minnesota.

While finding general agreement among stakeholders interviewed for the February 1999 study that uncompensated care was a problem in Minnesota, the Department also discovered that there were a variety of opinions regarding the extent of the problem and over what constituted the best approach to addressing uncompensated care.

As a result of these disparate opinions on the best approach to take on uncompensated care, and in recognition of the need to use multiple approaches, the Commissioner of Health convened a task force on uncompensated care to attempt to forge consensus on the next steps to address the issue. In August, the Health Department initiated the first of a series of meetings of the Minnesota Task Force on Uncompensated Care. The task force is comprised of members representing hospitals, physician clinics, health plans, consumers, advocacy groups, counties, and governmental entities. The task force was chaired by David S. Doth, Commissioner of the Minneapolis Department of Health and Family Support.

In its meetings, the task force reviewed past research on uncompensated care using MDH's February 1999 report "Uncompensated Health Care in Minnesota: An Interim Report to the Legislature" as a starting point for discussion. The MDH report indicates that approximately 1% to 2% of overall health care spending in the state of Minnesota is for uncompensated care. This amounts to well over $200 million in uncompensated care at hospitals, clinics, and among other health care providers; however, the impact of uncompensated care varies among providers.

In addition to a review of past research, the task force heard presentations on current outreach and enrollment efforts, examined scenarios which helped to define the characteristics of uncompensated care cases, and worked to forge consensus on a definition for bad debt and charity care. In addition, the task force formed a subcommittee to develop recommendations on health insurance access directed at both public programs and the private insurance market, and members were questioned as to their preferred approaches to addressing the issue of uncompensated care.

The task force, after reviewing this information and debating and discussing various approaches in its seven meetings over the period of 4 months, issued the following findings and recommendations.

Findings of the Task Force

The task force issued a series of findings which are intended to help guide policy development around the issue of uncompensated care.

- **Uncompensated care is a function of a lack of health insurance coverage or adequate health insurance coverage.** Task force members noted that uncompensated care is a symptom of a larger problem, the complete lack or the lack of adequate health insurance coverage for many Minnesotans.

- **Minnesota's aggregate burden of uncompensated care is below national norms.** Task force members examined data that found the burden of uncompensated care in Minnesota is below that of national norms.

- **The burden of uncompensated care is distributed unevenly among Minnesota providers**. While they found that the overall burden of uncompensated care is smaller in Minnesota, task force members noted that the burden is unevenly distributed. A particularly heavy burden is carried by large county operated facilities and community clinics.

- **Health care providers with a large burden of uncompensated care report immediate financial emergencies.** Many of the facilities with a large burden of uncompensated care noted that they were in a financial emergency due largely to the provision of uncompensated care. This case was made most notably by Hennepin County Medical Center, Regions hospital, and the Neighborhood Health Care Network.

- **Low public program reimbursement rates add additional burden to providers of uncompensated care.** Providers of uncompensated care also frequently serve a large volume of public program clients. Task force members were concerned that low public program payments rates were a "double burden" for uncompensated care providers.

- **The Minnesota Department of Human Services should continue efforts to improve outreach and reduce administrative barriers to public health care programs**. The task force strongly recommends that DHS improve access to public programs through better outreach efforts, reduced administrative barriers, simplified eligibility and policy development that result in continuous coverage.

- **Providers of uncompensated care have limited ability to cost shift.** Today's cost conscious environment has made it more difficult for providers to shift the cost of uncompensated care onto other payors.

- **Financial burdens from uncompensated care affect small and medium size providers, as well as large providers**. Task force noted that, while attention is often focused on large providers of uncompensated care, many small and medium-size providers also bear a burden.

- **While much of the attention on uncompensated care has focused on urban areas, uncompensated care is also a concern in rural Minnesota**. Most task force members recognized that the relative impact of uncompensated care on facilities in rural Minnesota can be equally or more significant than that of facilities located in metropolitan areas.

- **People without adequate health insurance often delay seeking care and present with more symptoms than if they had a payment source for regular care.** Task force members noted that persons with coverage are more prone to seek care in timely fashion, and therefore help avoid both poor outcomes and higher costs.

- **The effects of welfare reform will increase both the number of uninsured and the burden of uncompensated care**. Members of the task force were concerned that, as welfare reform is implemented, many eligible individuals will leave Medical Assistance and go without health coverage.

- **Uniform definitions of charity care and bad debt must be implemented.** The task force believed that, in order to guide current policy debates and future discussions, common and consistent definitions of charity care and bad debt must be implemented.

Recommendations of the task force

In considering recommendations, the task force utilized the following tenets as guiding principles:

- the incentives accompanying any proposed solution should be scrutinized to ensure that they are not likely to generate undesired outcomes;

- solutions should build on existing programs where possible;

- any funding for uncompensated care should be provided to a defined population for traditional medical services; and

- short-term emergencies should be considered in conjunction with long-term strategies.

The task force has recommendations in three areas. First, the task force agreed that increased access to health insurance is the best way to remedy the issue of uncompensated care. The task force provides recommendations on ways in which to increase access to public-sector health insurance coverage and on additional areas of study in the private sector market.

Second, the task force recommends improving the viability of providers of uncompensated care by recommending an increase in overall Medical Assistance rates for outpatient and ambulatory services as well as an add-on to Medical Assistance rates for those providers with a disproportionate burden of uncompensated care. Acknowledging the important role of the Federally-Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) in providing safety-net access to Minnesotans, the task force recommends reimbursement consistent with the federal government's approach under the 1999 BBA restoration package.

Finally, the task force believes that payments should be made to providers with a large burden of uncompensated care. In particular, the task force recommends that $20 million be made available for the funding of uncompensated care in 2001 and that the Commissioner include funding for uncompensated care as part of her biennial budget.

Access Recommendations

- **The task force strongly supports the Governor's Big Plan proposal from October 13, 1999 to eliminate uninsurance among children.**

- **Establish 12-month continuous eligibility for children eligible for Medical Assistance**. Twelve-month continuous eligibility will reduce gaps in insurance among MA-eligible children due to families dropping on and off Medical Assistance.

- **Remove the MinnesotaCare premium payment requirement for people with incomes below a certain threshold**. Low-income people are extremely sensitive to the price of insurance; thus, removing the premium requirement for low-income Minnesotans may encourage participation in MinnesotaCare.

- **Allow MinnesotaCare enrollees the option to pay an up-front discounted fee for annual enrollment**. An upfront, discounted fee would reduce administrative hassle for enrollees and the likelihood of dropping coverage.

- **Direct the Department of Human Services and the counties to improve communication to the dually-eligibles for Medical Assistance and MinnesotaCare to ensure that eligible Minnesotans become and remain enrolled**. The task force believed it important to discover why dually-eligible persons choose one program over another and to ensure that eligibles understand their choice of programs.

- **Raise the percentage that would qualify an employer contribution as "employer- subsidized" insurance for the purpose of MinnesotaCare. Study the impact of choosing different levels above the current 50 percent to arrive at a desirable level with minimum impact on existing private insurance coverage.** The task force was concerned that current employer-subsidy requirements may be locking some low-income individuals out of the insurance market.

- **Amend the provision that prevents same-month enrollment in MinnesotaCare and GAMC for those persons enrolled in MinnesotaCare who have exceeded the hospital charges limit of $ 10,000**. Removing this provision would allow GAMC to be used as a wraparound to pay for hospital inpatient charges in excess of the MinnesotaCare $10,000 cap.

- **Eliminate language and cultural barriers that prevent individuals and families with limited English-language proficiency (LEP) from accessing publicly-funded health care program**s. Persons with LEP should be provided adequate resources to facilitate access to public health care programs.

- **Consider implementing presumptive eligibility for children and pregnant women in order to reduce insurance gaps for Minnesotans and funding gaps for providers**. Presumptive eligibility would reduce some of the administrative barriers that deter some eligibles from applying for public health care programs.

- **Continue current efforts by the Department of Human Services to simplify and shorten the Health Care Application form and to reduce administrative barriers that prevent individuals and families from obtaining and retaining eligibility for publicly-funded health care programs**. Reduced administrative barriers would improve public health care program access and retention.

- **Improve enrollment opportunities through coordination of state agency programs that focus on providing assistance to low-income Minnesotans**. Different state agencies administer a variety of programs serving low-income individuals, such as the Special Supplemental Nutrition Program for Women,

Infants and Children, the Minnesota Working Family Tax Credit, and the Reduced or Free School Lunch Program. Coordination of efforts among agencies would improve program awareness and uptake among eligibles.

- **Carefully study the impact of the bill passed by the 1999 Legislature that allows insurance companies with market share of less than 3% to market and sell policies that have reduced benefit requirements**. The task force recommends monitoring the potential adverse effects on premium levels, risk selection, and cost shifting from the sale of these policies.

- **Examine the current funding and design of the Minnesota Comprehensive Health Association (MCHA) in light of affordability of premiums, characteristics of enrolled individuals and improvements in directing applicants, who have been denied private insurance coverage, to applying for the program**. The task force is concerned that current MCHA rates may be unaffordable, that rejection criteria are not standardized and that the fund itself runs the risk of insolvency.

- **Study the effect of health care premium taxes and health care coverage mandates on the ability of individuals to obtain and maintain health insurance coverage**. The task force recommends investigating whether mandated coverage minimums and premium taxes reduce the number of health insurance carriers and products in the market.

- **Undertake state-wide education efforts on the value of health insurance and continuous health care coverage**. The task force believes it is important to communicate to all Minnesotans the private and societal value of health insurance and continuous health care coverage. Groups that could benefit from such education efforts particularly are recent college graduates and new immigrant populations.

Public Program Payment Rates

The task force noted that many providers who have a disproportionately large burden of uncompensated care are also those who serve large numbers of public program clients. Task force members expressed concern that to the extent that rates for public programs are below market rates, this amounts to a "double hit" on these providers. This is particularly the case for core providers of the health care safety-net, those institutions and providers "devoting substantial resources to serving the uninsured and socially disadvantaged." (Baxter 9)

The task force recommends two strategies:

- **Medical Assistance payment rates for ambulatory and outpatient services should be increased**. Increased Medical Assistance payment rates will help ensure adequate access for low-income and disabled Minnesotans and enhance the viability of providers of uncompensated care.

- **Establish an add-on to Medical Assistance rates for providers serving a disproportionate number of patients for whom care is uncompensated**. Inadequate public payment rates reduce the ability of providers to meet the community's need for charity care.

In addition, the task force recommends the following reimbursement considerations for Federally Qualified Health Centers and Rural Health Centers.

- **The task force recommends that for the short-term the state continue reimbursement for services provided by Federally Qualified Health Centers and Rural Health Centers according to the 1999 BBA phase-down mechanism. For the long-term, the task force recommends that the Legislature consider restoring the 100 percent cost-based reimbursement**. The task force raised concerns over the impact that the reduced reimbursement would have on access to primary care for low-income Minnesotans, particularly those in rural areas.

Payments to Providers with Financial Emergencies Because of the Burden of Uncompensated Care

The task force also considered options for the financing of select providers of uncompensated care. While the task force members agreed that financial relief should be viewed as an interim solution until the larger problem of the uninsured is addressed through access strategies, a majority of task force members believe that interim payments would help sustain providers of uncompensated care until access strategies are implemented and take effect.

- Payments should be made to those providers who have emergency situations resulting from a large burden of uncompensated care. The task force is concerned that the financial viability of providers with a large burden of uncompensated care be preserved. Opinions varied on the task force varied as to the specific form that such support should take.

- The task force provided the following recommendations and guidance on direct funding, regardless of the form distribution takes:

  – The General Fund is the preferred financing source for payments to providers facing financial emergencies due in large part to their uncompensated care burden.

  – The task force believes that, while an insufficient sum, last year's $10 million appropriation was critical in enabling certain large providers of uncompensated care to operate.

  – The task force believes that this financing should be continued for the next year and recommends $20 million be appropriated for distribution to providers facing financial emergencies to which uncompensated care contributed significantly.

  – The task force recommends, however, that a different distributional method be used for the $20 million. In particular, the task force believes that community clinics should be included in the fund distribution with some portion (perhaps one third) of any appropriation dedicated to these clinics.

  – The task force also believes that the remainder of the appropriation should be focused on those hospitals who face financial emergencies due to their disproportionate burden of uncompensated care.

  – Finally, the task force recommends that the Commissioner of Health, in developing her budget package for the 2002-2003 biennium, include a budget initiative that contains a package of proposals to expand access and reduce uncompensated care. In developing this package, the

task force recommends the commissioner consider including interim funding for those providers experiencing financial emergencies due in large part to the provision of uncompensated care.

– The task force agreed that any payments for uncompensated care burdens should be targeted to individuals who are uninsured or who have private coverage that leaves them underinsured and with financial hardships. There was no consensus about the income levels of the uninsured that would qualify their care for uncompensated care payments.

Definitions

- The committee did not reach a consensus on a uniform definition. The MHHP in particular argued that individual hospitals should have full discretion in determining the exact level and definition of their uncompensated care.

- The task force agreed that if public funds support an uncompensated care financing mechanism then uniform and standard definitions should be used for the criteria of distribution. The Department of Health's definition of charity care and bad debt could be used as a starting point for that event.

I. Introduction

Uncompensated care (UC) has long been an issue of concern for policy makers, legislators, health care providers, advocacy groups, and others. The reality of the voluntary insurance system established in the United States is that certain individuals will not have health insurance coverage. In addition, many individuals, while having coverage for high cost, catastrophic care, may have high copays and deductibles on their health insurance and experience gaps in scope of covered services. As these insured or underinsured individuals seek care from health care providers around the state, they are often unable to pay for the cost of care, resulting in "uncompensated care" being provided to these individuals.

Policymakers and legislators in the state of Minnesota have shown increasing concern over the issue of uncompensated care. The 1998 Legislature directed the Minnesota Department of Health to report back on the levels of uncompensated care in Minnesota and to provide options to reduce the burden of uncompensated care for Minnesota's health care providers. That report "Uncompensated Care in Minnesota" was released in February 1999 and documented the extent of the uncompensated care problem in Minnesota. The uncompensated care report also presented the Legislature with a variety of options and potential policy tools for reducing the burden to providers.

While finding general agreement among stakeholders interviewed for the February 1999 study that uncompensated care was a problem in Minnesota, the Department also discovered that there were a variety of opinions regarding the extent of the problem and over what constituted the best approach to addressing uncompensated care. Some felt that direct financial relief for the large hospital-based providers was the best approach; others noted that uncompensated care was a symptom of a larger problem, the lack of health insurance coverage, and therefore efforts should be focused primarily on enrolling people in private and public health insurance; still others noted that community clinics may have unique needs not addressed through large pools.

As a result of these disparate opinions on the best approach to take on uncompensated care, and in recognition of the need to use multiple approaches, the Commissioner of Health convened a task force on uncompensated care to attempt to forge consensus on next steps to address the issue. In August, the Health Department initiated the first of a series of meetings of the Minnesota Task Force on Uncompensated Care. The task force is comprised of members representing hospitals, physician clinics, health plans, consumers, advocacy groups, counties, and governmental entities. The task force was chaired by David S. Doth, Commissioner of the Minneapolis Department of Health and Family Support.

This report provides the Commissioner of Health with the findings and recommendations from the task force, and represents the culmination of seven meetings over the course of nearly four months. The task force reviewed past research on uncompensated care, heard presentations on current outreach and enrollment efforts, examined scenarios which helped to define the characteristics of uncompensated care cases, and worked to forge consensus on a definition for bad debt and charity care. In addition, the task force formed a subcommittee to develop recommendations on health insurance access directed at both public programs and the private insurance market. Finally, members were questioned as to their preferred approaches to addressing the issue of uncompensated care.

II. History

The 1998 Legislature directed MDH to report on the problem of uncompensated care and to suggest options for reducing the need for uncompensated care and ways in which to finance it. Legislators' interest was prompted by the concerns of large hospitals as well as community clinics, both of which experienced continued increases in the burden of uncompensated care in both relative and absolute terms. Metro-based hospital providers also expressed concern that they were experiencing an increased flow of patients from counties outside of the Twin Cities metro area. The Department was charged with:

- documenting the extent of UC,
- discussing the feasibility of and evaluating options for financing UC (which include the option of reducing the need for UC through improving insurance access),
- evaluating approaches used by other states, and
- describing alternative approaches to encourage health care coverage.

In the resulting uncompensated care report, which was released in February 1999, Commissioner Malcolm expressed her commitment to convene a workgroup of stakeholders to address outstanding data and policy concerns.

The 1999 Legislature, working with the Department's report, chose to approach uncompensated care from two directions. First, the Legislature appropriated $10 million on a one-time basis to certain disproportionate share hospitals; secondly, the Legislature charged the commissioner with reporting on elements of the uncompensated care problem and developing recommendations for reducing uncompensated care through public program enrollment and simplification of the application process. In addition the Commissioner was charged with refining existing data collection mechanisms.

In August, the Commissioner convened a task force on uncompensated care. The charge of the group was two-fold. First, the task force was asked to provide input on the Department's Legislative mandates, both on definitions of bad debt and charity care and on ways in which to encourage greater enrollment in public and private health insurance. Secondly, and consistent with the Commissioner's letter in the February 1999 report, the Commissioner asked the group to use the February 1999 report as a starting point around which consensus on an approach to uncompensated care should be developed.

The task force meetings were held to provide a forum for key stakeholders to discuss and debate various potential approaches to uncompensated care. The primary purpose of the task force was to provide recommendations to the Commissioner for her report to the Legislature as well as for policy development for future initiatives.

III. Advisory Task Force: Development and Duties

Uncompensated care is a reality of the existing U.S. health care system, in which some individuals either by choice or due to lack of financial means and opportunities lack adequate health insurance. Given the complexity of the health care system with the multitude of payers and providers in an ever changing environment there are likely no simple answers to the issue of uncompensated care.

As a result, the Commissioner's convened task force was intended to represent a wide range of stakeholders who would be able to represent the variety of viewpoints on potential approaches to addressing the issue of uncompensated care. Consequently, members of the task force represent providers such as tertiary care hospitals, smaller rural hospitals and community clinics, advocacy organizations, health plans, Minnesota counties and the medical profession (Please see attachment A for a list of members.). The Commissioner of Health asked David S. Doth, Commissioner of the Minneapolis Department of Health and Family Support, to chair the task force.

IV. Overview of the Problem

As discussed in the February 1999 report "Uncompensated Health Care in Minnesota: An Interim Report to the Legislature," approximately 1% to 2% of overall health care spending in the state is for uncompensated care. This amounts to well over $200 million in uncompensated care at hospitals, clinics, and among other health care providers. While the report noted positive developments, such as a reduction in hospital-based uncompensated care since the implementation of MinnesotaCare and the fact that Minnesota's level of uncompensated care is considerably below the national average, the report also noted that the provision and burden of uncompensated care is unevenly distributed among providers.

In order to help guide the Commissioner in preparing her report to the Legislature, each task force member was asked to answer the question "Is there in fact an uncompensated care problem in Minnesota from your perspective? If so, how does it impact your stakeholder group or your institution?"

Responses to this question indicated near unanimity among task force members that uncompensated care is a problem in Minnesota. However, the impact of uncompensated care varies for different stakeholders on the task force. The wide array of identified impacts indicate the widespread problems that the lack of health insurance coverage can cause. For example:

- Large uncompensated care providers such as Hennepin County Medical Center (HCMC) and Regions Hospital indicated that they continue to provide the majority of the metro area uncompensated care and also a large share of uncompensated trauma care for the entire state. These hospitals reported that the provision of this care is placing an increasing strain on the finances of their institutions. For example, both HCMC and Regions have reported that their uncompensated care has grown significantly since 1995. Preliminary cost based data[1] for 1998 show uncompensated care of $19.8 million and $13.9 million, respectively.

- Advocacy groups such as the Children's Defense Fund-Minnesota and Minnesota Legal Services Advocacy Project noted that uncompensated care is indicative of a larger problem that affects their constituency groups, namely a lack of health insurance coverage and access, particularly through publicly-sponsored health programs.

- Providers operating community clinics, such as Cedar Riverside People's Center in Minneapolis and West Side Community Health Service in St. Paul indicated that they also see a disproportionately large number of uninsured or publicly-insured patients, straining their ability to continue to operate and provide safety net services. These providers pointed out that they have issues and concerns that differ from hospital concerns. Clinic providers argue their uncompensated care problem should not be compared with that of hospitals as clinics often have a narrower payer mix than hospitals, do not have as wide a scope of service categories, and oftentimes have an unfavorable patient mix.

- Representatives of such Rural Health Centers as Pine City and FQHCs as Leech Lake Tribal Health Services stated their concern over the expected financial impact of the Balanced Budget Act of 1997(BBA) directed phase-out of cost-based reimbursement on the survival of their clinics and health centers.

- All task force health care providers indicated that outpatient and ambulatory payment rates for Medical Assistance and General Assistance Medical Care are a concern and that these rates negatively affect the ability of providers to finance uncompensated care. In addition, task force members expressed concern about MinnesotaCare capitation payment rates.

- Task force members also noted the decreased ability to cost-shift in today's payment environment. Providers have traditionally shifted the cost of providing charity care and bad debt, as well as the cost of undercompensated public health care programs, onto the private health insurance market. In the current environment of stricter cost containment, the ability to cost shift has decreased considerably and has, task force members indicated, put many providers in financial distress.

[1] *Reported data are changes adjusted with a cost-to-charge ration developed by the American Hospital Association*

- The Minnesota Council of Health Plans noted that health plans are financially affected because the plans must pay higher fees to health care providers to cover providers' uncompensated care expenses. They also noted that providers with proportionately higher levels of uncompensated care may be at a disadvantage in negotiations with payers because their underlying costs are higher. Thus, in order to stay competitive, they may not be able pass through the entire cost of uncompensated care.

- The Association of Minnesota Counties expressed, along with others, a concern that uncompensated care raises concerns about the ability of consumers to access and utilize necessary care. More directly, they noted, providers solicit assistance from county government to help offset the cost of uncompensated care, and this results in an increased demand for property tax revenues.

- The Minnesota Hospital and HealthCare Partnership (MHHP), while noting that pockets of uncompensated care problems exist in certain parts of the state, stressed the need for additional data collection and research to determine whether a statewide problem exists.

V. Findings of the Task Force

The task force received input from the staff at the Departments of Health and of Human Services, derived information from discussions with their fellow members, other stakeholders and interested parties in attendance, and gained knowledge on the national debate through various publications on the topic of uncompensated care.

The task force choose two methods to synthesize the information available for the development of recommendations to the Commissioner: First, members of the task force formed a subcommittee charged with developing recommendations that would improve access to health insurance and eliminate gaps in eligibility for Minnesotans. Second, members of the task force submitted formal feedback to five core questions that outline their view of the uncompensated care problem and identify preferred strategies for addressing the problem.

A. Organization of Findings

The interim report on Uncompensated Care, published by the Minnesota Department of Health in February 1999, identified two general approaches to address the problem of uncompensated care.

- The first approach recognizes that uncompensated care is a symptom of a larger problem - namely, the complete lack or the lack of comprehensive health insurance coverage. Therefore, the first approach is to maximize the number of individuals covered under adequate health insurance.

- The second approach recognizes that, given the voluntary system of health insurance in the U.S., we are unlikely to completely eliminate the need for provision of uncompensated care. Therefore, a second approach would provide financial support to those providers who serve individuals who lack health insurance coverage or are underinsured, i.e., have inadequate coverage for their medical needs and for their financial means.

As a result, the task force examined the availability and efficacy of public and private health insurance options in Minnesota and the financial burden that uncompensated care poses to providers of such care.

In the course of studying and discussing these points, the Task Force developed a number of findings on the problem. These general findings are listed below.

B. General Findings on the Problem of Uncompensated Care

- **Uncompensated care is a function of a lack of health insurance coverage**. Nationally, Minnesota is recognized as a state with comparably high levels of insurance coverage, both through employer-sponsored coverage and the availability of public programs. Minnesota's high levels of insurance coverage likely explain its moderate levels of uncompensated care compared to the nation. However, in spite of our relatively low numbers of uninsured, Minnesota still has at least 250,000 residents without health coverage3 and a sizeable number of Minnesotans who, while having some level of coverage, face sizeable out-of-pocket expenses due to less-than-comprehensive policies. In addition, it is important to note that many of the gains made in health insurance coverage over the past several years result from the tight labor market, which has led to an increase in employer-sponsored coverage. The possibility of an economic downturn brings the prospect of reduced employer coverage.

- **Minnesota's aggregate burden of uncompensated care is below national norms**. Relative to national statistics, uncompensated care is a smaller percentage of Minnesota's hospital expenses than elsewhere in the country. Much of this relates to Minnesota's relatively low rate of uninsurance, and data indicates that uncompensated care in Minnesota (adjusted for inflation and to cost) has declined relative to expenses since the implementation of MinnesotaCare. Comparable national data shows a stable level of uncompensated care. Undoubtedly, the implementation of the subsidized health insurance program (MinnesotaCare) as well as the strong economy and tight labor markets, have kept coverage levels high in Minnesota.

- **However, the burden of uncompensated care provision continues to be unevenly distributed**. One of the primary findings of the February 1999 MDH uncompensated care report was that, while Minnesota's overall level of uncompensated care was below the national average, the provision of uncompensated care was unevenly distributed among providers, with a disproportionate burden falling on relatively few hospital and clinic-based providers. Recent data on uncompensated care underscore this fact: According to preliminary data for 1998, ten hospitals provided 64 percent of all uncompensated care in the state. Two hospitals alone account for about 32 percent. Similarly for physician clinics, the most recent data (1997) show that ten clinics, with their $51 million of uncompensated care, account for 66 percent of the total uncompensated care incurred in physician clinics. In addition to the mentioned provider groups, community clinics see a disproportionate number of uninsured which results in significant levels of uncompensated care.

- **Health care providers who provide a disproportionate amount of charity care report immediate financial emergencies**. Regions Hospital reports operating deficits for 1997 and 1998, at least partially driven by the provision of uncompensated care. HCMC projects an increase in the provision of uncompensated care of over 60 percent since 1995. Community clinics report that 46 percent of their patients are uninsured and 38 percent are public program enrollees. Further, they report that the safety-net nature of their service provision puts them in ever-increasing financial difficulty. Providers reported that these financial concerns have led to visible effects: Hennepin County Medical Center and Regions Hospital have reported that their responses to the rising uncompensated care burden range from staff reductions

and compromised staff development to selected discontinuation of services. Community clinics have a less favorable payer and patient mix than hospitals and unstable funding sources. As such, some have been forced to scale back the range of services they provide to their communities and to reduce their days open per week during times of budget shortfalls.

- **While not directly an uncompensated care problem, low public program reimbursement rates negatively influence providers of uncompensated care in several ways**. First, many providers who serve large numbers of public program enrollees also serve large numbers of uninsured patients and must find ways to recoup costs for both of these patient groups. Second, as public program payment rates continue to diverge from market rates, it may increase the likelihood that fewer plans or providers will continue to participate in these programs, with the likely result being a decrease in access to care. Third, low payment rates relative to costs reduce the ability of providers to finance free or reduced care provision out of current resources.

- **Task force members expressed strong concern about the effects of welfare reform on health coverage**. In the 1996 federal welfare reform legislation, Congress de- linked eligibility for Medicaid from eligibility for cash assistance. While this was, at least in part, intended to ensure that low-income individuals moving off cash assistance would have access to health insurance, Medical Assistance (MA) enrollment in Minnesota has declined by 25,000 individuals in the last several years. Some of this decline likely relates to individuals moving into the workforce. Task force members expressed concerns that many eligible families are dropping off MA due to excessive administrative requirements or because of the impression that they are no longer eligible under welfare reform.

- **The continued evolution of Minnesota's health care marketplace, with its increased emphasis on cost containment, means that the ability of providers of uncompensated care to cost-shift is limited**. Traditionally, providers of uncompensated care have financed a portion of uncompensated care through cost-shifting. In general, this was accomplished by building in a portion of the cost of care to uninsured and of lower payments by government programs into the rates charged to private insurers. As cost containment in the private sector has become more aggressive, the ability of providers to build in these additional costs is diminished.

- **Financial burdens from uncompensated care are not restricted to large providers**. For some smaller hospitals and clinics, the relative burden (as measured by uncompensated care as a percent of operating expenses) exceeds that of large providers. In addition, smaller providers are often further disadvantaged because they rely on fewer payers. Oftentimes, the federal government is significant payer for these institutions; thus, the effects of the BBA will likely compromise smaller providers' abilities to make uncompensated care available to their communities.

- **While much of the attention on uncompensated care has focused on urban areas, uncompensated care is also a concern in rural Minnesota**. Administrators of most rural health care facilities currently do not characterize their financial situations, as a result of uncompensated care, as emergencies. However, uncompensated care burdens in some rural facilities, as measured by the percent of expenses, equal that of metropolitan providers. That burden is worsened for some facilities because of their limited sources of revenue and a more limited ability to cost shift than their metropolitan counterparts.

- **People who are without adequate insurance and cannot pay often seek care later and present with more symptoms than if they had a payment source for regular care**. Safety net providers play an important role in the delivery of preventive and primary care for many individuals who lack any or adequate health insurance coverage. The safety-net continues to provide an access point for quality care to uninsured and underinsured individuals. However, it is common for these individuals to seek care only when their health condition has become acute and requires immediate attention. This situation is less than optimal since it increases the likelihood of poor outcomes and leads to higher overall health care costs.

- **Uniform definitions of bad debt and charity care should be implemented.** It is important, as the discussion moves forward, that uniform definitions of bad debt and charity care be applied. This will allow not only the development of consistent estimates of the size of the uncompensated care problem, but also ensure that any estimates of the distribution of the burden of care among facilities is done on a uniform and consistent basis. Task force members heard from and commented on definitions developed by MHHP, the Department of Health, and HCMC. In the absence of consensus, staff were directed to develop a definition that meets the legislative charge. (As a starting point, the MDH has developed a working definition which is included in the attachments).

- **While the Department of Human Services has made significant improvements to the enrollment and verification process for public programs, it could further optimize both through improved outreach and reduced administrative barriers that have been found to discourage applicants**. Through its deliberations, the task force determined that, although DHS and the Legislature have make significant steps at reducing administrative barriers to enrollment in public health care programs, additional work needs to be done to continue to made progress on enrolling and continuing enrollment for eligible individuals. The specific recommendations of the task force are included in the recommendations section of this report to the Commissioner.

C. General Observations on Proposed Solutions to the Issue of Uncompensated Care

- **It is important to consider and analyze the incentives that are introduced into the health care system by proposed solutions to the uncompensated care problem.** Task force members cautioned that many policy responses to reduce uncompensated care, whether through increased enrollment in publicly-funded health insurance programs, private market insurance reforms, or direct funding mechanisms, would introduce potential incentives for behavior and practice modification on the part of the patients and providers. While some of these modifications may be acceptable or positive from the standpoint of reducing uncompensated care, others may not. Thus, task force members urged that the implications of these policy responses be thought through carefully prior to implementation so that unintended consequences are minimized.

- **Solutions to the uncompensated care problem should, to the extent possible, build on existing program structures. If new financing or programmatic mechanisms are put in place, they should be as administratively streamlined as possible**. Task force members agreed that, given the array of public health insurance program options currently available, it would be preferable to improve and enhance existing

structures rather than create new programs. However, should new mechanisms be put in place to reduce uncompensated care, task force members suggested that those mechanisms be as simple as possible to access and administer.

- **Any direct funding mechanisms for uncompensated care be for care provided to a defined population for given services**. Task force members agreed that a funding mechanism for uncompensated care should primarily be used to pay for services provided to people who are uninsured or, in certain circumstances, those with inadequate health insurance coverage (underinsured). The task force believes these concepts should be captured in the definitions for charity care and bad debt developed by the Health Department for submission to the Legislature.

- **In addition to developing long-term strategies, some task force members stressed the necessity to address short-term emergencies at safety-net providers**. Some task force members, while supportive of long-term access strategies, indicated that there are certain emergencies that need to be addressed immediately regardless of progress on longer-term strategies.

VI. Specific Task Force Recommendations

As mentioned previously, the recommendations of the task force toward reducing the burden of uncompensated care fall into two broad categories: **initiatives and policy recommendations to increase access to health insurance coverage** and **mechanisms to directly fund or offset the costs of uncompensated care**. In addition, the task force provides recommendations on the **overall funding and rates for public sector health insurance programs** and provides comments and recommendations to move toward a **common definition of bad debt and charity care**. This section of the report will discuss the task force's recommendations in these areas.

Overall, task force members agreed that the preferred strategy for reducing uncompensated health care was through expansion of health insurance coverage. In addition, some in the task force talked of the need for short-term, medium-term, and longer-term solutions.

Regarding the short-term, some members of the task force noted specific emergencies for disproportionate providers of uncompensated care and strongly believed that the viability of the state's safety net would be compromised without addressing this short-term need. Regarding the medium-term, members expressed concern that the cumulative effect of changes brought by the Balanced Budget Act, welfare reform, DSH caps, and a potential economic downturn would increase the need for uncompensated care. Members stressed that over the longer-term, the solution to uncompensated care is ensuring health coverage for all Minnesotans and that a long-term solution must be focused on access.

With that in mind, task force members believe that improved access is the preferred solution to the problem of uncompensated care in Minnesota and that significant efforts should be undertaken to ensure increased enrollment and continuous enrollment for Minnesotans.

The task force strongly supports the Governor's October 13, 1999 Big Plan proposal, in which he stated his intention to ensure that by the end of his term in office every child in Minnesota have health insurance. The task force challenges the Governor to pursue this goal without delay.

A. Policy Changes to Increase Access and Continued Eligibility

This section presents the task force's first set of recommendations developed from the above analysis of the uncompensated care problem and the resulting list of findings. These recommendations focus on efforts to increase access and continued eligibility through public programs.

Recommendations will be discussed in the context of individual programs. However, this discussion should not be interpreted as an endorsement for the continuation of the separation of public health insurance programs. In fact, task force members expressed concern over the parallel and overlapping nature of many of these programs, which can add to confusion and detract from the seamless provision of care. The task force urges that additional work be done to examine ways to make program enrollment and care provision as seamless as possible.

Recommendation 1: Establish 12-month continuous eligibility for children on Medical Assistance.

Information from the Minnesota Department of Human Services shows that extensive "churning" exists in Minnesota's Medical Assistance Program (MA). That is, a large number of children enroll and disenroll from the program over the course of a year. It is likely that during the time without MA coverage many of these children do not have access to preventive care and that the cycle of enrollment and disenrollment detracts from the continuity of care received. In addition, task force members expressed concern over the administrative burdens placed on providers, enrollees, counties, and the Department of Human Services by the need to reenroll eligible children.

At the same time children are disenrolling from MA, the Minnesota Department of Human Services expends considerable efforts and resources through outreach to enroll children in health insurance programs, and groups such as the Children's Defense Fund-Minnesota have begun aggressive campaigns to find and enroll children. Continuous eligibility offers a way to keep eligible children enrolled in MA for up to one year once their initial eligibility has been determined. Task force members believed this would have a strong positive effect on the coordination of care that these children receive and would remove the administrative burdens associated with repeatedly enrolling the same children.

According to a report of the Medi-Cal Policy Institute (May 1999), [ten states are currently implementing continuous eligibility in their Medicaid program]. (Medi-Cal Policy Institute 1,2) Some of these states have relied in part on federal CHIP funding to draw down an enhanced federal match for continued eligibility expansions. While it is unlikely that Minnesota could access its CHIP allotment in this way, it is worth noting that other states have pursued continuous eligibility.

Staff from the Minnesota Department of Health are working with the Department of Human Services to develop cost estimates of this proposal.

Recommendation 2: Remove the MinnesotaCare premium payment requirement for people with incomes below a certain threshold (for example, below 125 %, 150 % or 175 % of the Federal Poverty Guideline).

National studies have shown that families with income levels below 200 percent of the Federal Poverty Guideline (FPG) are extremely sensitive to the price of insurance. Because these families have little disposable income available, small variations in the price of health insurance (such as between $0 and $4) can have strong effects as a deterrent/encouragement to obtain health insurance. In addition to the cost, logistic realities make it difficult for some lower income individuals to pay their MinnesotaCare premium on a monthly basis.

Some states, such as New York and Wisconsin, in implementing CHIP programs have chosen not to charge premiums to individuals below 150 percent of poverty. Several task force members noted that dropping the premium below 150 percent of poverty would be akin to establishing twelve month guaranteed eligibility for these individuals, since MinnesotaCare uses an annual reverification process.

Staff from the Minnesota Department of Health are working with DHS to develop cost estimates of this proposal. Further, these agencies are researching the possibility of accessing CHIP funding for this policy change.

Recommendation 3: Allow MinnesotaCare enrollees the option to pay an up-front, discounted fee for annual enrollment.

Under the current system, everyone on MinnesotaCare pays a premium. Task force members voiced a concern that the logistics of paying a monthly premium, especially for financially-distressed families, may be difficult and may lead to disenrollment and the subsequent discontinuity of care that results. The task force recommends that people enrolling or renewing in MinnesotaCare be given the option of paying a flat, discounted annual fee. This would guarantee coverage for the following 12 months, and may enhance the prospect of continuous and seamless coverage.

Recommendation 4: Direct DHS and the Minnesota counties to improve communication to those dually-eligible for Medical Assistance and MinnesotaCare to ensure that eligible Minnesotans become and remain enrolled in public health insurance programs.

Eligibility provisions for Minnesota's MA and MinnesotaCare programs allow for the possibility that some individuals are eligible for both programs. If enrolled in MinnesotaCare, these individuals are required to pay a monthly premium corresponding to their level of income.

Some task force members expressed concern that the necessity of premium payments under MinnesotaCare may prove to be a barrier to continuous enrollment for this population. The task force therefore recommends that further study be done on the reasons why people, who are eligible for either MA or MinnesotaCare, are enrolled in MinnesotaCare. Further, the task force recommends improving communication to individuals regarding their choices of public health insurance.

Recommendation 5: Raise the percentage that would qualify an employer contribution as "employer-subsidized" insurance for the purpose of MinnesotaCare. Study the impact of choosing different levels above the current 50 percent to arrive at a desirable level with minimum impact on existing private insurance coverage.

Current law renders individuals ineligible for MinnesotaCare if their employer offers health coverage and contributes at least 50 percent toward the purchase of that health insurance. Task force members expressed a concern that many lower-income Minnesotans may be effectively locked out of the insurance market, since the remaining 50 percent share of an employer premium is unaffordable, and they are ineligible for MinnesotaCare.

Recent data collected by the Minnesota Department of Health indicates that the state average for an employer contribution to employer-sponsored insurance is 82 percent of the premium for employee-only coverage and 70 percent for family coverage. In effect, MinnesotaCare is locking people out in situations where their employer contributes considerably below the state average. The task force, therefore, recommends that the percentage at which employer-based coverage is considered "subsidized" be raised from the current 50 percent. Task force members noted that other states, such as Wisconsin, have adopted similar higher standards thresholds for determining when employer-subsidized coverage disqualifies individuals from eligibility for the CHIP program.

Recommendation 6: Amend the provision that prevents same-month enrollment in MinnesotaCare and GAMC for those persons enrolled in MinnesotaCare who have exceeded the hospital charges limit of $10,000.

Single adults, enrolled in MinnesotaCare, are subject to a $10,000 cap. Those who reach the cap may select to move to the General Assistance Medical Care Program in order to cover the inpatient charges that they are liable for. However, the current process of moving from MinnesotaCare to GAMC is very complex and likely serves as an impediment for moving between the two programs. The process of moving from MinnesotaCare to GAMC can take as long as 3 or 4 months, during which time individuals are liable for costs above the $10,000 cap.

The statutory provision that prohibits a person from being eligible for MinnesotaCare and General Assistance Medical Care (GAMC) in the same month should be amended to allow persons on MinnesotaCare who have a $10,000 inpatient limit to use GAMC as a wraparound to cover hospital charges that exceed $10,000.

Recommendation 7: Eliminate language and cultural barriers that prevent individuals and families with limited English-language proficiency (LEP) from accessing publicly-funded health care programs.

Task force members are concerned about barriers to accessing publicly-funded health care experienced by individuals and families with limited English-language proficiency. An October 1999 report on health care access for Minnesota's Latino community, published by the University of Minnesota's School of Public Health, states "Latinos of all ages are the least likely of any racial/ethnic group to have health insurance. (University of Minnesota 13). The report goes on to say that for many Latinos, language barriers present significant obstacles to receiving adequate health care. In addition, the report states that despite the fact that these families are eligi-

ble for MA and GAMC and that federal and state laws require access to linguistically appropriate health care, the needs of many Minnesotans with limited English-language proficiency are not being met. (University of Minnesota 14, 15).

A February 1999 Department of Human Services (DHS) Legislative report regarding their limited English-language proficiency (LEP) plan states that in Minnesota, the largest number of non-English speaking individuals are in the Hmong and Hispanic communities, but that groups speaking African and Eastern European languages are growing rapidly. (DHS 1). The report states there is a need for counties and other service providers to develop strategies to provide services to LEP populations so that they will have equal access to human services programs for which they are eligible. (DHS 3, 12). Both the DHS and the University of Minnesota reports emphasize a need for more education and outreach to LEP communities. The reports also emphasize a need for bilingual staff, interpreters and cultural liaisons to assist LEP families.

Recommendation 8: Consider implementing presumptive eligibility for children and pregnant women in order to reduce insurance gaps Minnesotans and funding gaps for providers.

Presumptive eligibility for children under age 19 and pregnant women should be considered. Health care providers and community-based organizations could enroll children and pregnant women on a temporary basis relying on information provided by the family that income falls below the income limits and ensure reimbursement for care. Under this proposal, the family would have until the last day of the next month to file an application with the state agency to continue eligibility. Federal financial participation is available for the period of presumptive eligibility even if the child or pregnant woman is ultimately not found eligible.

Recommendation 9: Continue current efforts by the Department of Human Services to simplify and shorten the Health Care Application form and to reduce administrative barriers that prevent individuals and families from obtaining and retaining eligibility for publicly-funded health care programs.

Task force members discussed the concern that the application process and the reporting and verification requirements for publicly-funded health care programs present significant barriers to ongoing eligibility. DHS estimates that 50 percent of eligible Minnesotans are not enrolled in MinnesotaCare.

Many eligible people are also terminated from MinnesotaCare, MA and GAMC for failure to comply with administrative requirements, such as returning an income report or other forms, even though they are not required under federal or state law. The task force recommends that DHS continue to simplify and streamline eligibility requirements.

Recommendation 10: Improve enrollment opportunities through coordination of state agency programs that focus on providing assistance to low-income Minnesotans.

Task force members noted that there are a variety of programs in place to promote the self-sufficiency of the low-income or indigent Minnesotans. For instance, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) is a supplemental food and nutrition program for low-income pregnant, breastfeeding and postpartum women, and for infants and young children who are at nutritional risk; the Minnesota Working Family Tax Credit is a tax credit for low-income families; the federal Earned Income Tax Credit is a similar program at the federal level; and the Reduced or Free School Lunch program provides assistance to lower-income families to help ensure their children receive lunch while at school.

Each of these programs is administered by different agencies. Task force members noted that, since the target population of each program is similar to persons eligible for MA and MinnesotaCare, outreach efforts could be made to allow people to apply for health care coverage at the same time they apply for these programs.

B. Policy Recommendations regarding the Private Health Insurance Market

In addition to expansion of public sector health insurance programs, task force members recognized that two-thirds of all Minnesotans are enrolled in private-based coverage. Task force members agreed that the preferred strategy for reducing uncompensated health care was through the expansion of health insurance coverage. Therefore, members were also interested in examining the private sector health insurance market, and reviewing and analyzing potential reforms or changes in that market that may increase access to coverage. Members discussed various possible strategies of reform but felt they did not have adequate time to arrive at consensus for recommending specific next steps. However, the task force did feel there was a need for, and value in, further discussion on a given set of reform possibilities. To begin that conversation, the task force recommends that the Commissioner to study the following issues:

Recommendation 11: Carefully study the impact of the bill passed by the 1999 Legislature that allows insurance companies with market share of less than 3% to market and sell policies that have reduced benefit requirements.

Concerned over the price and affordability of insurance policies, the 1999 Legislature allowed insurance companies with market shares of no greater than 3 percent to sell health insurance policies that could exclude benefits that would otherwise be mandated by law. Because they have a lower level of benefits, these policies could be priced at a lower level, making them attractive to certain employers and individuals, who might not otherwise be able to afford health coverage.

The task force recommends that the impact of reduced-benefit packages on the health insurance market be monitored. Some task force members expressed concern that adverse selection could result in the small employer market if employers initially purchase policies without certain benefits, then upgrade to more complete benefit sets when the need for a given service arises. This may lead to increased premiums in the small employer market. Therefore, the task force recommends the monitoring of potential adverse effects on premi-

um levels, risk selection, and cost shifting from the sale of these policies. Questions that should be answered in this context are: Who buys these policies? What coverage, if any, did employees have or did employers provide before? Who sells these policies? Do individuals buying such policies upgrade their benefits through the provision of guaranteed eligibility?

The task force notes that there is a trade-off between expanded eligibilty levels versus expanded benefits. In addition, remains an unanswered question as to whether covering more people with more affordable but less comprehensive benefits is preferable to covering perhaps fewer individuals with more comprehensive benefits.

Recommendation 12: Examine the current funding and design of the Minnesota Comprehensive Health Association in light of affordability of premiums, characteristics of enrolled individuals, and improvements in directing applicants who have been denied private insurance coverage to applying for the program.

The Minnesota Comprehensive Health Association (MCHA) is the state's high risk pool for individuals unable to obtain coverage in the private insurance market. Task force members expressed a variety of opinions and options related to MCHA. Some raised concern over the cost of MCHA premiums, which are set at up to 125% of the individual market rates, a market that is already relatively expensive. Others expressed concern over whether there are individuals in MCHA who should otherwise be in the private individual market and suggested an examination of MCHA enrollee characteristics. Others noted that each individual company is able to set its own standards for rejection for the individual market and suggested that a standardized set of characteristics should be implemented for admission into MCHA as should guaranteed issue in the private insurance market for those individuals who fail to meet MCHA, eligibility criteria. Finally, some members suggested exploring ways to direct applicants who have been denied private insurance coverage to the MCHA program or other insurance options.

Recommendation 13: Study the effect of health care premium taxes and health care coverage mandates on the ability of individuals to obtain and maintain health insurance coverage.

Some task force members expressed concern that the current system of health care taxes and mandates for coverage benefits add costs to the health care system and may make it less affordable for individuals and employers to purchase coverage. Current taxes and mandates may also make it more difficult for individuals to maintain coverage once in the system.

Recommendation 14: Undertake state-wide education efforts on the value of health insurance and continuous health care coverage.

The task force recognizes that a certain segment of the population, primarily younger adults, makes a conscious choice not to purchase health insurance coverage, given their relative good health and the lower value they place on health coverage relative to other expenditures. However, this population also generates uncompensated care, and the task force feels that, in a voluntary system, it is important to educate the general public and, in particular, the voluntarily uninsured, about the value of health insurance, continuous coverage, and an individual's social responsibility to maintain insurance.

In addition, task force members have pointed out that the opportunity for enrollment in health insurance programs escapes new immigrant populations since they may not be familiar with an insurance-based health care system. Education efforts are needed to aid new immigrant populations understand and master the complex Minnesota health insurance system. While not recommending a specific vehicle for this education, the task forces stresses the need for the state to undertake such a campaign and supports the development of such initiatives.

C. Public Program Payment Rates

Recommendation 15: Medical Assistance payment rates for ambulatory and outpatient services should be increased.

Recommendation 16: Establish an add-on to Medical Assistance rates for providers serving a disproportionate number of patients for whom care is uncompensated.

The task force was nearly uniform in its concern over the payment rates for public sector health insurance programs. Since many providers of uncompensated care also serve large numbers of public program enrollees, the task force repeatedly noted that low payment rates serve as a "double hit" for these providers.

As a result, the task force believes that payment rates for ambulatory and outpatient Medical Assistance (MA) should be increased to ensure adequate access for low-income and disabled Minnesotans and to enhance the financial viability of providers of uncompensated care. While recognizing that General Assistance Medical Care rates are below those of MA, the task force also recognizes the value of federal matching funds, and therefore recommends that the outpatient and ambulatory services for MA, where payment rates are considerably below market rates, be increased. In addition, the task force recognizes that certain providers have a large burden of uncompensated care and the task force therefore recommends an add-on to MA rates be established for those providers with a heavy uncompensated care burden.

Finally, most public program dollars to community clinics come from PMAP through contracts with health plans. Special attention should be paid to assure that the increased MA rate is passed on to the community clinics. State statute initiated in 1996 (256 B.69 sub 3A), allows the counties the right (with DHS) to mutually select and renew health plan contracts for PMAP. This role, commonly referred to as "enhanced PMAP" should be used to assure that safety net providers remain accessible to this target population and that the MA reimbursement rates and add-ons are passed on to these providers.

Recommendation 17: The task force recommends that for the short-term the state continue reimbursement for FQHC and RHC services according to the BBA 1999 phase-down mechanism. For the long-term, the task force recommends that the Legislature consider restoring 100 percent cost-based reimbursement.

Federally Qualified Health Centers and Rural Health Centers play an important role in guaranteeing access to medical care for low-income populations and individuals in rural, medically underserved areas. To promote

their role as community health centers, FQHCs and RHCs have historically been reimbursed at 100 percent of reasonable costs.

Under current law, payments to community health centers are scheduled to be phased down beginning in 2000. Task force members have raised concerns over the impact that the reduced reimbursement would have on access to health care. The task force recommends, therefore, a dual strategy:

The task force recommends, for the short-run, that the Legislature adopt the decelerated Balanced Budget Act (BBA) phase-down provision, which is part of the 1999 BBA restoration. As a long-term strategy, the task force recommends that the Legislature consider restoring 100 percent cost-based reimbursement for FQHCs and RHCs.

D. Financing of Providers of Uncompensated Care

As discussed earlier in this report, one general approach to reducing the problem of uncompensated care is by financially supporting those providers that make free and discounted care available to populations in need. Task force members agreed that financial relief should be viewed as an interim solution until the larger problem of the uninsured is addressed through other strategies. However, members disagreed about the period over which this interim relief should be provided.

A majority of task force members believe that interim payments would help sustain providers of uncompensated care as the broader access strategies recommended earlier are implemented and take effect. However, some task force members expressed concern that providing even short- term, temporary relief will shift the focus away from dealing more globally with the underlying access problems.

Opinions also varied on the task force as to the specific form that such support should take. Regardless of the form distribution takes, the task force members provided the following recommendation:

Recommendation 18: Payments should be made available to those providers who have emergency situations resulting to a significant extent from a disproportionate burden of uncompensated care.

While the task force did not achieve consensus on the specific distribution mechanism or tool, the task force recommended the following:

- The General Fund is the preferred financing source for payments to providers facing financial emergencies due in large part to their uncompensated care burden.
- The task force believes that, while an insufficient sum, last year's $10 million appropriation was critical in enabling certain large providers of uncompensated care to operate.
- The task force believes that this financing should be continued for the next year and recommends $20 million be appropriated for distribution to providers facing financial emergencies to which uncompensated care contributed significantly..

- The task force recommends, however, that a different distributional method be used for the $20 million. In particular, the task force believes that community clinics should be included in the fund distribution with some portion (perhaps one third) of any appropriation dedicated to these clinics.

- The task force also believes that the remainder of the appropriation should be focused on those hospitals that face financial emergencies due to their disproportionate burden of uncompensated care.

- Finally, the task force recommends that the Commissioner of Health, in developing her budget package for the 2002-2003 biennium, include a budget initiative that contains a package of proposals to expand access and reduce uncompensated care. In developing this package, the task force recommends the commissioner consider including interim funding for those providers experiencing financial emergencies due in large part to the provision of uncompensated care.

- The task force agreed that any payments for uncompensated care burdens should be targeted to individuals who are uninsured or who have private coverage that leaves them underinsured and with financial hardships. There was no consensus about the income levels of the uninsured that would qualify their care for uncompensated care payments.

- The committee did not reach a consensus on a uniform definition. The MHHP in particular argued that individual hospitals and their governing boards should have full discretion in determining the exact level and definition of their uncompensated care.

E. Progress Towards a Consistent Definition and Comparable Data

In the February 1999 report on uncompensated care, the Department of Health stressed the importance of a uniform definition of charity care and bad debt applicable across providers and specifically, the Department pointed out:

> "Hospitals' classification and accounting of the components of uncompensated care, charity care and bad debt, is inconsistent ... (and) make(s) a direct comparison of the uncompensated care components ... difficult across providers. ... Therefore, until uniform definitions and standards are in place, both components need to be combined for analysis." (MDH 13)

In response, the 1999 Legislature charged the Commissioner of Health with "... determin[ing] a definition for charity care and bad debt that distinguishes these two items for inpatient and ambulatory care." (1999 Minnesota Laws)

Both MDH staff and representatives of the Minnesota Hospital and Healthcare Partnership (MHHP) were asked by the Task Force to comment on their definitions. MDH staff provided a working definition, presented an analysis of the MDH and MHHP definitions, and laid out the policy-driven need for a distinction between charity care and bad debt. MHHP presented on the results of its work group, which developed definitions of bad debt and charity care that were adopted by the MHHP Board of Directors. In addition, community clinics, HCMC, and Regions Hospital provided comments and direction during this process.

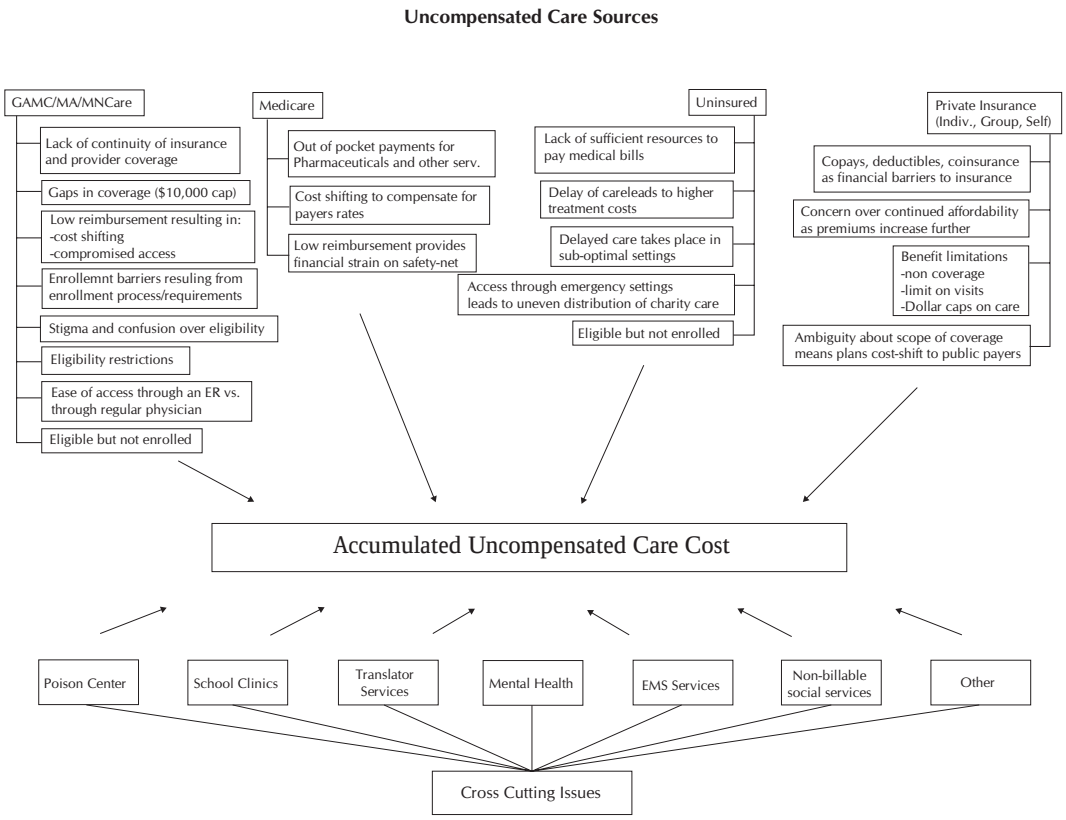
In the five questions posed to task force members, members were asked to respond to the MHHP definitions of charity care and bad debt, noting both their strengths and weaknesses. Some task force members felt that the

MHHP definitions were an improvement over current definitions, and that they provided a clearer distinction between what constitutes bad debt and what distinguishes charity care. In addition, it was noted that the MHHP definition of charity care would allow for flexibility by enabling individual communities to define charity care policies. A weakness identified was that the MHHP definition would lead to a large degree of variation among providers. There was also some concern expressed over the practice of determining eligibility for charity care through third-party collection agencies. Most importantly, several members felt the definitions did not go far enough in ensuring comparability and uniformity of reporting in the data.

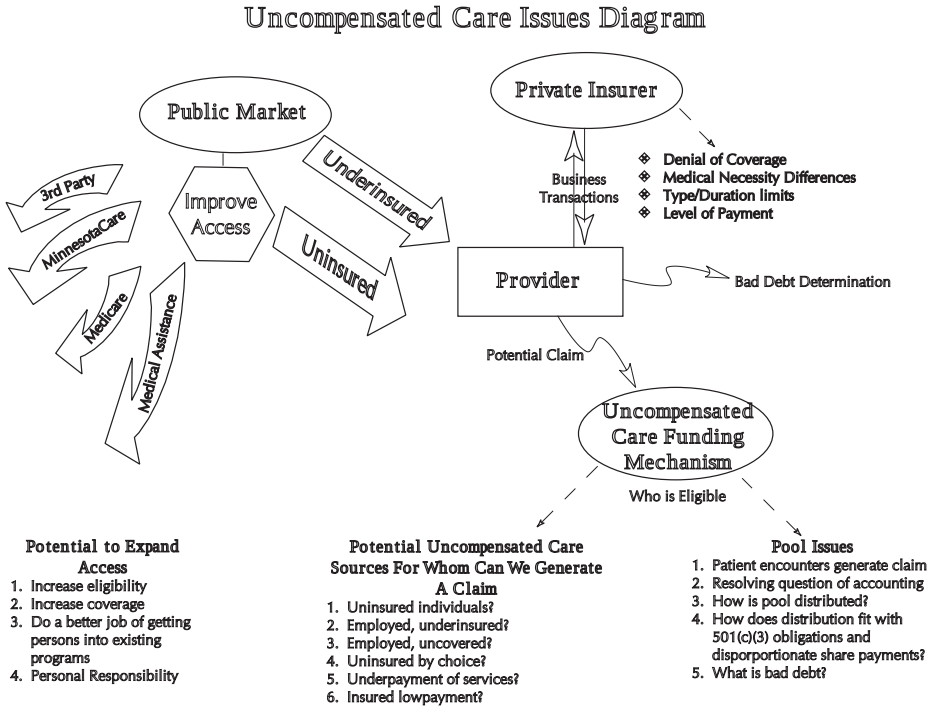
Task force members expressed a need to consider alternative definitions for community clinic. As such, the following language was proposed: "Bad debt expense represents the financial obligation for care of patients with the ability to pay but who have not demonstrated a willingness to do so. This includes explicitly that portion of the payment that individuals on a sliding-fee-scale were assigned but have not paid."

The task force did not reach a consensus on a uniform definition. The MHHP in particular argued that individual hospitals should have full discretion in determining the exact level and definition of their uncompensated care. However, the task force agreed that if public funds support an uncompensated care financing mechanism then uniform and standard definitions should be used for the criteria of distribution. The Department of Health's definition of charity care and bad debt could be used as a starting point in that event. The Department's definition may be found in the Commissioners Report to the Legislature.

Uncompensated Care Sources (Aug. 19, 1999)



Uncompensated Care Issues Diagram (Sept. 15, 1999)



Policy Levers by Population (Sept. 15, 1999)

Uncompensated Care in Minnesota

Minnesota Task Force on Uncompensated Care

Scott Leitz, Director
Health Economics Program/MDH
Stefan Gildemeister
Health Economics Program/MDH

September 15, 1999

Overview

A first cut at describing, in general, the policy levers available to address health insurance coverage and access issues.

Potential Policy Interactions with Uncompensated Care (UC)

	Public Programs			Private Insurance			Funding Issues		
Target Population	Admin. Barrier	Access/ Coverage	Premiums and Cost	Access	Extent of Coverage	Cost	Pool Paym.	Paym. Rates	Other
Indigent (unemployed)									
facing financial and personal barriers		√	√			√	√		
facing adminstrative barriers to health ins.	√	√							√

Potential Policy Interactions with Uncompensated Care, cont. 2

	Public Programs			Private Insurance			Funding Issues		
Target Populations	Admin. Barrier	Access/ Coverage	Premiums and Cost	Access	Extent of Coverage	Cost	pool Paym.	Paym. Rates	Other
Indigent (unemployed)									
facing financial and personal barriers			√	√		√	√		
facing adminstrative barriers to health ins.		√	√						√
Employed (not covered)									
can't afford and/or			√	√		√	√		√
not offered			√	√		√	√		

Potential Policy Interactions with Uncompensated Care, cont. 3

	Public Programs			Private Insurance			Funding Issues		
Target Populations	Admin. Barrier	Access/ Coverage	Premiums and Cost	Access	Extent of Coverage	Cost	pool Paym.	Paym. Rates	Other
Indigent (unemployed)									
facing financial and personal barriers			√	√		√	√		
facing adminstrative barriers to health ins.		√	√						√
Employed (not covered)									
can't afford and/or			√	√		√	√		√
not offered			√	√		√	√		
Employed (undercov.)									
large co-pays						√	√		
limited benefits					√		√		

Potential Policy Interactions with Uncompensated Care, cont. 4

	Public Programs			Private Insurance			Funding Issues		
Target Populations	Admin. Barrier	Access/ Coverage	Premiums and Cost	Access	Extent of Coverage	Cost	pool Paym.	Paym. Rates	Other
Indigent (unemployed)									
facing financial and personal barriers			√	√		√	√		
facing adminstrative barriers to health ins.		√	√						√
Employed (not covered)									
can't afford and/or			√	√		√	√		√
not offered			√	√		√	√		
Employed (undercov.)									
large co-pays						√	√		
limited benefits					√		√		
Uninsured by choice	√					√	√		

Potential Policy Interactions with Uncompensated Care, cont. 5

	Public Programs			**Private Insurance**			**Funding Issues**		
Target Populations	Admin. Barrier	Access/ Coverage	Premiums and Cost	Access	Extent of Coverage	Cost	pool Paym.	Paym. Rates	Other
Indigent (unemployed)									
facing financial and personal barriers			√	√		√	√		
facing adminstrative barriers to health ins.		√	√						√
Employed (not covered)									
can't afford and/or			√	√		√	√		√
not offered			√	√		√	√		
Employed (undercov.)									
large co-pays						√	√		
limited benefits					√		√		
Uninsured by choice	√					√	√		
Bouncers (short term uninsurance)	√	√	√	√		√	√		

Potential Policy Interactions with Uncompensated Care,cont. 6

	Public Programs			Private Insurance			Funding Issues		
Target Populations	Admin. Barrier	Access/ Coverage	Premiums and Cost	Access	Extent of Coverage	Cost	Pool Paym.	Paym. Rates	Other
Indigent (unemployed)									
facing financial and personal barriers			√	√		√	√		
facing adminstrative barriers to health ins.		√	√						√
Employed (not covered)									
can't afford and/or			√	√		√	√		√
not offered			√	√		√	√		
Employed (undercov.)									
large co-pays						√	√		
limited benefits					√		√		
Uninsured by choice	√					√	√		
Bouncers (short term uninsurance)	√	√	√	√		√	√		
Some public/private resulting in self-pay		√	√	√		√	√		

Options to Increase Access and Continued Eligibility

Material from the 2nd Commissioner's Uncompensated Care Task Force and the February '99 report

This document is intended to serve as a summary of policy options that will, through their impact on public programs, reduce the need for uncompensated care currently provided in Minnesota.

Part 1 presents some core points of what is known about the uninsured and public program enrollment dynamics. Part 2 reports on those policy options, developed for the 1999 report on uncompensated care, that were enacted by the 1999 Legislature. This is followed by a list in part 3 of options that were not enacted but are still considered relevant. Finally, in part 4, a list of further policy options to reduce uncompensated care is presented. This list was drawn from the discussions of the Task Force.

The list in part 4 is not an exhaustive one. It should be considered a working document for review and comment. A final version will the basis for developing recommendations to the Commissioner on how to improve public program access in Minnesota to effectively reduce the need for uncompensated care.

1. Summary points from presentations

Representatives of the Minnesota Department of Health and the Department of Human Services (DHS) provided updates on the status of access to public programs and changes to the administrative structure and eligibility criteria of those programs:

Data on Enrollment Trends - Julie Sonier, MDH/Health Economics Program

- The rate of uninsurance in Minnesota of 6 to 9 percent is relatively low compared with national levels. Minnesota's uninsured are primarily white (87%), employed (82%), adults between the ages of 18 and 44 (65%).

- Most recent data on the uninsured (1995) show that since the enactment of the MinnesotaCare program, a lower proportion of the uninsured are children. At the same time, more of the uninsured are between the ages of the 25 to 44 (about 42%).

- Fewer of the uninsured (about 17%) have low incomes (<100% of FPG). Public programs, therefore, have succeeded in reaching the population they were intended to.

- Take-up rates in public programs continue to be relatively low. About 50 percent of eligible children are enrolled; enrollment of the total eligible population is estimated between 30 and 40 percent. As observed in other states, enrollment of eligible individuals in MA, as a direct result of welfare reform, is expected to decline in Minnesota as well.

Efforts to Increase Enrollment of eligible populations in MinnesotaCare - Mary Kennedy, DHS

- Outreach has shown modest increases in MinnesotaCare but has also helped to increase enrollment in Medical Assistance.

- The remaining uninsured are not a homogenous group that is static over time. Instead, its make up is a function of fluctuating employment and income status, of hardships other health care, immigration concerns, and is due to the special character of health care - information regarding health care are not sought until care is needed. Personal choice is only one factor among many to determine lack of insurance.

- Further outreach, therefore, will be complex and time consuming. Outreach will need to include aggressive follow-up with every step of the application process and one-to-one assistance.

2. Options enacted into law by the 1999 Legislature (or changes taking place)

The report on uncompensated care, prepared by the Health Economics Program of the Department of Health (Uncompensated Health Care in Minnesota, Feb. 99), contained a number of suggested policy options intended to reduce the need for the uncompensated care.

This section lists those policy options that were targeted at improving effectiveness of public programs in providing health insurance to eligible Minnesotans and that were enacted by the 1999 Legislature or are in the process of being implemented:

- Certain administrative provisions and elements of the application process function as unintended barriers to enrollment in public programs.

  MinnesotaCare adults are no longer required to apply for MA to cover their inpatient stay.

  For those applicants who appear eligible for the MA/GAMC or MinnesotaCare program eligibility is presumed for 30 days pending verification. An asset test for children was removed.

  DHS is in the process of completing the simplification of the application form. The form will be reduced in length to 3 and 5 pages.

  DHS has streamlined its' processing from several months to 13 days. Reduced processing time will provide an incentive for applicants to follow-through with their application.

  DHS has proceeded with consolidating information to be made accessible to applicants at the point of application. Customer service in general has been improved.

- Uncompensated care costs are incurred often for individuals who are in transition between public programs.

  The four months block-out penalty for late payment of MinnesotaCare premiums has been eliminated for enrollees who comply within a period of 20 days after cancellation.

  Individuals leaving MA or GAMC are entitled to retroactive MinnesotaCare coverage.

  The four month non-payment penalty for pregnant women was eliminated.

- While public programs are intended to provide affordable access to health insurance for an eligible population, some financial provisions have formed barriers to enrollment, while others have created large financial burdens that are eventually born by the safety net community:

  The co-payment for MinnesotaCare parents with income below 175 percent of the federal poverty guideline (FPG) of $1,000 was eliminated.

  The enrollment fee for the Senior Drug program of $120 was eliminated.

  Income earned by high school students will be disregarded for eligibility determination.

Asset standards for people with disabilities were increased to $20,000 to provide a work incentive for that group of the MA population.

3. Options Not Enacted by the 1999 Legislature

This section lists policy options related to public programs that would decrease the need for uncompensated care in Minnesota. Options listed here were included in the February 1999 report on uncompensated care but were not pursued by the 1999 legislature:

- Allow additional flexibility in MinnesotaCare premium payment. One option the Legislature could consider would allow individuals to pay a flat enrollment fee which is discounted from the monthly rate. For example, individuals now paying $4 per month could be offered the option of paying $30 for a year of coverage.

- Provide 12 month guaranteed eligibility for enrollees in the Medical Assistance program. Enrollees in MA, and specifically children, have been documented as switching in and out of the program based on marginal changes to their families' income status. Twelve months guaranteed eligibility would interrupt the periods of intermittent uninsurance while at the same time reduce the significant administrative costs of re-enrolling eligible individuals.

  Costing ???

- Examine ways to assist individuals with access to employer-based health insurance coverage to become and stay insured. Possibilities include subsidizing the employee contribution for individuals in income brackets below 275 percent of FPG and increasing eligibility for MinnesotaCare by raising the employer subsidy cap and by providing financial incentives to employers to provide health insurance.

4. Additional Options for Consideration Discussed at Task Force Meetings

- Allow flexibility in the location at which premium payments for MinnesotaCare can be made.

- Consider eliminating premium payments for individuals in certain income groups (100%, 150%, 175% FPG).

- Consider presumptive eligibility (moral hazard?) to reduce the burden on the safety net providers.

- Establish a free rider penalty for non-indigent individuals that do not take-up and insurance options.

- Adopt a "one gateway" approach to public program enrollment to eliminate the need of the applicant to distinguish between eligibility standards for different programs (and for different family members).

- Remove the hospital cap of $10,000 from the MinnesotaCare program

- Review low-income individuals' affordability of employee contribution of their employer-based health coverage. Align such contribution with income burdens as are established for the MinnesotaCare program.

- Revisit the requirement to shift select GAMC populations to MinnesotaCare beginning January 1, 2000 (confusion over lack of retroactive eligibility to the program compared with GAMC/MA).
- Free rider penalty.

Uncompensated Care Scenarios (Oct. 7, 1999)

Uncompensated Care Scenarios

Minnesota Department of Health
Uncompensated Care Task Force

October 7, 1999

Hospital (Non ER) Eligibility Scenario		
Care Setting		
Patient payer	Outpatient	Inpatient
PMAP	No	No
MNCare	No	Yes? (if charges exceed $10,000 cap?) If so, are there private market effects?
MA-FFS	No? (are MA rates adequate?) Inpatient-yes probably	No? (are MA rates adequate?)
Private - Limited coverage	Yes? Underinsurance maybe like uninsurance	No? There may be a problem with bad incentives
Uninsured	Yes-but only after a certain point?	Yes

Clinic Eligibility Scenario

Patient Payer	With Managed Care contracts	Without Managed Care contracts
PMAP	No-but don't want patient shifting	Yes? (Are clinics different than hospitals?)
MNCare	No - But are MNCare rates adequate?	Yes? (Are clinics different than hospitals?)
MA-FFS	No - But are MA rates adequate?	Yes? (Are clinics different than hospitals?)
Private - limited coverage	Yes? Underinsurance maybe like uninsurance No? There may be a problem with bad incentives	Yes? (Are clinics different than hospitals?)
Unisured	Yes	Yes? (Are clinics different than hospitals?)

Outpatients: How well do doctors/clinics divert patients into network?
How well do hospital clinics divert patients into network?

Hospital ER Eligibility Scenario

	Presenting Situation		
Patient Payer	Life Threatening; Health in danger	Non-life threatening but Prudent layperson	Non life threatening; situation doesn't meet with Prudent layperson
PMAP	No-Payer should be identified by hospital	No - Payer should be identified by hospital, individual enrollee should take responsibility for staying in network	No
MNCare	Yes? (If above $10,000 for single cap for single adults and parents >175%)? Is this better handled through benefit expansion?	No	No
MA-FFS	No? (are MA rates adequate?) Inpatient-yes probably	No? (are MA rates adequate?) Outpatient-?	No
Private Insurance - Limited Coverage	? EMTALA requires stabilization; hospitals-collections obligation? Do we set up private insurance disincentives?	No	No
Uninsured	Yes-but only after a certain point?	Yes-but only after a certain point?	No

ER patients: Emergeny Medical Treatment and Active Labor Act

Assume: Medically necessary (traditional medicine)

Prudent Layperson
Non-prudent Layperson

MHHP Definition of Uncompensated Care

The MHHP Uncompensated Care Work Group determined that uncompensated care is charity care and bad debt and defined those categories as follows:

Charity Care

"Charity care" means health care services provided to people who are determined to be unable to pay for the cost of health care services. Inability to pay shall be determined through examination of one or more of the following: individual and family income; assets; employment status; family size; or, availability of alternative sources of payment. A hospital may determine inability to pay at the time care is rendered or through subsequent efforts to collect sufficient information to make such a determination.

The following are points of clarification for the MHHP definition of charity care:

1. Charity care may include services where the provider is obligated to provide them regardless of its ability to collect.

2. Charity care may include low-income patients who meet the hospital's guidelines, who have partial coverage, e.g., no fault care insurance, secondary Medical Assistance or Medicare, but who are unable to pay the remainder of their bills.

3. Charity care may include low-income patients who may qualify for a public assistance program and meet the hospital's guidelines, but who do not complete the application process despite the hospital's best efforts.

4. Charity care does not include contractual allowances - the difference between gross charges and payments received under contractual arrangements with insurance companies, Medicare and Medicaid, and health plans.

5. Charity care does not include bad debt.

6. Charity care does not include the cost of operating public programs, defined as the costs in excess of public program payments. This is appropriately reported in hospital community benefit reports.

7. Charity care does not include cases which are paid through a charitable contribution, through a third party or hospital related foundation.

Bad Debt

"Bad debt" expense represents the unpaid obligation for care provided to patients who have been determined to be able to pay, but have not demonstrated a willingness to do so.

The following are points of clarification for the MHHP definition of Bad Debt:

1. Bad Debt includes any unpaid patient responsibility which may include, but is not limited to, deductibles, co-insurance, co-payments and non-covered services.

2. Patients are presumed to be able to pay until and unless information is obtained which indicates an inability on their part to do so.

Hennepin County: Proposed System for Defining Charity Health Care as a Basis for Pool Distribution (November 1, 1999. version 2.4)

Proposed System for defining Charity Health Care as a basis for pool distribution.

Version 2.4

Rationale:

There are two approaches to ameliorating the effects of uncompensated health care being delivered by providers throughout the state. The first is to improve access to public health care programs (Medicaid, GAMC and MinnesotaCare.) The second is to implement a charity care pool. The funds in this pool would be distributed to providers based on the amount of charity care they provide. This is the approach taken in the last legislative session for "out of county" charity care.

For a pool system to work effectively the definition of charity care is critical. It is assumed that the funding source for charity care will be limited and therefore a narrow and targeted definition of charity care is needed. Therefore this proposal does not include underpayment by public programs or the community benefit programs of providers. These are much larger issues that would overwhelm any small targeted charity care pool. In addition, the proposal does not include any payment for bad debt.

Proposal:

All providers in the state would be eligible to participate in this program if they are willing to abide by the process described below and their annual aggregate charity care is within the upper quartile of charity care of all like providers in the state (e.g. hospitals, clinics, ambulance services etc.) Provider groupings could be subdivided into urban/rural. The quartile calculation would be based on each provider's ratio of charity care to their total operating cost.

Charity Care would be defined by a consistent process as outlined in Appendix A and would and have two components - A and B. Only those health services contained in the Medicaid benefit set are eligible for inclusion as Charity Care.

Charity Care type A would be defined and administered prospectively by the provider. It would include income definitions. It would be used in advance of providing treatment and agreed to by the patient.

Charity Care type B would be defined prospectively but administered retrospectively. Providers would submit a tabulation of unpaid claims for each individual to this system annually. The county in which the provider resides would administer the system. The type B system would check appropriate data bases (Revenue recapture, JTED, geocoded income correlations, etc.) to determine the patient's income. The patient's income determination will be for the most recent year in which they filed their state income tax even if it is a year prior to the delivery of the care. If the patient's income qualified them for charity care these costs would be accumulated as Type B charity care.

Providers that choose to implement type B charity care systems would be required to obtain releases from patients allowing access to the appropriate databases. MDH would oversee and approve both type A and type B charity care systems.

Each year, eligible providers would report to MDH their total type A and B charity care. MDH would make proportional payments to eligible providers based on the funds available in the pool.

Appendix A - Definitions of Uncompensated Care(Adapted from MHHP)

Charity Care

"Charity care" means health care services provided to people who are determined to be unable to pay for the cost of health care services. Inability to pay shall be determined through examination of one or more of the following: individual and family income; assets; employment status; family size; or availability of alternative sources of payment. A provider may determine inability to pay at the time care is rendered (Type A) or through subsequent efforts to collect sufficient information to make such a determination (Type B.)

The following are points of clarification for the definition of charity care:

1. Charity care may include services where the provider is obligated to provide them regardless of its ability to collect.

2. Charity care includes low-income patients who meet the provider's guidelines, who have partial coverage, e.g., no fault care insurance, secondary Medical Assistance or Medicare, but who are unable to pay the remainder of their bills. The guidelines are included as Appendix B.

3. Charity care may include low-income patients who may qualify for a public assistance program and meet the guidelines, but who do not complete the application process despite the provider's best efforts.

4. Charity care does not include contractual allowances – the difference between gross charges and payments received under contractual arrangements with insurance companies, Medicare and Medicaid, and health plans.

5. Charity care does not include bad debt.

6. Charity care does not include the cost of operating public programs, defined as the costs in excess of public program payments.

7. Charity care does not include cases which are paid through a charitable contribution, through a third party or provider related foundation.

Bad Debt

"Bad debt" expense represents the unpaid obligation for care provided to patients who have been determined to be able to pay, but have not demonstrated a willingness to do so.

The following are points of clarification for the definition of Bad Debt:

1. Bad Debt includes any unpaid patient responsibility which may include, but is not limited to, deductibles, co-insurance, co-payments and non-covered services

2. Patients are presumed to be able to pay until and unless information is obtained which indicates an inability on their part to do so.

Appendix B - Charity Care Guidelines

Charity Care of both types A and B will be based on the MinnesotaCare Family income guidelines (150% of FPG - $48 annual premium for family size of 1). There will be no patient asset determination necessary for the application of these guidelines. Any services rendered to individuals with annual incomes below these guidelines will be considered Charity Care. These guidelines will be updated whenever the MinnesotaCare guidelines are changed.

Family Size	*Annual Income*	*Monthly Income*
1	$12,360	$1,030
2	$16,590	$1,383
3	$20,820	$1,735
4	$25,050	$2,088
5	$29,280	$2,440
6	$33,510	$2,793
7	$37,740	$3,145
8	$41,976	$3,498
9	$46,200	$3,850
10	$50,436	$4,203

Endnotes:

1999 Minnesota Laws, Chapter 245, Article 4, Section 105.

Baxter R.J., and R.E. Mechanic. (1997) "The Status of Local Health Care Safety Nets," Health Affairs, 16(4): 7-23.

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For more information, contact:
Health Economics Program
Minnesota Department of Health
121 East Seventh Place
PO Box 64975
St. Paul, Minnesota 55164-0975
Phone: (651) 282-6367
Fax: (651) 282-5628
TDD: (651) 215-8980

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