NATIONAL ASSOCIATION OF URBAN HOSPITALS

Private Safety-Net Hospitals Caring for Needy Communities

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Latest Health Care Reform Financing Deal Could Devastate Private Urban Safety-Net Hospitals

(Washington, D.C.) The agreement reached yesterday by the Obama administration, the Senate Finance Committee, and several hospital groups to reduce federal health care spending as a means of helping to pay for health care reform could deal a potentially devastating blow to the nation's private, non-profit urban safety-net hospitals and the urban health care safety net.

Under the reported terms of the deal, hospitals would relinquish $155 billion in Medicare and Medicaid payments over the next 10 years to help pay for health care reform.

Approximately $50 billion of the total would come in the form of reduced disproportionate share hospital (DSH) payments – payments made by Medicare and Medicaid to hospitals that care for especially high proportions of low-income and uninsured patients. Hospitals must meet specific state and federal criteria to qualify for DSH payments, but under the reported deal, they could see those DSH payments fall 40 percent during years six through ten under a reformed health care system.

"Funding health care reform on the backs of the very providers that play the biggest role in caring for low-income and uninsured Americans is just plain wrong, and it's unconscionable," said Ellen Kugler, executive director of the National Association of Urban Hospitals (NAUH). "Even contemplating doing so is based on a fundamentally flawed premise: that health care reform will leave this country with no uninsured people, thereby eventually eliminating the need for DSH payments."

While universal coverage would be the ideal outcome of reform, Kugler notes, that ideal is unlikely.

"Health care reform is not going to reach illegal residents. It's not going to reach many people with chronic behavioral health issues. It's not going to reach many homeless people. It's not going to reach many young people who think they don't need health insurance," Kugler explained. "We've learned this from the health care reform experiment in Massachusetts: no matter what you do, no matter how hard you try, no matter how skillfully you think you've crafted the legislation, some people are still going to fall through the cracks. We all know that health care reform isn't going to reach everyone. We've seen estimates that the number of Americans who won't be helped by health care reform could be as high as 20 million or even 30 million people."

When such post-reform uninsured individuals need health care, Kugler maintains, they will continue to seek care – often, from private, non-profit urban safety-net hospitals.

"These are the patients we treat now, and they will continue to turn to us for care when they are sick or injured. That's our job, and we're going to care for them, but this agreement assumes that such individuals will all but disappear. We wish that were true, but we know it won't be."

A better approach, according to Kugler, can be found in the reform legislation proposed jointly by the House Energy and Commerce, Ways and Means, and Education and Labor committees.

"Those committees understand that reform will most likely reduce the number of uninsured patients we treat," she explains. "But they acknowledge that it's impossible to project how much those numbers will fall. Instead of assuming numbers that may or may not be accurate, their bill calls for implementing reform, creating ample opportunity for people to get insurance, and then quantifying – instead of guessing – the continuing financial burden of treating uninsured patients for safety-net hospitals. Then and only then would they make accurate, data-based adjustments in their Medicare and Medicaid DSH payments.

"The House proposal calls for a 'ready-aim-fire' approach. This new agreement is more like 'ready-shoot-aim.'"

Failing to aim before shooting, Kugler adds, could have dire consequences.

"Cutting Medicare and Medicaid DSH payments by 40 percent would jeopardize the delivery of care in many urban communities. These hospitals are absolutely dependent on Medicare and Medicaid DSH payments for their survival. We believe some hospitals would be so seriously harmed by such cuts that they could end up closing. Many that remain open may have to cut back severely on services. The impact would most likely be greatest in inner-city communities, but it would by no means be limited to those communities."

Kugler credits the hospital groups involved for working cooperatively with the administration and Congress to find ways to save money and help pay for health care reform.

"We appreciate that they're looking for solutions, but this happens to be a particularly bad solution. They need to rethink this approach – or they need to give more serious thought to how the surviving hospitals and the federal government will pick up the slack when this approach leaves the urban health care safety net in tatters."

The National Association of Urban Hospitals advocates for adequate recognition and financing of private, non-profit, urban safety-net hospitals that serve America's needy urban communities. These private, urban safety-net hospitals differ from other hospitals in a number of key ways: they serve communities whose residents are much older and poorer; they are far more reliant on Medicare and Medicaid for revenue; they provide far more uncompensated care; and unlike public safety-net hospitals, they have no statutory entitlement to local or state funds to underwrite their costs. NAUH's role is to ensure that when federal officials make policy decisions, they understand the implications of those decisions for these distinctive private, urban safety-net hospitals. NAUH pursues its mission through a combination of vigorous, informed advocacy, data-driven positions, and an energetic membership with a clear stake in the outcome of public policy debates.

Additional information about NAUH – including detailed correspondence with congressional committees on how health care reform can be achieved without jeopardizing the urban health care safety net – can be found on its web site: www.nauh.org.

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