
The Challenges Facing Safety-Net Hospitals in Pennsylvania

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The Challenges Facing Safety-Net Hospitals in Pennsylvania

Executive Summary

Today, Pennsylvania's safety-net hospitals face enormous challenges – challenges to their financial viability, challenges to their existence, and challenges to their ability to continue fulfilling their mission of caring for the poor and the disadvantaged as well as their communities as a whole.

In the absence of the kind of public hospital system found in most large states, poor and uninsured Pennsylvanians rely exclusively on a private health care safety net: forty-eight out of 192 private acute care hospitals that bear the largest share of responsibility for caring for the poor as measured by their service to Medical Assistance, Medicare SSI, and uninsured patients.

The ability of safety-net hospitals to function in the current reimbursement environment has been affected by several major changes in government health care reimbursement, including the introduction of prospective payment systems, such as DRGs, increased use of managed care, and reductions in various federal Medicare payments.

Safety-net hospitals are severely underpaid. Pennsylvania's Medical Assistance program pays them only eighty cents on the dollar for their costs, and these hospitals proportionally treat three times as many Medical Assistance recipients as non-safety-net hospitals and serve two-thirds more uninsured patients. Safety-net hospitals cannot rely on private health insurers to cover the gap between their costs and what they receive from public payers since they treat fewer privately insured patients and those insurers pay only 104 percent of the cost of caring for their members, compared to 125 percent in 1992. As a result, safety-net hospitals see only ninety-two percent of their costs covered by patient revenue; non-safety-net hospitals receive ninety-seven percent. In 2000 alone, that amounted to a revenue shortfall of \$345 million – even after accounting for various supplemental payments that the state makes to these hospitals.

These hospitals can neither set their own prices nor control demand for services. They also are not traditional businesses functioning in a traditional market: they serve communities with higher proportions of low-income, uninsured, and underinsured residents.

Safety-net hospitals cannot manage their way out of this problem because ultimately, it is a revenue problem, not an expense problem (a recent study performed for the General Assembly found Pennsylvania hospitals to be among the most efficient in the nation). As long as a situation exists in which safety-net hospitals are expected to absorb significant losses from treating low-income patients, some hospitals will constantly battle insolvency and others will probably close. The financial challenges of providing health care to the low-income patients they leave behind, however, will not go away but will simply shift to other hospitals.

In the end, hospitals are businesses, and no business can operate indefinitely without enough revenue to cover its costs. A number of safety-net hospitals in Pennsylvania have closed in the last decade, and without a better approach by the state, more will close in the future. In the meantime, Pennsylvania is jeopardizing its private safety-net hospitals in a way that will affect the disadvantaged who count on those hospitals as well as insured Pennsylvanians who live in or near areas where safety-net hospitals are located. Addressing these problems calls for timely and effective action by state government working in partnership with its health care safety net to assure access to care for all Pennsylvanians.

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Poor, uninsured, and disadvantaged Pennsylvanians rely to a significant degree on the state's health care safety net for medical services. The health care safety net in Pennsylvania today consists, in large part, of the twenty-five percent of the state's hospitals that bear the largest share of responsibility for caring for the poor as measured by the combined proportion of care they provide to Medical Assistance, Medicare SSI, and uninsured patients. These three factors – Medical Assistance, Medicare SSI, and uncompensated care – constitute what is known as a "low-income variable," and the health care safety net in Pennsylvania today consists of the twenty-five percent of the state's hospitals with the highest low-income variables.

Pennsylvania's safety-net hospitals – forty-eight of the state's 192 privately owned hospitals – are located throughout the commonwealth in both urban and rural areas. They are large and small, teaching and non-teaching. They share the following common characteristics:

- they serve an especially large proportion of poor patients;
- they have a distinctive payer mix with a particularly large portion of payers that reimburse them for far less than the cost of the services they provide;
- they have held their growth in expenses per patient day to a significantly lower level than non-safety-net hospitals; and
- they have a significantly lower ratio of total assets to total liabilities than non-safety-net hospitals.

Together, these qualities pose enormous financial challenges to safety-net hospitals. On one level, they threaten their very financial viability; on another, they threaten their ability to compete for patients; and on another, they threaten their ability to pay for the improvements they need to continue providing high-quality health care services.

In this paper, we will examine the challenges that face Pennsylvania's safety-net hospitals today, including:

- changes in government health care reimbursement practices and policies;
- a poor payer mix;

- an inability to invest in patient care, equipment, and capital improvements at the same rate as other hospitals;
- the imperfections of the health care market and the lessening of the role of health insurers in the health care safety net; and
- the inadequacy of the Commonwealth of Pennsylvania's response to these challenges.

Challenge Number One:
Changes in Government Health Care Reimbursement

The past two decades have witnessed significant efforts by government at both the state and federal levels to reduce their health care expenditures. Health care costs have historically risen at a faster rate than overall inflation, but beginning in the 1980s, this growth became increasingly dramatic. In response, government took a number of steps to reduce its health care expenditures – or at least reduce the rate of growth of those expenditures. Among the steps it took are:

- the introduction of prospective payment systems, such as DRGs, in Medicare and Medicaid;
- increased use of managed care, such as HMOs, in Medicare and especially in Medicaid;
- reductions in Medicare disproportionate share and other Medicare payments; and
- repeal of the Boren Amendment, a federal law that required states to reimburse health care providers adequately for the care they provide to Medicaid recipients.

These changes have affected all hospitals, but they have had an especially significant impact on safety-net hospitals because safety-net hospitals receive a far larger proportion of their revenue from government sources than non-safety-net hospitals. All of these changes have had a detrimental effect on safety-net hospitals and have made it more difficult for them to function in the current reimbursement environment.

Challenge Number Two: *A Poor Payer Mix*

By definition, safety-net hospitals serve more poor and disadvantaged patients than other hospitals. This can be illustrated by comparing the payer mix of safety-net and non-safety-net hospitals in Pennsylvania.¹

Exhibit 1 Payer Mix Comparisons of Safety-Net Hospitals and Non-Safety-Net Hospitals

Payer Category	Safety-Net % of Net Revenue	Non-Safety-Net % of Net Revenue
Private insurance	38.97	43.63
Medicare	37.30	46.90
Medical Assistance	16.99	5.37
Uncompensated care	6.74	4.10

Payer mix, in turn, is important because not all payers reimburse providers with the same degree of adequacy, as the following exhibit illustrates.²

Exhibit 2 Payment-to-Cost Ratio by Type of Payer

Payer Category	Payment-to-Cost Ratio
Private insurance	104.23%
Medicare	100.24%
Medical Assistance	80.12%
Uncompensated care	3.00%

In other words, private insurers pay hospitals slightly more than the actual costs that hospitals incur treating their members, so the more privately insured patients a hospital treats, the more money the hospital makes – and the more resources it has to offset expected losses from inadequate or non-payers. Medicare is virtually a wash: it covers patient care costs, but no more, no less. Medical Assistance, on the other hand, poses an enormous challenge to all hospitals: on average, for every dollar that hospitals spend treating Medical Assistance recipients in Pennsylvania today, they receive only eighty cents in return, losing twenty cents in the process. The state, in essence, requires hospitals to give away some health care services. Consequently, the more Medical Assistance recipients a hospital treats, the more money it loses.

¹ The sorting of hospitals into “safety-net” and “non-safety-net” categories is based on low-income percentages calculated by the Pennsylvania Department of Public Welfare for use in the distribution of tobacco settlement funds. The revenue percentages are derived from data in the Pennsylvania Health Care Cost Containment Council’s *Hospital Financial Analysis for Fiscal Year 2000*.

² The Lewin Group, *An Analysis of Pennsylvania Medical Assistance Payments as it Relates to the Financial Health of Pennsylvania Hospitals*, prepared for the Pennsylvania Legislative Budget and Finance Committee, March 2001.

Clearly, this poses the greatest challenge for Pennsylvania’s safety-net hospitals, which proportionally serve more than three times as many Medical Assistance recipients as non-safety-net hospitals. Compounding this challenge is uncompensated care: safety-net hospitals proportionally serve sixty-four percent more uninsured patients than their non-safety-net counterparts.

The cumulative effect of this inferior payer mix is considerable.³

**Exhibit 3
Payer Mix Effect on Covering Hospital Costs**

Payer Category	Safety-Net Hospitals		Non-Safety-Net Hospitals	
	% of Net Revenue	% Contribution to Cost	% of Net Revenue	% Contribution to Cost
Private insurance	38.97	40.61	43.63	45.48
Medicare	37.30	37.39	46.90	47.01
Medical Assistance	16.99	13.61	5.37	4.30
Uncompensated care	6.74	0.20	4.10	0.12
% of Hospital Costs Reimbursed		91.81		96.91

As this exhibit illustrates, non-safety-net hospitals, with their current mix of revenue sources, see nearly ninety-seven percent of their costs covered by their payers. Safety-net hospitals, on the other hand, see only ninety-two percent of their costs covered. This is a significant difference – and a significant problem for safety-net hospitals, putting them at a major financial – and, inevitably, an operational – disadvantage.

How great a problem is it? We will examine this more closely in the next section.

**Challenge Number Three:
*An Inability to Invest in Patient Care, Equipment, and Capital Improvements at the Same Rate as Other Hospitals***

Variations in payer mix among hospitals leads to some hospitals having more money than others. In Pennsylvania, non-safety-net hospitals have more money than safety-net hospitals. As a result, safety-net hospitals often must watch their pennies more carefully, offering fewer of the amenities that attract both privately insured patients and physicians who can bring them more privately insured patients and deferring maintenance and improvements that also can help attract more privately insured patients.

³ The sorting of hospitals into “safety-net” and “non-safety-net” categories is based on low-income percentages calculated by the Pennsylvania Department of Public Welfare for use in the distribution of tobacco settlement funds. The revenue percentages are derived from data in the Pennsylvania Health Care Cost Containment Council’s *Hospital Financial Analysis for Fiscal Year 2000*. The cost reimbursement according to payer was obtained from Lewin, *op. cit.*

With more money, non-safety-net hospitals are free to invest in improvements that will help them increase their advantages over safety-net hospitals.

A basic reality of health care economics is that hospitals must bring in more money than they spend on a daily basis if they are to survive. They need some kind of reserves so they can save money for bad times, replace capital, improve facilities, and upgrade technology. This is not, moreover, an expense problem: it is a revenue problem. Hospitals can and always should look for ways to manage more efficiently and reduce their operating expenses, but they cannot manage their way out of this problem because the problem is inadequate revenue, not inflated expenses. In fact, a study prepared for the Pennsylvania Legislative Budget and Finance Committee in March of 2001 concluded that Pennsylvania's hospitals rank second nationally in management efficiency.⁴ Consequently, in the long run, if the best that a hospital can do is pay its expenses and keep its doors open and its facility operating, it cannot remain viable and have a future.

The differences in how safety-net and non-safety-net hospitals operate as a result of their considerable disparity in financial resources can be seen in two key measures of hospital financial activity: spending per patient day and the ratio of hospital assets to liabilities.

Hospital Spending Per Day

Safety-net hospitals, even though their patients often come to them sicker than patients in average hospitals,⁵ have seen their patient care expenditures per day grow at a much slower rate than non-safety-net hospitals. Pennsylvania's safety-net hospitals increased their spending per patient day by twenty-two percent between 1996 and 2000. Non-safety-net hospitals, by contrast, increased their spending per patient day by twenty-eight percent during the same period – twenty-seven percent more than their safety-net counterparts. Thus, safety-net hospitals have underspent their non-safety-net counterparts by nearly \$1.4 billion during this period – a difference that cannot help but be visible within their walls.

While this ability to limit day-to-day cost increases is admirable and can be viewed, at least in part, as good management, it is not, by itself, enough to ensure a safety-net hospital's future. A hospital that tightens its belt effectively today may cover its payroll, keep the bond-rating agencies happy, and keep its doors open next week, next month, and perhaps even next year, but it also is probably putting off spending that it needs to undertake to keep its facilities in repair, invest in improvements, stay on the cutting edge of medical care, and attract as many privately insured patients as it can reasonably expect.

⁴ Lewin, *op cit*.

⁵ Hegner, Richard E. *The Health Care Safety Net in a Time of Fiscal Pressures*, National Health Policy Forum, April 2001.

One key area where underspending undoubtedly hurts safety-net hospitals is personnel. Staffing is a hospital's single biggest cost and all hospitals compete for personnel – especially for nurses. Hospitals so clearly lacking in revenue cannot possibly expect to compete successfully, on a continuing basis, for this scarce and costly resource without reducing potentially critical expenditures and possibly affecting operations in other areas.

The Ratio of Assets to Liabilities

If changes in spending per patient per day can be viewed as a short-term indicator of hospital spending trends, differences in hospital ratios of assets to liabilities can be viewed as a long-term extension of that short-term measure. Non-safety-net hospitals have a 2.02-to-one ratio of total assets to total liabilities; this means they have \$2.02 in assets available for every one dollar in obligations. Their safety-net counterparts, on the other hand, have an average ratio of total assets to total liabilities of only 1.28 to one.⁶ The lower assets-to-liabilities ratio of safety-net hospitals makes it more difficult for them to borrow money and, consequently, makes it more difficult for them to replace capital and make upgrades and improvements that ensure their ability to provide high-quality care and attract patients.

The Impact of These Spending Differences

When some hospitals are able to spend more per patient per day and borrow money more easily to invest in equipment and facility improvements than others, patients and visitors can see and feel the differences. In some hospitals, patients lay on better sheets, eat better food off better plates, and have more nurses on hand to care for them. They are treated by physicians who choose to practice at hospitals that upgrade their facilities at their request, provide more comfortable waiting areas for their patients, and offer a wider choice of medical supplies and surgical instruments. As a result, these hospitals are more likely to attract patients with private insurance – insurance on which hospitals make money, and which affords them the opportunity to make such improvements and enables them to offset their losses from serving Medical Assistance and uninsured patients. This cycle then continues and perpetuates itself.

The outcome for safety-net hospitals is not nearly as desirable. Safety-net hospitals need opportunities to compensate for the financial shortfalls they suffer because they serve so many Medical Assistance and uninsured patients. The best opportunity, in theory, is to attract privately insured patients, but in truth, safety-net hospitals generally have relatively few genuine opportunities to compete with non-safety-net hospitals for

⁶ Based on Pennsylvania Medicaid cost reports for 1995-1996.

insured patients. Poor people are not evenly distributed throughout Pennsylvania: instead, they are generally concentrated in specific areas. Consequently, safety-net hospitals are safety-net hospitals because of where they are located and because a significant proportion of the residents of the low-income communities they serve are underinsured, insured by Medical Assistance, or not insured at all. In the end, safety-net hospitals do not compete with non-safety-net hospitals for patients: they compete for survival against market forces, including declining reimbursement from public and private payers, that continually undermine their financial viability – and they cannot be competitive if they must give away their services.

As a result of these forces, safety-net hospitals are increasingly unlikely to be able to find effective ways to offset the financial losses they incur when they care for Medical Assistance patients, for whom they are reimbursed only eighty cents on the dollar, and for uninsured patients, for whom they are not reimbursed at all. And because safety-net hospitals serve so many more Medical Assistance and uninsured patients than other hospitals, the financial hole in which they find themselves only grows deeper: the hospital playing field grows increasingly uneven with every year that passes without a solution to this problem.

Challenge Number Four:

The Imperfections of the Health Care Market and the Abandonment of the Health Care Safety Net by Health Insurers

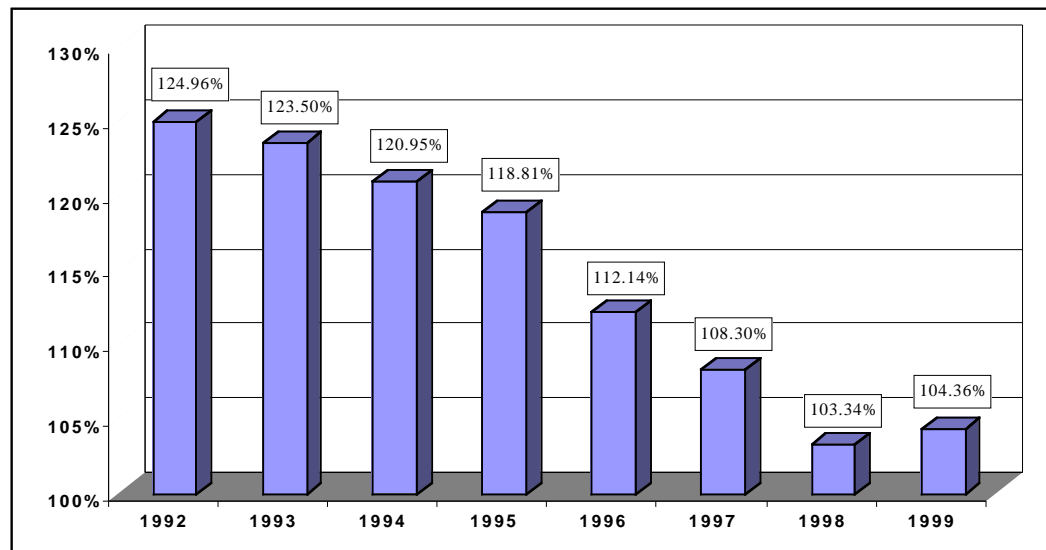
Historically, health insurers were part of the health care safety net, but over the past twenty years or so they have increasingly stepped back from this role, leaving greater responsibility to hospitals in general and to safety-net hospitals in particular. Health insurers have, in effect, forced safety-net hospitals into the role of insurers, responsible for finding their own way to cover the losses they suffer when they care for large proportions of Medical Assistance and uninsured patients.

In the past, more generous private insurance payments helped hospitals cover the losses they incurred treating publicly insured and uninsured patients; this is known as cost-shifting. As health care costs rose in the 1980s and especially in the 1990s, however, private insurers found themselves under growing pressure from their customers – mostly, businesses that provide health insurance for their employees – to keep their insurance premiums low, or at least to keep the increases in those premiums as small as possible. In response, health insurers stepped back from their traditional role of helping hospitals cover their losses from serving underinsured and uninsured patients and introduced and promoted new health insurance products, such as managed care plans, that were designed to drive down health care costs and force hospitals to compete with both their own past cost structure, through prospective payment systems and rates negotiated with private insurers, and with one another. The following exhibit shows the declining

contribution of private insurers to the health care safety net in Pennsylvania in recent years.⁷

Exhibit 4

Trend of the Payment-to-Cost Ratio for Private Insurers in Pennsylvania



In parts of Pennsylvania that are dominated by just a few health insurers, hospitals have had little choice but to bow to the wishes of those insurers or risk being excluded from their provider networks. Under such circumstances, cost-shifting has become increasingly difficult and hospitals with large proportions of Medical Assistance and uninsured patients find it more difficult to price their services competitively when they vie for managed care contracts because they need to find ways to compensate for their enormous Medical Assistance and uninsured patient losses.

Difficulty providing care at costs that health insurers are willing to pay is not a matter of lack of efficiency or management ability within the Pennsylvania hospital industry, either: to the contrary, a March 2001 report prepared for the Pennsylvania Legislative Budget and Finance Committee by the Lewin Group, entitled *An Analysis of Pennsylvania Medical Assistance Payments as it Relates to the Financial Health of Pennsylvania Hospitals*, found that Pennsylvania's hospitals are, as a group, among the most efficient in the country. Over the years, virtually all of Pennsylvania's hospitals – safety-net and others – have proven adept at managing and driving down their costs.

What they cannot do, however, is overcome some of the basic realities of the health care and hospital markets and industries. The key to hospital financial performance, as we have seen, is payer mix: payer mix drives all key aspects of that financial performance. When individual hospitals are unable to alter their payer mix and

⁷ Lewin, page 80.

increase revenue, this does not necessarily signify their shortcomings in a competitive market. Instead, it may only reflect some of the key imperfections inherent in that market.

- *Most businesses can set their own prices; hospitals, except in very minor and marginal ways, cannot.* For the most part, hospitals must accept whatever insurers are willing to pay them. Hospitals that care for larger proportions of poor patients, moreover, cannot negotiate higher payments than hospitals that treat fewer poor patients. While there is some room for negotiation, it is marginal in most cases. Hospitals have virtually no voice in setting Medicare and Medical Assistance payments; those decisions are made by government, with relatively little consultation with the hospital industry.
- *Most businesses can pick and choose their customers; hospitals are not traditional businesses, and safety-net hospitals have chosen to serve communities with higher proportions of low-income, uninsured, and underinsured residents.* For the most part, hospitals serve the geographic communities in which they are located. Some of those communities are financially stronger than others, some have more elderly residents insured by Medicare, some have more disadvantaged residents insured by Medical Assistance, and some have more poor residents with no health insurance at all. But once they decide on their location, hospitals cannot pick and choose their customers: they must treat whomever comes through their doors, regardless of who – if anyone – is paying for their care. Safety-net hospitals, moreover, are community resources – and they consciously choose to view themselves that way. They are mission-driven institutions that choose to remain in low-income communities where they know their services are needed.
- *Most businesses can exercise some degree of control over the demand for their services; hospitals cannot.* Hospitals cannot change where the poor and disadvantaged live, cannot prevent them from suffering illnesses and injuries, cannot eliminate money-losing services for which there is meaningful demand, and cannot turn their backs on people who turn to them for care. Safety-net

hospitals recognize and understand all of this – and they choose to remain where their services are needed.

Challenge Number Five:
The Inadequacy of the Commonwealth of Pennsylvania’s Response to These Challenges

The Commonwealth of Pennsylvania recognizes – albeit to a limited degree – the special role that safety-net hospitals play in caring for its poor and disadvantaged residents. Like the federal government, it provides supplemental payments to these hospitals to help them pay for the additional services they provide to individuals who do not have private health insurance. Beside funding and administering the Medical Assistance program, it supplements Medical Assistance reimbursement with Medicaid disproportionate share payments, Medicaid outpatient disproportionate share payments, and money from the Community Access Fund. Collectively, these programs provide a considerable sum to help hospitals with the cost of providing care to the uninsured and under-insured. In addition, the state pays some portion of its share of the cost of medical education.

Despite this, the revenue gap between safety-net hospitals and non-safety-net hospitals is astounding. In 2000, Pennsylvania’s forty-eight safety-net hospitals, as noted previously, receiving reimbursement for just ninety-two percent of their costs, had combined total revenue of \$6.2 billion. This means that their total, cumulative competitive disadvantage, in comparison to non-safety-net hospitals, was \$345.2 million for that year alone. In other words, these forty-eight hospitals, serving the poorest Pennsylvanians, would have needed \$345.2 million in additional revenue – *even after the commonwealth’s various efforts to supplement their revenue to help them fulfill their role in the state health care safety net* – to bring them up to the ninety-seven percent level of overall reimbursement enjoyed by non-safety-net hospitals.⁸

Saddled with this additional financial burden, safety-net hospitals must find their own way to make up for this shortfall so they can meet their financial obligations, serve their patients, upgrade their medical equipment and facilities, and continue to compete for patients in what are, in some cases, highly competitive markets. Ultimately, safety-net hospitals cannot manage their way out of this problem because in the end, it is a revenue problem, not an expense problem, and their opportunities for increasing their revenue are limited and marginal.

⁸ This figure does not include tobacco settlement funds, since there were no tobacco payments for uncompensated care in 2000. In 2002, less than \$45 million was distributed to safety-net hospitals under this program.

The Curious Case of Hospital Margins

Interestingly, one area in which the difference in resources among hospitals does not manifest itself in a quantifiable manner is hospital operating margins. Generally speaking, the operating margins of Pennsylvania's safety-net hospitals are more or less the same as those of non-safety-net hospitals.

This curious result, which defies logical, intuitive thinking, most likely reflects the response of safety-net hospitals to the financial realities they must deal with every day. Because safety-net hospitals need to watch every penny to ensure their ability to cover their payrolls and preserve their bond ratings, they appear to manage their money more carefully than other hospitals; they also most likely defer needed maintenance and major capital improvements. Non-safety-net hospitals appear more likely to spend up to a level of income that they know is safe and secure and function with smaller operating margins – but do so comfortably amid the expectation that future revenue will certainly cover their costs and continue to make such spending possible in the future.

Seemingly similar entities with different levels of resources can easily have similar operating margins while functioning, on a daily basis, nothing like the other. Consider the analogy of two families: an upper-income family and a working-class family. Both can have negative margins, no margins, or modest margins and yet live drastically different lives.

The upper-income family, secure with the knowledge that tomorrow's income will pay for today's expenditures, can take large mortgages on new or even second homes and make extensive use of credit to purchase cars and take expensive vacations. In the end, this family's spending may lead to a negative margin for the year, but it has lived life well and improved its quality of life through its choices. The working-class family, on the other hand, might manage its money effectively but need to make time payments on a new refrigerator so it can keep fresh food in the house after its old refrigerator stopped working. This family, too, would have a negative margin, but it would be running this negative margin only to maintain its standard of living, not to improve it.

The two families can have no operating margins and also have different levels of change in their lives. The upper-income family could have a significant amount of money left after paying its living expenses for the year and indulge itself in one or two major luxuries, knowing that by the end of the year, it will have paid for these luxuries and have no debt but also no new savings. The working-class family could develop and adhere to a strict budget that uses every penny it has to cover daily living expenses, but with no luxuries. The first family gets additional pleasure, the second family does not, but at the end of the year, they have identical margins.

Finally, both families could have modest, positive margins and again have vastly different living experiences. The upper-income family could cover all of its living expenses, enjoy some of the better things in life, and still end the year with modest new

savings – a positive operating margin. The working-class family, on the other hand, might decide not to replace its second car and instead have one of its breadwinners use public transportation to go to work, doing so with the expectation that this will enable it to save some money and begin to create a cushion in anticipation of the need to address a roof that is now twelve years old and will soon need replacement. This family, too, would end the year with new, modest savings – its positive margin – but will have experienced a reduction in the quality of its life because it no longer has the second automobile.

Returning to hospitals, the operating margins that safety-net hospitals experience in Pennsylvania today suggest that they are deferring paying for improvements in their quality of life – their facilities, their equipment, their staff – in exchange for ensuring their ability to cover their payroll and keep their facilities in basic repair. Non-safety-net hospitals, with their more generous payer mixes, are in a position to spend more money on improvements without mortgaging their future and without sacrificing their ability to preserve a modest operating margin. If non-safety-net hospitals invested in assets at the same rate as safety-net hospitals – keeping in mind the wide disparity in the ratio of assets to liabilities among hospitals noted earlier – their operating margins most likely would be much higher than those of safety-net hospitals. Consequently, it would be misleading to look at hospital operating margins – as some policy-makers in the federal government have attempted to do – and draw conclusions about the true financial health of hospitals. Just as people tend to live up to or down to their income, hospitals manage their margins to reflect their means; those margins are not a measure of financial health.

The Implications for All Hospitals and All Health Care Consumers

In an ideal health care market, all participants would have control over matters such as price, demand, location, and payer mix – in other words, control over the key factors that determine their destinies. The health care market today, however, as we have seen, is not an ideal market.

In an ideal market, poor patients would be distributed evenly throughout the state and all hospitals would participate equally in caring for them. But again, the health care market is not an ideal market: the poor are not distributed evenly throughout the state and all hospitals do not share equally in caring for them. Instead, a core group of safety-net hospitals, because of where they are located and the mission they have chosen for themselves, care for a disproportionate share of these poor patients.

These safety-net hospitals, with their large proportions of Medical Assistance and uninsured patients, recognize that they cannot recoup their losses serving these patients by increasing their rates for privately insured patients because private insurers will not pay such increased fees: instead, they will send their members to hospitals with lower rates.

Ultimately, the uneven distribution of disadvantaged and poor patients in Pennsylvania is not an issue that can be managed at the individual hospital level; effective management practices cannot solve this problem because it is a revenue problem, not an expense problem, and it is a problem because the state, in essence, requires hospitals to give away services, and it requires some hospitals to give away such a high quantity of services that it jeopardizes their ability to continue operating. This problem, moreover, jeopardizes more than the existence of individual hospitals: it jeopardizes the entire health care system.

If the market functions in its normal manner and drives hospitals with inferior payer mixes out of business, this does not solve the broader problem of underpayment or non-payment for care because the poor, the uninsured, and the underinsured patients do not disappear along with the newly shuttered hospital: they simply turn to the nearest surviving hospital and take the financial challenges of providing for their care with them. Unless such patients are equally distributed among all surviving hospitals – an exceedingly unlikely occurrence – the result, over time, is likely to be similar: the new hospital will be overwhelmed with financial problems and eventually close.

With each such hospital closing, more than the poor are affected: all of the hospital's patients are affected. Patients whose insurers did not cause the financial problems – those served by private insurers and Medicare – lose their hospital as well. Rich and poor are affected, and they will continue to be affected, until the problem caused by an unequal distribution of poor patients in an imperfect market is satisfactorily addressed.

As long as hospitals cannot control demand for their services – including demand for free and discounted services – and as long as the poor are not evenly distributed throughout the state, the health care market will not be an ideal market and a market solution alone will not suffice. A public policy solution also is needed – but a public intervention that does not erode or jeopardize the capacity of the market to deliver the needed services.

Conclusion: The Consequences of Not Addressing This Problem

Hospitals are businesses, and mission-driven or not, non-profit or for-profit, no business can operate indefinitely without sufficient revenue to cover its costs. A number of safety-net hospitals throughout Pennsylvania have closed their doors in the last decade. More will probably do so in the coming years as well.

There is no indication that anything is happening that will change this. In fact, the opposite seems true: the trend appears more likely to get worse than to get better. The number of uninsured residents in Pennsylvania continues to increase, rising twenty-one percent between 1991 and 1999, and is likely to rise even more now during this time of economic uncertainty; the pressure on insurers to keep their premium increases to a

minimum continues; the federal government resists the efforts of some to enhance Medicare payments to safety-net hospitals and is actually considering reducing their adequacy; and the Commonwealth of Pennsylvania, already paying providers only eighty cents on the dollar for Medicaid services, now faces recession-related budget problems that make it highly unlikely that it will address the inadequacies of those payments in the foreseeable future and is aggressively pursuing the expansion of managed care in its Medical Assistance program. Under such a burden, Pennsylvania's health care safety net could very well collapse.

Other states – states comparable to Pennsylvania – do more to support their health care safety nets. New York, California, Texas, Ohio, and New Jersey all have public hospitals as the foundation of their health care safety nets, and they support their safety-net hospitals far more generously than Pennsylvania. According to the National Association of Public Hospitals and Health Systems, a significant amount of the funds for these public safety-net hospitals comes from local subsidies – funds over and above Medicare disproportionate share and state Medicaid disproportionate share payments. Pennsylvania, with no public hospital system, provides no such payments at all.

Pennsylvania's approach is jeopardizing the future of the state's safety-net hospitals, and that, in the end, will affect people – both the poor and disadvantaged who count on safety-net hospitals and those who have private insurance or Medicare but happen to live in areas where safety-net hospitals close because of this continuing financial shortfall. Those who need emergency care may find themselves precious minutes farther from the vital services they need. Entire rural communities could lose their hospitals and find themselves miles from accessible, quality care. The health care safety net – and other parts of the health care industry – could collapse in ways that would affect more than the poor and disadvantaged: it could affect thousands or even millions of Pennsylvanians who use that system.

One of the great challenges that the health care system poses today is that it often hides the signs of its problems very well: individual hospitals cover revenue gaps with a combination of lay-offs and increased fundraising; larger health care systems acquire smaller, struggling community hospitals amid pledges to bring improvements and efficiencies; and institutions move into and out of bankruptcy protection. These and other actions tend to be viewed by the public and policy-makers as separate and distinct rather than as part of a larger picture. They are not: they are the unmistakable signs of a health care system, and a health care safety net, that is greatly troubled today, and that calls for action now, before the signs of problems become too obvious to be overlooked any longer.

The Safety-Net Association of Pennsylvania

The Challenges Facing Safety-Net Hospitals in Pennsylvania was prepared by the Safety-Net Association of Pennsylvania. The Safety-Net Association of Pennsylvania represents the interests of private, acute-care hospitals that play the leading role in caring for the poor, the disadvantaged, and the uninsured residents of the commonwealth. Safety-net hospitals are the twenty-five percent of hospitals in Pennsylvania that care for the highest combined proportion of uninsured patients, Medical Assistance recipients, and Medicare SSI recipients and that therefore constitute the state's health care safety net. As a result of the patients they serve, safety-net hospitals face a significant, continuing, disproportionate challenge to their financial health. Today, there are forty-eight safety-net hospitals in Pennsylvania out of 192 acute-care hospitals in the state overall.

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For further information about the Safety-Net Association of Pennsylvania or the information presented in this report, or to request additional copies of this report, please contact Charles DeBrunner, president, at 717-234-6970 or charlie@debrunnerandassociates.com.