

One-quarter of the population in Miami-Dade County, Florida, lacks health insurance, a fraction well above the national average (about one-sixth of the nation's population is without health insurance). To address the problem of financing health care for the uninsured in Miami-Dade and elsewhere, the state of Florida in 1991 passed legislation allowing local jurisdictions to impose a surtax on sales. The legislation restricted the use of the proceeds of any Miami-Dade County surtax to support the activities of the county's sole public health-care facility, Jackson Memorial Hospital (JMH). Miami-Dade County voters approved the surtax, which has helped stabilize the financially troubled hospital. In the past ten years, JMH has grown and improved financially and is a leader in treating eye disorders and pediatric patients. Recently, advocates for better access to health care by the poor, along with representatives from other not-for-profit hospitals, have suggested that surtax revenues be distributed across a wider range of institutions. But do hospitals other than JMH provide uncompensated care, and at what level? And might the greater access to surtax-funded care at JMH be causing patients to pass up facilities much nearer to their homes and travel long distances for care?

WHO PROVIDES UNCOMPENSATED CARE?

Analysts of hospital finances typically recognize two types of uncompensated care: charity care, which includes cases for which the hospital knows on admission that it is unlikely to be compensated, and bad debt, which includes cases for which payment may have been expected but none was made. The 24 general acute-care hospitals in

Miami-Dade County provided \$404 million of charity care and incurred \$250 million of bad debt in 1999. The \$650 million in uncompensated charges represents \$281 million in costs of uncompensated hospital care provided to county residents.

Of JMH’s nearly \$714 million in operating costs, charity care accounts for 23 percent, and bad debt accounts for another 2 percent (see Figure S.1). This estimate, however, ignores the \$142 million received from the surtax. To the extent that JMH is being reimbursed by the taxpayers for providing charity care, the burden of that care on the hospital’s operating expenses would be reduced. In recent calculations, the Florida Hospital Association has arbitrarily assumed that half of the surtax proceeds are devoted to indigent care and half are used for other purposes. If the half for indigent care is subtracted from the costs of charity care, net charity-care costs total 13 percent of operating expenses. The surtax legislation was motivated, however, by a desire to support indigent care, and in all other Florida

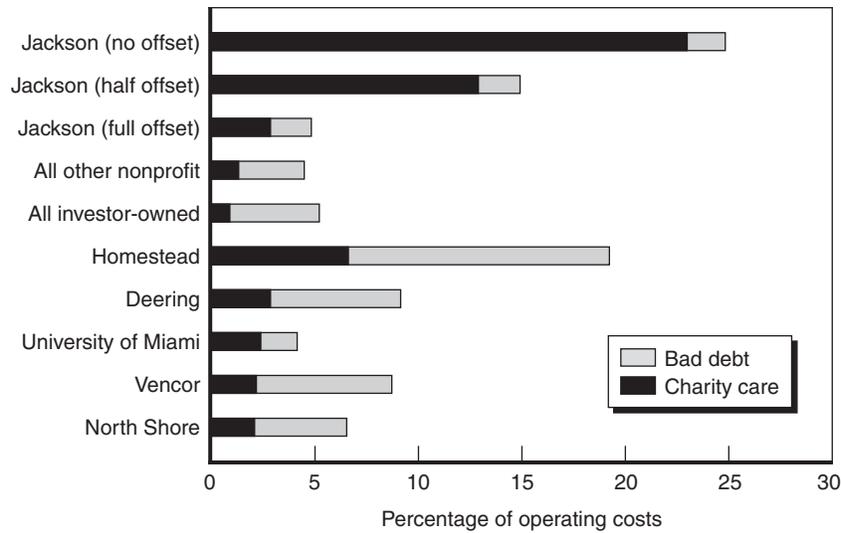


Figure S.1—Percentage of Operating Costs Used for Charity Care and Bad Debt at Selected Miami-Dade County Hospitals, 1999

counties it is restricted to that purpose. If all of JMH's surtax proceeds were regarded as supporting charity care, the costs for that care would be offset by the full amount of the surcharge. Charity care would then account for only 3 percent of JMH's operating expenses.

Regardless of how the surtax is used by JMH, charity care is a greater burden on operating expenses there than it is at the average not-for-profit or investor-owned hospital in Miami-Dade County. When bad debt is taken into account, however, the total burdens of uncompensated care are similar. Indeed, as a percentage of operating expenses, the burdens of charity care (and total uncompensated care) at some hospitals approach or even exceed those at JMH, but only if all surtax revenues are regarded as intended for indigent care.

This disagreement over the interpretation of the surtax legislation (i.e., how *much* of the proceeds were intended for indigent care) has caused a difference of opinion on whether and how the proceeds should be distributed. Some argue that if the surtax legislation was motivated by the need to support indigent care generally, the proceeds should be more widely allocated to offset the costs of that care. However, three arguments may be made against such claims: First, Florida's surtax legislation did not restrict the tax's use in Miami-Dade County to indigent care but did restrict it to JMH, so the law would have to be changed. Second, private not-for-profit hospitals should be returning some benefits to the community without receiving compensation, in return for their nonprofit status (of the hospitals other than Jackson shown in Figure S.1, only Homestead and the University of Miami Hospital and Clinics are nonprofit institutions). Third, the large bad-debt burdens at some hospitals may be due as much to bad fiscal management as they are to the need to write off care for patients who cannot afford to pay.

HOW FAR DO THE UNINSURED TRAVEL FOR CARE?

Is the greater availability of charity care at JMH (and the surtax offset permitting that availability) drawing uninsured patients away from hospitals closer to their homes? This is a question of some concern, since, other things equal, hospitalization near home is less burdensome to families, particularly poor families who may have to rely on public transportation.

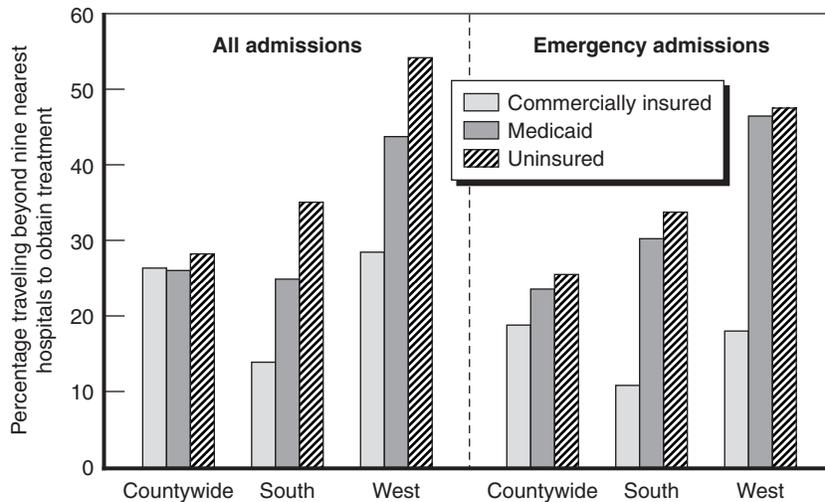


Figure S.2—Percentage of Adult Patients Traveling Beyond at Least Nine Hospitals to Obtain Treatment, Miami-Dade County, 1999

Across Miami-Dade County in 1999, approximately 40 percent of adult patients under the age of 65 were treated in the hospital nearest or second-nearest to their homes. There was little difference among commercially insured, Medicaid-insured, and uninsured patients.¹ Neither were there appreciable differences among these categories of patients in the percentage that traveled beyond at least the nine nearest hospitals to get treatment (see Figure S.2, first three bars). (Our travel analyses excluded patients traveling outside the county for care.)

Uninsured patients living farther from JMH, in the southern and western parts of the county, however, were more likely to travel beyond numerous closer hospitals to get care than were Medicaid patients, who were in turn more likely to travel beyond numerous

¹In Figure S.2, all differences between pairs of bars within three-bar sets are statistically significant at the 5 percent level or above, except for commercial versus Medicaid, countywide (all admissions).

hospitals than were the commercially insured.² Even among those seeking emergency care, Medicaid and uninsured patients were more likely to travel farther than were the commercially insured, despite a state law requiring all hospitals to treat any emergency patient. This difference was not due to the case-mix of Medicaid and uninsured patients. Even when we restricted our analysis to cardiac conditions (other than heart attack), the findings were the same.

Children were less likely than adults to be transported past many hospitals to get care, as shown in Figure S.3.³ However, those from the southern and western parts of the county who were transported farther were more likely to be uninsured than Medicaid-insured, and more likely to be Medicaid patients than commercially insured. Again, this finding held true even in emergencies.

Travel patterns are not necessarily the result of access limitations, however. They can reflect a patient's personal choice, recommendations by friends or family members, or the admitting privileges of the patient's physician. That is why we compared uninsured and insured persons, since any differences not related to insurance should average out across the large number of patients considered. It thus appears that patients who are not commercially insured, and particularly those without Medicaid, are being directed for care, either by their own volition or by the health care system, past numerous hospitals, even in emergency situations. Where are these patients going? When we look at the hospital destinations for those patients who travel beyond their local hospitals, JMH is the most frequent choice for uninsured and Medicaid patients. Commercially insured also go to JMH when they travel beyond the nine nearest hospitals for care, but they do so less frequently. Are more of the uninsured traveling to JMH because they feel they have greater access to the health-care

²We focus on the southern and western regions of the county, because residents there are unlikely to use hospitals outside of Miami-Dade County. Residents in northern Dade could easily cross into Broward County for hospital care, which would complicate a travel analysis.

³In Figure S.3, all differences between pairs of bars within three-bar sets are statistically significant at the 5 percent level or above, except for commercial versus uninsured and Medicaid versus uninsured, countywide (all admissions) and all comparisons, countywide (emergency admissions).

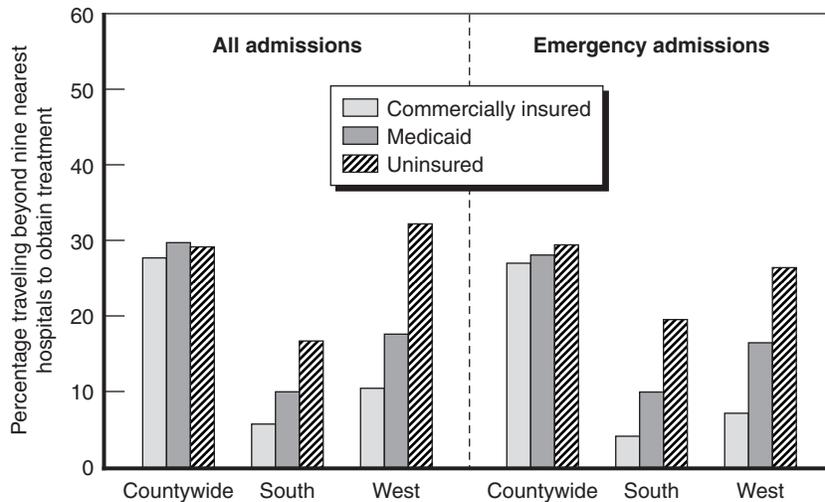


Figure S.3—Percentage of Pediatric Patients Traveling Beyond at Least Nine Hospitals to Obtain Treatment, Miami-Dade County, 1999

system there than they can get closer to their homes? That is an interesting question that deserves further investigation.

RECOMMENDATIONS

Our analysis suggests the following issues and policy options that might be considered by policymakers, stakeholders, and community members in Miami-Dade County.

Reduce the number of uninsured persons in the county.

- Increase the enrollment of persons into Medicaid and other state and federal programs. Much effort is currently being devoted to increasing enrollment for children.
- Expand Medicaid and other public programs to include more adults. Many uninsured adults are being hospitalized, and their lack of health insurance affects their geographic access to care. Undoubtedly, some of the patients whose care is uncompensated are eligible under the current Medicaid program or under allowed expansions. Some level of compensation is preferable to no compensation.

Revisit the financing of health care for the indigent.

- Reconsider the intent of the half-penny sales tax and, in light of this analysis and any other pertinent facts, either endorse its current allocation or seek ways to alter it. The \$142 million in surtax is insufficient to cover the cost of uncompensated care provided by the county's 24 acute-care hospitals.
- Explore ways to increase the distribution of care and funds for care for the uninsured throughout the county. Policymakers should consider having the county provide or subsidize health insurance that would enable patients to obtain care wherever they choose, with the assurance that reimbursement will follow.

Consider the role of community benefits in the county and their impact on the provision of indigent care.

- Clarify the community's sentiment about specifying levels of community benefits that nonprofit agencies must provide. Does the county want to rely on the quid pro quo of tax exemption and provision of charity care to maintain the safety net? Miami-Dade County should consider explicitly detailing the level of community benefits it expects from nonprofit entities. How much charity care could be provided through a community benefits program?

Monitor the dynamics of hospital care provision in the county and publicize any changes.

- During the period in which these analyses were conducted, the Public Health Trust and the Jackson Health System purchased Deering Hospital, located in South Miami-Dade. This purchase will bring this hospital into the county system. Assuming that patients are well informed of this change, Deering should provide some relief for uninsured patients who currently travel long distances to JMH. It may also provide relief to Homestead Hospital, also located in the South Dade region, which provides a high level of uncompensated care. When data become available, analysis of the travel patterns in South Dade will show whether the introduction of another public hospital brings the expected relief to Homestead Hospital and to uninsured patients.