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Uncompensated Care Raises Costs for the Insured

Three problems integral to the healthcare crisis are:

- escalating healthcare costs
- the growing number of uninsured
- increases in the number of bankruptcies for medical reason

All three problems are related to the issue of uncompensated care.

Uncompensated care, or care given by healthcare providers for which no payment is received, can be the treatment of last resort for the uninsured. As one researcher commented,"It is an implicit assumption of the U.S. healthcare system that poor, uninsured persons who become ill can obtain free or discounted care. "[1] However, with rising medical costs and increasing numbers of uninsured, hospitals face a challenge to provide the amount of uncompensated care that is desired and needed. And increasingly, uninsured and underinsured individuals face the threat of bankruptcy from healthcare bills that they are unable to pay.

The cost of uncompensated care has increased from $3.9 billion in 1980 to $31.2 billion in 2006, an increase of 700%.

Bad Debt Vs. Charity Care

For accounting purposes, uncompensated care is considered either bad debt or charity care. Uncompensated care does not include other discounts or "reductions in revenue," such as underpayments from Medicaid and Medicare and discounts to private payers.[2]

In strict accounting terms, *bad debt* consists of the total amount of payments that providers anticipated but did not receive. *Charity care,* in contrast, consists of the value of services for which providers never expected payment.[1] The difference between the two sounds straightforward, but in practice, providers sometimes have difficulty distinguishing between them.

Providers give varying amounts of charity care depending on their mission, financial condition, and other factors. The provider must budget for and finance charity care. Some providers use a formal process in advance of billing to identify those who cannot afford to pay. This helps them anticipate whether the patient's care could be funded through an alternative source, such as a charity care fund. On the other hand, some providers use the billing and collection process to identify patients who are unable to pay. Uncompensated care that is called charity care by one provider may be considered bad debt by another. This does not mean, however, that care classified as bad debt was provided to patients who can afford to pay. On the contrary, bad debt can be generated by people with limited resources, and this explains why many providers are unable to distinguish between the two and often treat them as interchangeable. Because of institutional practices, bad debt and charity care are not strictly comparable across facilities.

Some researchers have suggested that most healthcare bad debt encompasses care provided to people who cannot afford to pay their healthcare bills.[2] It is, therefore, reasonable to consider bad debt as a component of a provider's total burden of care to the medically indigent and underinsured. However, the Internal Revenue Service is now reconsidering this practice. As it is, nonprofit hospitals receive tax exemptions in return for providing subsidized care and services to the community, but the IRS is considering eliminating bad debt as a source of community benefit. If this happens, bad debt would not be eligible for subsidization.[3]

Cost of Uncompensated Care

The cost of uncompensated care as a percentage of total expenses for hospitals increased from 5.1% in 1980 to 5.6% in 2006, but the current level is lower than the peak of 6.4% in 1986.[2] While uncompensated care is a small percentage of total expenses, the cost is considerable because of the magnitude of overall expenses, and while the percentage has grown slowly, the actual cost to hospitals has risen steadily because of increases in healthcare spending.[2] The cost of uncompensated care has increased from $3.9 billion in 1980 to $31.2 billion in 2006, an increase of 700%.[2]

The United States Government Accountability Office collected data regarding uncompensated care from 97 Indiana hospitals. Table I summarizes the percent of uncompensated care and patient operating expenses for three categories of hospitals: nonprofit, for-profit,

and government and state hospitals.[4] Most uncompensated hospital care in Indiana is provided by nonprofit hospitals (79%), while state and government hospitals provide 17%, and for-profit hospitals provide 3%.

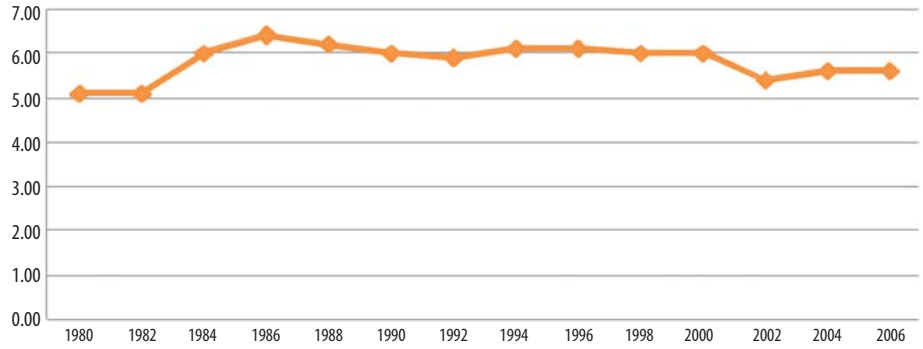
As a result of uncompensated care by providers, other patients may ultimately bear some of this cost as a result of *cost shifting*. Cost shifting occurs when providers charge higher prices to one group of payers to offset lower prices paid by another.[5] To the extent that public programs do not fully cover healthcare costs and the uninsured obtain services for which they do not fully pay, hospitals attempt to make up the difference by charging higher prices to the privately insured. This additional charge can be considered a form of health insurance premium taxation on those who are privately insured. The extent to which hospitals are able to cost shift depends on their market power and varies over time and region. Funding charity care through cost shifting is less transparent than directly funding charity care through government dollars, and for this reason it is less desirable.[5]

Table I. Percentage of Uncompensated Care and Patient Operating Expenses for Three Categories of Hospitals, Indiana 2003

	Nonprofit Hospitals	For-Profit Hospitals	Government and State Hospitals
Percentage of total hospitals	56%	9%	35%
% Uncompensated Care (of $342 million)	79%	3%	17%
Average patient operating expenses (in millions)	$116.1	$62.1	$47.6

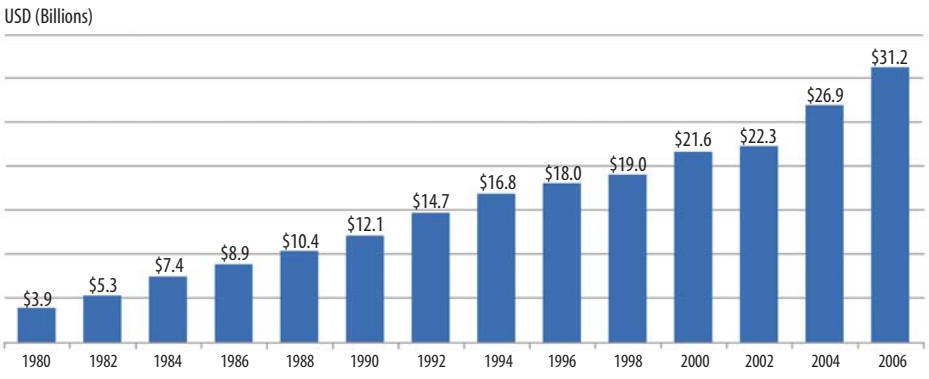
Source: Walker, 2005[4]

Figure 1. Uncompensated Care as Percent of Total Expenses



Source: American Hospital Association, 2005[2]

Figure 2. Cost of Uncompensated Care



Source: American Hospital Association, 2005[2]

Thoughts for Policymakers

The problem of uncompensated care is one that could be alleviated or virtually eliminated by policy changes.

Long-term Approaches — One way to solve the problem of uncompensated care is through an individual mandate for minimum healthcare coverage. Requiring residents of Indiana to have a healthcare plan, either through private insurance or through a state plan, would create near universal coverage. In turn, the cost of uncompensated care to providers would decrease significantly, depending on the insurance level.[6]

Other states have assessed the impact of insurance coverage on uncompensated care. In Oregon, for example, researchers found that one uninsured adult leads to an increase of about $852 in the uncompensated care provided by hospitals.[7] Hospital uncompensated care expenses in that state soared from approximately $175 million in 2002 to approximately $299 million in 2004, during a time when nearly 75,000 Oregon residents lost their health insurance coverage. Prior to this, uncompensated care expenses had been relatively stable, averaging about $150 million per year. This increase in the amount of uncompensated care can be directly linked to the end of open enrollment in the Oregon Health Plan and the large-scale Oregon Health Plan disenrollment which occurred in 2003.[7]

In addition to the reduction in uncompensated care costs, universal coverage would increase the amount of health services sought. According to the Institute of Medicine, people with insurance generally seek out more medical care, and as a result, providers would realize an increase in revenue as costs are kept down.[8]

Short-term Approaches — In the short-term, other regulations need to be implemented in order to reduce the amount of uncompensated care. One option is for Indiana lawmakers to implement more uniform policies for hospital charity care reporting and debt collection.[8] As it is, many Indiana hospitals use different definitions for charity care. A standard definition and reporting procedures would greatly reduce administrative costs, resulting in savings for providers. In addition, a universally accepted definition would allow for tighter monitoring by the IRS. As the IRS develops its policies on uncompensated care, providers would be in a better position to comply with the new regulations if the services that could be classified as such were clear.

Hospitals and other providers could also be required to implement better policies to identify uninsured individuals who are eligible for public programs, and assist those individuals in enrolling in these programs. Although partial payment for Medicaid services is an expense incurred by providers, the cost is less than bad debt expenses.[8] It would be in providers' best interest to ensure enrollment in such programs, especially since bad debt may soon be disqualified as a tax exemption.

These policy changes would help reduce the amount of uncompensated care provided by Indiana hospitals. Policymakers would have a better understanding of the amount of uncompensated care provided and the proportions of uncompensated care that are charity care compared to bad debt. While government spending will be required to extend health insurance to the needy in Indiana, it will also reduce the burden of uncompensated care for providers, thereby reducing cost shifting and the cost of healthcare to those who are privately insured.

Uncompensated care is a poor substitute for insurance coverage, both because it encourages uninsured patients to seek treatment in the emergency room and because many uninsured are unaware of the availability of charity care. Comprehensive healthcare reform in Indiana would reduce the burden of uncompensated care on Indiana's healthcare providers.

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About This Report

This report is part of a series on the healthcare system in Indiana. It was created as a result of the work of the Indiana University Heathcare Reform Faculty Study Group, a group of faculty members and analysts from the following Indiana University organizations:

- IU Center for Health Policy
- IUPUI Consortium for Health Policy, Law, and Bioethics
- William S. and Christine S. Hall Center for Law and Health
- IU School of Medicine

The Indiana University Center for Health Policy is an independent, nonpartisan applied research unit within the Indiana University School of Public and Environmental Affairs at Indiana University–Purdue University Indianapolis (IUPUI). CHP researchers work on critical policy issues related to the health of Hoosiers and the quality and accessibility of health care in Indiana. The CHP is part of the Indiana University Public Policy Institute and the Consortium for Health Policy, Law, and Bioethics, a Signature Center at IUPUI. For more information, visit the CHP Web site at http://www.healthpolicy.iupui.edu.

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