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Larger City Subsidy Saves Public Hospitals, For Now

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SUMMARY

NEW YORK CITY HAS PROVIDED FINANCIAL SUPPORT to the Health and Hospitals Corporation since its creation as a public benefit corporation in 1970. That support has been essential to the corporation's mission of providing health services to New Yorkers regardless of their ability to pay.

Over time, the city has developed a complex, frequently shifting fiscal relationship with the hospitals corporation. Over the past few years, changes in state Medicaid policy have allowed the city to provide more supplemental Medicaid payments to the hospital agency, which are matched dollar for dollar by the federal government. The resulting improvement in the agency's financial condition has allowed the city to greatly scale back the other channels through which it had previously supported the Health and Hospitals Corporation.

IBO finds that the net effect of the changes in Medicaid payments and other funding streams was a significant increase in the city subsidy to the public hospitals system:

- From 1999–2004, the average annual subsidy was $290 million
- For 2005–2008, the subsidy rose to an average of nearly $1.2 billion a year (including the federal match triggered by the city's additional Medicaid payments).

This increase has allowed the corporation to build a cash balance of more than $1 billion. The hospitals coporation is projected to spend down that balance over the next four to five years, however, again putting the corporation in a challenging financial position. Absent major changes in state or federal law, the Health and Hospitals Corporation's current funding will be insufficient after 2012, and another change in the fiscal relationship between the city and public hospital system will be necessary.

New York City
Independent Budget Office
Ronnie Lowenstein, Director
George Sweeting, Deputy Director
110 William St., 14th floor
New York, NY 10038
Tel. (212) 442-0632
Fax (212) 442-0350
e-mail: iboenews@ibo.nyc.ny.us
http://www.ibo.nyc.ny.us

BACKGROUND AND HISTORY

The Health and Hospitals Corporation (HHC) is the nation's largest municipal hospital system, consisting of 11 acute care hospitals, six diagnostic and treatment centers, and four long-term care facilities located throughout the five boroughs of New York City. HHC also operates 80 community-based health clinics; Home and Health Care, a certified home health agency; and MetroPlus, a managed care plan. HHC accounts for approximately one million emergency room and five million outpatient visits annually, approximately a third of such visits in New York City.

HHC is the successor to the municipal Hospitals Department, which was established in 1929 to provide health care to all residents who were unable to obtain care from private providers because of poverty, location or discrimination. (Individual hospitals in the system are older–the oldest, Bellevue, was established in 1736.) By the 1960s, there were widespread concerns about the quality and efficiency of the public hospital system. In response, the state passed legislation in 1969 creating HHC as a public benefit corporation governed by a 16-member board of directors, and in 1970 the corporation came into being in its present form. The hospital facilities continue to be owned by the city and are leased to HHC for an annual rent of $1.00.[1]

While the creation of Medicaid and Medicare in 1965 had reduced the cost to the city of the public hospital system, it was clear that additional monies would be needed for HHC to be sustainable. The city planned to continue providing a lump-sum appropriation to HHC in recognition of the financial challenges of serving uninsured and Medicaid patients. That subsidy was set at $175 million for the first year and was to be adjusted annually for increases in health care costs and for changes in programs. (This requirement remains in effect but is understood to be satisfied by the city's mandated Medicaid payments.) The city retained ownership of HHC facilities and over the years has paid for capital improvements.

HHC'S FISCAL RELATIONSHIP WITH THE CITY

There are five main channels through which funds flow from the city to HHC:

1) Mandated Medicaid Payments. New York State requires that all counties and New York City pay for a share of the Medicaid expenses incurred locally. As recently as 2005, the city was required to pay 25 percent of acute care costs and 10 percent of long-term care costs. But beginning in 2006, growth in the local share of Medicaid costs is capped at a set percentage of 2005 expenditures, with any growth in costs above that level borne by the state. In 2005, approximately 18 percent of city Medicaid expenditures were for services provided at HHC facilities.

2) Supplemental Medicaid Payments. In addition to the Medicaid payments made for services to particular patients, HHC hospitals receive additional lump-sum payments through Medicaid's Disproportionate Share Hospital (DSH) and Upper Payment Limit (UPL) programs. While the state formally makes these payments, the funds come from the city, with a one-for-one federal match. (See sidebar, Understanding "DSH" and "UPL.")

3) City as Contractor for HHC Services. The city contracts with HHC to carry out services for a variety of agencies including the medical treatment of prisoners and uniformed services personnel and the operation of AIDS programs and child health clinics. In 2007, city contracts with HHC totaled $124 million. Because the city pays for these services fully, these contracts do not represent a subsidy to HHC.

4) City as Buyer on HHC's Behalf. The city uses its superior purchasing power on HHC's behalf, with HHC fully or partially reimbursing the city for the expenses. The city pays HHC's energy costs and retiree health benefit expenses; it also pays for HHC's medical malpractice settlements and for the legal personnel and contracts to defend these cases. This arrangement means HHC does not have to purchase malpractice liability insurance. Also, the city uses its higher credit rating to issue bonds on HHC's behalf and pays for debt service. Currently, HHC fully reimburses the city for all spending on its behalf (except a modest amount for legal services), so there is no net payment in this category. In the past, however, HHC did not reimburse the city for spending on debt service and, before that, malpractice settlements; if the city needed to increase its financial support for HHC in the future, ending the corporation's reimbursements for debt service payments would be a likely approach.

5) Unrestricted City Subsidy. Finally, until this year the city has provided an unrestricted subsidy in acknowledgement that the payments associated with particular services and patients do not cover the full costs of the corporation's safety net role and are not sufficient to meet its financial needs.

In 1992, faced with public concerns about the quality of care at HHC, Mayor David Dinkins convened a commission to make recommendations on HHC's future. Among other findings, that commission suggested that the uncertainty surrounding the city's annual unrestricted subsidy payment hindered HHC's ability to make long-term financial

plans. A resulting Memorandum of Agreement required that the city increase its subsidy to HHC when the corporation's deficits reached a pre-defined share of annual expenses.

This agreement ended, however, when Mayor Rudolph Giuliani took office two years later. The new administration initially proposed privatizing a number of HHC facilities. When HHC faced large budget deficits after Giuliani's election, the city chose not to fund those deficits and lowered its unrestricted subsidy, leading HHC to reorganize and make significant budget cuts. In its early years especially, the Giuliani Administration took the view that HHC was an independent entity that should be self-supporting beyond a modest fixed subsidy, while both prior and subsequent administrations have seen HHC as an integral part of city government whose funding depends on its financial needs.

RECENT CHANGES

Under the Bloomberg Administration, there have been two major shifts in the financial relationship between the city and HHC. First, in 2002, the city stopped paying for HHC's medical malpractice settlements and began paying its debt service instead (all budget references are in terms of the fiscal year). Second, in 2006, changes in state Medicaid policy allowed the city to substantially increase its supplemental Medicaid payments to HHC. (The payments in 2006 and 2007 were exceptionally large because they included retroactive payments for earlier years.) The result of these changes is that HHC is now in better financial condition than at any point in its recent history.

Through 2002, the city paid HHC's malpractice costs while HHC reimbursed the city for debt service paid on HHC capital investments. In 2003, the city and HHC negotiated a "swap" whereby HHC would instead reimburse the city for medical malpractice settlement costs paid on its behalf. The swap was intended to provide greater incentive for HHC to rein in malpractice claims. Following a number of years of 10 percent annual increases, HHC payouts to settle malpractice lawsuits dropped 12.4 percent in 2004 and another 16.7 percent in 2005, presumably at least in part as a result of this swap.[2] The city has continued providing malpractice-related legal services to HHC worth approximately $30 million a year.

In 2006, the relationship changed again. HHC again began to reimburse the city for debt service, while continuing to bear its own malpractice costs. But the city made $725 million in supplemental Medicaid payments on HHC's behalf through the Disproportionate Share Hospital (DSH) and Upper Payment Limit (UPL) programs (see sidebar, Understanding "DSH" and "UPL"). This allowed the corporation to access an equal amount of federal matching dollars. In 2007, the city made a similar supplemental payment transaction, resulting in another $1.5 billion in DSH/UPL funds for HHC, again half city funds and half federal match. The majority of this money represented retroactive payments for 2003 and 2004; under federal law, HHC (like other public hospitals) was eligible for higher disproportionate share payments in those years but the necessary state action to access those payments was not taken at the time. Going forward, the city has assumed in its financial plan total annual DSH payments (city plus federal match) of $330 million a year through 2011. An additional $433 million in UPL funds is contingent on approval by the federal government.

The city's use of DSH/UPL payments is a significant shift in how it provides funding to HHC. With the minor exception of certain legal services, the city is phasing out the other channels through which it has supported HHC in the past. Two years of exceptionally high DSH/UPL payments, plus changes in state policy allowing HHC to retain its full UPL funding going forward, have solidified the hospital corporation's financial position and allowed the city to eliminate the unrestricted

Net City Subsidies to HHC, 1999-2011

Dollars in millions

Fiscal Year	Unrestricted	Malpractice	Debt Service	DSH/UPL (City)	**Total Cost to City**	DSH/UPL (Federal)	**Total Received by HHC**
1999	$71.3	$134.2	$17.5	-	**$223.1**	-	**$223.1**
2000	64.2	158.1	58.9	-	**281.2**	-	**281.2**
2001	82.5	168.9	-5.1	-	**246.3**	-	**246.3**
2002	116.6	194.5	-70.1	-	**241.1**	-	**241.1**
2003	111.7	26.3	165.6	64.9	**368.5**	64.9	**433.4**
2004	92.3	5.6	113.6	53.1	**264.5**	53.1	**317.5**
2005	243.5	-2.2	178.2	99.8	**519.2**	99.8	**619.0**
2006	297.6	28.4	-9.9	725.0	**1,041.0**	725.0	**1,765.9**
2007	61.4	-7.1	13.5	753.0	**820.8**	753.0	**1,573.7**
2008*	123.7	12.7	-75.9	381.5	**442.0**	381.5	**823.5**
2009**	-	29.6	-	381.5	**411.1**	381.5	**792.5**
2010**	-	29.6	-	381.5	**411.1**	381.5	**792.5**
2011**	-	29.6	-	381.5	**411.1**	381.5	**792.5**

SOURCES: IBO; Health and Hospitals Corporation.
NOTES: * Estimate, ** Projection. Numbers may not add due to rounding.

subsidy and the payments for HHC debt service. As the table below shows, HHC has experienced a significant increase in city subsidy compared with the pre-2005 period.

SIZE OF THE NET CITY SUBSIDY

Taking into account the various ways in which the city relates to the Health and Hospitals Corporation, IBO has calculated a net city subsidy for the years 1999–2011 (2008–2011 are projections from city financial plan documents). The subsidy is estimated by subtracting the reimbursements HHC pays the city from the payments the city makes to the corporation or on its behalf. It does not include city contracts with HHC or mandated Medicaid payments.

The city's subsidy to HHC is therefore larger and more broadly defined than the unrestricted subsidy. From 1999-2007, the subsidy calculated by IBO rises from twice the unrestricted subsidy to 13 times greater—or 25 times greater if the federal share of DSH/UPL is included. After 2008, the unrestricted subsidy will be eliminated completely.

The net subsidy increases beginning in 2005. From 1999-2004, the average annual subsidy was $290 million, but it rose to nearly $1.2 billion (counting the federal match) for 2005-2008. There was a particularly large increase from 2005 to 2006, from $619 million to $1.77 billion, both because of the retroactive payments described above and because a change in state policy allowed HHC to retain the full amount of UPL payments, instead of only 10 percent of the total as previously.

FINANCIAL ISSUES FACING HHC

HHC's mission of providing health services to New Yorkers regardless of their ability to pay has meant significant and ongoing financial issues for the organization. In a rapidly changing health care environment, these fiscal challenges are magnified. Over the next several years, HHC forecasts slow growth in revenues, while expenses will continue to rise more rapidly. The enhanced assistance the city has provided HHC will help the corporation address its deficits temporarily, but will not solve its long-term financial problems.

Revenues. Nearly all of HHC's revenues come from third-party payments: public programs (Medicare and Medicaid), managed care organizations, private insurance companies, and the state's Indigent Care pool of funds that help subsidize hospital spending on care for the uninsured. The recent improvement in HHC's financial situation is in large part due to access to Medicaid UPL payments on more favorable terms; by the same token, its financial outlook depends on whether federal regulations allow these payments to continue.

The hospital corporation's third-party revenues are projected to decline from $5.2 billion in 2007 to $4.4 billion (15 percent) in 2008, but if the city is able to continue UPL payments at the current level, revenues will then begin to rise, reaching $4.8 billion in 2012. If the city is unable to continue the UPL payments, however, HHC will see its third-party revenue continue to decline after 2008. In this case, cash reserves could be exhausted well before 2012.

On the positive side, expanded insurance coverage resulting from recent state policy changes have helped HHC.[3] In 2001, the state introduced Family Health Plus, a program to provide insurance to low-income working parents and other adults with incomes above regular Medicaid eligibility levels. In the 2007 legislative session, the state extended coverage in its child health insurance program to 400 percent of the poverty level, the broadest coverage of any state in the country. While implementation of the higher eligibility level has been delayed because the federal government has refused to provide matching funds, the Governor has included state funds in the 2009 budget to go ahead with the expansion.

Any future state or federal actions to further expand health coverage will presumably improve HHC's finances, given its large volume of uninsured patients. Other changes to state health policy are likely in the near term, but their impact on HHC is unclear. Notably, the Spitzer Administration recently proposed major changes to the state Indigent Care pools and Medicaid rates, in order to link reimbursements more closely to costs of care. HHC's Indigent Care pool payments currently cover only 25 percent of the costs of uncompensated care, compared with over 60 percent for voluntary hospitals.[4] These proposals have not yet been enacted, and may be modified by the Legislature. But as proposed, the reforms will not narrow the gap between indigent care reimbursements for public and voluntary hospitals and are unlikely to have a major impact on HHC revenue.

Expenses. HHC projects that its expenses will continue to grow at a faster pace than revenues in coming years. Expenses could grow even more rapidly if assumptions about malpractice cost containment and other initiatives prove overly optimistic.

From 2007 through 2012, operating expenses are expected to grow by $1.3 billion (23 percent) to $6.7 billion, with the largest increases coming in fringe benefits and affiliations. Fringe benefits are projected to grow by $205 million (25 percent) over this period while affiliations costs will grow by $165 million (24

UNDERSTANDING "DSH" AND "UPL"

Disproportionate Share Hospital (DSH) and Upper Payment Limit (UPL) are two federal programs intended to provide additional Medicaid funding to high-need hospitals. Both programs provide a one-for-one federal match for certain state and local payments. The improvement in the Health and Hospitals Corporation's financial position in recent years is in large part due to its increased access to DSH/UPL funds.

Both DSH and UPL are administered by the Center for Medicare and Medicaid Services and are limited to institutions that serve a disproportionate share of uninsured and Medicaid patients. An eligible hospital can generally receive DSH funds of up to its total unreimbursed costs for care to uninsured and Medicaid patients. There is also an overall cap under federal law on the total amount of DSH funds distributed in a given state; the New York State cap is currently $1.513 billion.[1] The term "facility cap" used below means the maximum amount of DSH funds a given hospital is eligible for. In New York, most hospitals in most years receive less than this amount of DSH funds; in other words, it is the statewide cap and not the facility cap that typically binds. For 2003 and 2004, both the facility and statewide caps were raised to 175 percent of their usual level.

UPL payments go to the same high-need hospitals as DSH payments, but do not count against the statewide DSH cap; instead, they must be made in accordance with a state plan approved by federal Medicaid officials. With UPL, the state raises its Medicaid reimbursement rates for certain hospitals to the Medicare rates, which are generally higher. Since this reduces the hospital's losses on Medicaid patients, it reduces its maximum DSH payments by an equal amount; for this reason, a given institution is usually funded only through one of the two programs.

In New York State, the largest use of DSH funds is the Indigent Care pool, which reimburse private, nonprofit hospitals for more than 60 percent of their losses on care for the uninsured and public hospitals for about 25 percent. Additional DSH funds are paid out directly to particular institutions. For HHC, these supplemental payments are fixed at $330 million—half paid by the city, and half the federal match. These payments fall well short of HHC's actual losses from uncompensated care to the uninsured and to Medicaid patients. For 2006, the shortfall after both sets of DSH payments was $725 million. This shortfall was made up by UPL payments at the two HHC hospitals that receive them, but the other nine HHC hospitals receive considerably less DSH money than they would be eligible for under the facility caps.

UPL payments go to specific hospitals designated in a state plan filed with the Center for Medicare and Medicaid Services and are equal to the difference between what the hospital was paid through Medicaid and what Medicare would have paid for the same services. In New York State, UPL payments go to just two HHC hospitals, Coney Island ($152.4 million in 2006) and Coler-Goldwater ($434.1 million), both of which mainly serve seniors and have very few Medicaid or uninsured patients. Prior to 2006, the state made UPL payments to these hospitals and then reclaimed 90 percent of the combined state and federal money to fund other state health care spending. In 2006, the state halted this practice and instead allowed the city to make UPL payments that are fully retained by HHC, an arrangement the Spitzer Administration has committed to maintaining.[2]

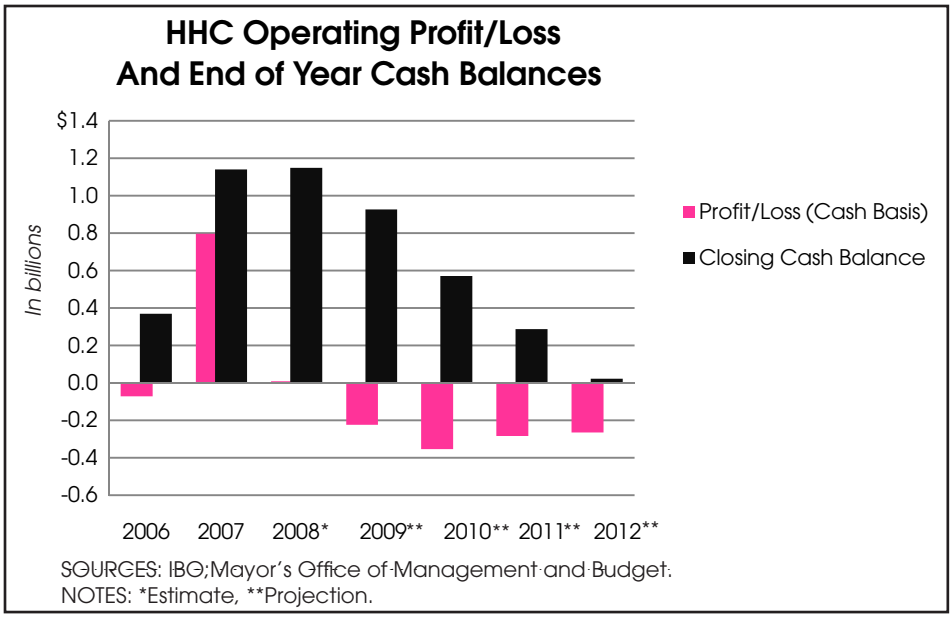
HHC's access to its full UPL payments instead of the 10 percent it received previously is a primary reason for its improved financial situation. A second reason for HHC's increased access to DSH/UPL funds is the 2003 and 2004 increase in DSH caps mentioned above. The state did not take advantage of the increased caps at the time, so a portion of DSH funds for 2006 and 2007 are retroactive payments for those earlier years.

In general, the current level of DSH/UPL funding for HHC is determined by the state, not the city. Because the city is now able to fund HHC through DSH and UPL, it has been able to reduce other forms funding it has used in the past.

[1]"Fiscal Year Disproportionate Share Hospital Allotments and Disproportionate Share Hospital Institutions for Mental Disease Limits," *Federal Register*, Vol. 71, No. 191.
[2]See "Pataki Gift to Spitzer: An $800 Million Problem," *The New York Sun*, April 13, 2007.

percent). The fringe benefit cost increases are largely the result of collective bargaining and growth in general employee benefit costs, including pension contributions and health insurance premiums. The projected increase in the cost of affiliations, which are contracts HHC enters into with other medical institutions and groups, are consistent with past trends.

Malpractice settlement costs are projected to remain constant between 2008 and 2012, but there is a risk that this will prove optimistic and there will in fact be an increase in expenses here. From 1999-2003, malpractice costs increased at a rate of approximately 10 percent annually. The plan for 2008-2012 also counts on $150 million annual cost-saving and revenue-boosting initiatives.



In recent years HHC has taken steps to control the rate of expense growth and operate more efficiently. From 1999 to 2007, HHC was able to slightly reduce its total number of beds even as its annual inpatient caseload increased from 214,000 to 224,000, by reducing the average length of stay from 11.7 days to 10.8. Outpatient and emergency room visits also increased slightly during this period.

The Bottom Line. The bottom line for HHC's finances is that payments for patient care only cover about two-thirds of its operating expenses. This makes the corporation's solvency dependent on its ability to access additional funds from the city, state, and federal governments. There is no built-in mechanism to ensure that those payments increase in line with the demands on HHC's services. As a result, the hospitals corporation faces significant operating deficits beginning in 2008. Even if federal regulations allow UPL payments to continue at their current level, these deficits will average $314 million annually through 2012. If UPL payments cease, the operating deficit will average $639 million over these four years. As the federal government has yet to approve the state's full Medicaid plan for even 2006 and 2007, there is a real question about availability of UPL funds in the out-years.

HHC will be able to temporarily weather these operating deficits because the increased subsidy from the city in 2005-2008 has helped it build a cash balance of more than $1 billion. While other hospitals in New York City struggle with significant deficits, HHC recently had its credit rating upgraded.[5] But even if the federal government allows the UPL payments to HHC to continue at their current level and the planned expense and revenue actions are realized, this cash reserve will be exhausted by 2012, meaning a return of serious financial challenges for HHC. In the absence of major expansion in health insurance coverage or changes to state health care finance, it is likely that the city will have to find ways of increasing its financial support to HHC at that point, even as it faces significant budget challenges of its own.

This report prepared by J.W. Mason

ENDNOTES

[1]See Council of the City of New York v. Giuliani, 1999 N.Y. Int. 0041 (Mar. 30, 1999).
[2]The mechanism here would presumably be more aggressive settlement policies rather than reduced medical errors, given the timing. However, it is worth noting that "The number of new medical malpractice claims filed was 699 in Fiscal Year 2006, the lowest number in the last ten years and 15 percent less than in Fiscal Year 2005." *Claims Report, Fiscal Year 2005-06*, New York City Office of the Comptroller, p. 16.
[3]Elizabeth Solomont, "City Hospitals Chief Describes 'Activist Agenda," *The New York Sun*, August 13, 2007.
[4]Hospital Indigent Care Pool Technical Advisory Committee, "Summary Report," June 13, 2007, p. 16-17.
[5]Elizabeth Solomont, "Hospital Spending Racing Past Revenues," *The New York Sun*, August 8, 2007.