



2008-2009 Report on Residual Uncompensated Care Costs

Executive Summary

This report provides context for understanding hospitals contributions toward care for the uninsured and the indigent. It provides a framework for considering the interrelations between these programs and the related funding streams.

Uncompensated care has typically been reported as the sum of charity care and bad debt charges. In 2008, these totaled \$13.6 billion.

Charges are not the best measure of uncompensated care since charges can vary widely between hospitals. Therefore this analysis converted charges to cost. While there are a variety of methods and data sources for doing so, this report used financial information in the Annual Hospital Survey to calculate a ratio of costs to charges (RCC) for each hospital. These RCCs were then applied to charity and bad debt charges to estimate uncompensated care costs for 2008 at \$4.7 billion.

Based on survey responses, there was about \$200 million in payments related to charity care patients. While this amounts to less than 10 percent of estimated charity care costs, these amounts should still be considered when evaluating the impact on hospitals of providing this care.

There are also a variety of lump sum revenues that hospitals receive. While these amounts are not linked to specific patients, they can serve to help offset some of the costs of uncompensated care. These lump sum revenues include tax revenues, donations and federal grants. In the 2008 survey, these amounts totaled just under \$3 billion.

After considering these funding sources, hospitals have \$1.5 billion in charity and bad debt costs that are unreimbursed from the \$13.6 billion in reported charges.

Because hospitals' participation in governmental health programs (Medicaid, Medicare, other state and local programs) can influence how much charity and bad debt hospitals can absorb, this report also estimated the costs of these government programs. Hospitals that treat government program patients also tend to treat the uninsured and may have a harder time shifting the costs to payers. After considering program payments, these government programs have an estimated \$1.9 billion of unreimbursed costs.

From a hospital perspective, uncompensated care and government program shortfalls combined leave \$3.1 billion in costs unreimbursed.

Almost all of the data in the report are from the 2008 Annual Hospital Survey. The 2009 survey responses were still in the data verification process while the analysis was underway and should be considered preliminary.

When the analysis allowed for options, the report errs on the side of either increasing hospital costs or reducing revenues. The goal was to provide additional information, but not arbitrarily minimize hospitals' efforts in treating those not covered by private insurance.

While all hospital types contribute to care for the indigent and uninsured, nonprofit and public hospitals typically do so to a greater degree. However, these hospitals also have greater access to lump sum funding to offset those costs. Public hospitals are supported by their local tax revenue. Nonprofit hospitals have different cost structures than their for profit counterparts due to the value of tax exemptions. When allocating state resources to address uncompensated care in the future, consideration may need to be given to hospitals' financial status.

Key Findings

- Nonprofit and public hospitals have the bulk of their uncompensated care in the form of charity care charges, where for profit hospitals uncompensated care is concentrated in bad debt. (Table 2)
- Public hospitals have a substantially higher amount of their gross charges related to uncompensated care. (Table 4)
- There are differences in the source of uncompensated care charges. For profit hospitals have their largest share of uncompensated care from inpatient bad debt charges; nonprofit hospitals are their largest share from inpatient charity charges; public hospitals have their largest share of uncompensated care from outpatient charity charges. (Table 5)
- After converting to costs, public hospitals have a significantly higher portion of their activity related to uncompensated care, almost twice the statewide average. (Table 6 and Figure 1)
- There is about \$3 billion of lump sum revenue available to offset charity and bad debt costs. (Table 12)
- Hospitals have \$1.5 billion in unreimbursed charity care and bad debt costs after considering lump sum funding. (Table 13)
- Government program shortfalls amount to about \$1.9 billion in unreimbursed costs to hospitals. (Table 17)
- When lump sum revenues are considered as offsets to both charity and bad debt costs, as well as government program shortfalls, hospitals have \$3.1 billion in residual unreimbursed costs. (Table 18)

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Texas has the highest rate of uninsured in the nation, with 25 percent of the population, or just over 6 million people, lacking insurance. About 60 percent of Texas' uninsured adults have incomes below 200 percent of the Federal Poverty Level, typically an upper boundary for assistance programs. About 90 percent of the uninsured reside in metropolitan areas, equal to the distribution of the Texas population as a whole.

Today, care for uninsured Texans too often takes place in hospitals and emergency rooms – the most expensive points in the health care system. The cost of that care is passed on to local governments and those with private insurance. When businesses drop group coverage because of rising costs, this means more uninsured people in Texas emergency rooms (or on Medicaid or other public programs), which leads to even higher costs for those who can pay. It is estimated that \$1,500 is added to the cost of Texas family premiums for costs for the uninsured that have been shifted to commercial payers. Not only is there a general cost shift to insured Texans but taxpayers also subsidize the health care costs of the uninsured through the various reimbursement programs for uncompensated care in Texas.

The 81st Legislative Session directed the Health and Human Services Commission to submit a biennial report on uncompensated care costs which considers the impact of patient specific and lump sum funding as offsets to uncompensated care costs.¹

Typically when hospital uncompensated care has been reported in the past it has been characterized as the sum of bad debt and charity care charges. These costs are largely related to Texas' large uninsured population. However, bad debt and charity care charges are only part of a much larger complex issue. The goal of this report is to provide additional context through analysis of bad debt and charity care costs, as well as the funding sources that are available to offset some of the costs. Many of those funding sources are related to governmental programs that also reimburse the health costs of low income Texans so they will also be considered in an analysis of residual uncompensated care.

For the purposes of calculating residual uncompensated care², uncompensated care includes the charges for the uninsured (those with no source of third party insurance) and the underinsured (those with insurance who after contractual adjustments and third party payments have a responsibility to pay for an amount they do not pay). Uncompensated care also includes the unreimbursed costs from government sponsored health programs. Against these costs, both patient specific funding and lump sum funding will be reported to show amounts available to offset the cost of uncompensated care.

Understanding residual uncompensated care is an important foundation for consideration of the impact of federal health care legislation.

While care for the uninsured has direct and indirect costs to society, measuring the exact scale is problematic. The general concept of uncompensated care is relatively simple in theory (care that

¹ Senate Bill 1, 81st Legislature, Regular Session, p. II-95.

² Unreimbursed costs of uncompensated care, after consideration of patient specific and lump sum funding.

a provider receives no payment for) in practice there are multiple avenues through which uncompensated care arises. While the traditional view of uncompensated care is that of the person in a hospital emergency room with no insurance, there has arisen a more complex picture of uncompensated care where even patients with insurance can create uncompensated care by not being able to afford to pay their coinsurance and/or deductibles. As more individuals and employers select insurance policies with higher deductibles and more cost sharing by the patient, bad debt resulting from the underinsured or partially insured may continue to grow, yet current reporting mechanisms do little to measure this effect.³

Uncompensated care (UCC) is typically reported in terms of gross charges, without consideration of offsetting payments received. However, programs exist to reimburse uncompensated care costs. Some are targeted to a particular type of care or population group, while others are more encompassing. As these funding streams developed independently of each other, there is little consideration of the interaction between them and limited understanding of the actual financial burden of uncompensated care on hospitals. To better assess the effectiveness of the various governmental funding streams directed at reducing the unreimbursed costs associated with uninsured Texans they must be considered together.

What is needed is an understanding of residual uncompensated care, that is, an aggregate measure of unreimbursed costs after considering all of the funding streams (amounting to billions of dollars) available to offset those costs. This report will begin to frame those discussions. There may be alternative methods of calculating residual uncompensated care, but by converting charges to cost and considering all revenue sources should be the basis of future considerations of uncompensated care.

The Current System

To begin to better understand the landscape of uncompensated care reporting, this report will discuss the various programs shaping the current system and key concepts that influence uncompensated care reporting and financing. Understanding these components will provide context for the analysis of residual uncompensated care.

County indigent health program—indigent health services

The Texas Constitution delineates care for the uninsured as a local government function. Counties are required to provide certain services to all persons at or below 21 percent of the Federal Poverty Level.⁴ The required basic health services include primary and preventative services, inpatient and outpatient hospital services, rural health clinics, laboratory and X-ray services, family planning services, physician services, prescription drugs, and skilled nursing facility services, regardless of the patient's age.

³ Federal health care reform may mitigate this effect through limitations on out-of-pocket expenses for people receiving subsidies to purchase insurance.

⁴ Counties may elect to serve residents at higher than 21 percent FPL. The cost of care for individuals up to 50 percent FPL may be included in the county's request for state assistance funds.

Counties report expenditures on a monthly and annual basis to the Department of State Health Services (DSHS). If the cost of services exceeds eight percent of the county's general tax levy, a county is eligible to request state assistance funds. If state appropriations for assistance are not available, the county is not liable for the cost of care that exceeds the eight percent.⁵

Where they exist, public hospitals and hospital districts have the same constitutional obligation to provide care to indigent persons. Using local tax revenues, these hospitals often provide more care to the uninsured than the constitutional minimum requirement.

Various state and federal funding sources are available to offset some of the costs of care for the uninsured, however, providing the care (and financing it) remains largely a local responsibility.

Community benefit/charity care—unreimbursed costs

In addition to the requirements placed on counties and hospital districts, Texas statutes also require nonprofit hospitals to provide charity care to low income Texans. Texas Health and Safety Code Chapter 311 (sometimes called the Charity Care Law) sets out requirements for certain hospitals to maintain their status as nonprofit entities in the state of Texas. This statute requires nonprofit hospitals to establish a charity care policy that provides free or reduced price care to low income persons.⁶ The value of the tax benefits received in a sense “pay for” the charity care provided. By not having to pay taxes, a nonprofit hospital is able to afford to provide more free care than it would as a for-profit hospital.

Each nonprofit hospital has flexibility to set the income level qualifications for the charity care, provided that it covers, at a minimum, persons at less than 21 percent of the Federal Poverty Level (FPL). A hospital may set its charity care policy to cover persons up to 200 percent FPL.⁷ This means there is significant differences among hospitals with respect to what is bad debt or charity care. Care for a person at 100 percent FPL could be fully covered by charity care, partially covered on a sliding scale, or not covered as charity (and likely resulting in bad debt).

This implies that any universal definition of uncompensated care that focuses exclusively on charity care will be misleading with respect to the burden of health care costs for the uninsured. To provide meaningful perspective for public policy discussions, the measurement of uncompensated care must not arbitrarily limit the scope of uncompensated care by limiting its definitions.

Among other requirements for nonprofit hospitals is the filing of the Annual Statement of Community Benefit (ASCB). The ASCB is also required of public hospitals, as well as for profit hospitals that participate in the Disproportionate Share Hospital program. The ASCB report

⁵ The Department of State Health Services distributed about \$2.3 million in State Assistance Funds to qualifying counties in fiscal 2009.

⁶ For profit hospitals are not required to provide charity care. However, those that operate emergency rooms must treat people who have emergency medical conditions, regardless of their ability to pay.

⁷ Reportable charity care may also include care for patients above 200 percent FPL if the patient is determined to be medically indigent by the hospital's eligibility system. Bills remaining after payment by third-party payers exceed a specified percentage of the patient's income and the person is financially unable to pay the remaining bill(s).

requires a hospital to demonstrate that they provide community benefits at a level sufficient to meet at least one of several standards:

- “reasonable” as it relates to their community’s needs, resources of the hospital, and tax exempt benefits received;
- 5 percent of net patient revenues, as long as charity care and government sponsored indigent health care equal at least 4 percent of net patient revenues; or
- amounts equal to tax benefits of nonprofit status, excluding federal income tax.

Charity care is free or reduced price care provided to low income persons who qualify based on the hospital’s eligibility standards. Community benefits are other activities undertaken by hospitals that serve a broader population or where the hospital receives payments but does not cover its costs. Community benefits include activities that are not directly related to patient care such as health fairs, immunization programs, and education of medical staff,⁸ as well as operation of subsidized health services (emergency, trauma, neonatal intensive care and community clinics). Hospitals may also count as a community benefit the unreimbursed costs from governmental programs.

These unreimbursed costs of government programs fall into two categories—government sponsored indigent health care and other government sponsored programs. The first is for costs for providing health services to programs based on financial need. Medicaid is the primary example, but other federal, state and local indigent care programs that are means-tested also fall in this category. Other government sponsored programs are for the costs for providing health care that is not based on need. Medicare is the principal component, but so are CHAMPUS, Tricare and other federal, state or local programs.

In the community benefit reporting mechanism, hospitals are allowed to use an RCC that is calculated from their financial statements. The financial statements must be prepared in accordance with generally accepted accounting principles (GAAP) so this ratio is sometimes referred to as a GAAP RCC. This RCC is higher than those calculated from Medicare/Medicaid cost reports since the financial statements will reflect hospital expenses that are not allowed on the cost reports for governmental health programs.⁹

While the ASCB is required of public and for profit hospitals that participate in DSH, they are not required to complete all of the data elements in the report. This exclusion limits the usefulness of the ASCB data for a comprehensive analysis of uncompensated care. In particular, the information on revenues or value of tax exempt status that helps to offset the costs of uncompensated care is not known.

⁸ Measurement of community benefits can be difficult, especially when they involve activities where there is no charge for services (such as a health fair) as there is not a readily available financial data element to capture. Likewise, hospitals may face difficulty in estimating the value of their tax exempt status. This can be especially true as it relates to the value of a property tax exemption. The appraised or market value of the hospital’s facilities and land are typically not known.

⁹ Some of the items that are not allowed on the Medicare/Medicaid cost reports include some general and administrative costs, physician on-call charges, and portions of depreciation and interest costs.

Annual Hospital Survey–Uncompensated care

The Annual Hospital Survey (AHS) sponsored by the American Hospital Association (AHA) in conjunction with the Texas Hospital Association and the Department of State Health Services (DSHS) provides one of the most comprehensive measurements of uncompensated care. In that instrument, uncompensated care is defined as the sum of inpatient and outpatient charges for charity care and the inpatient and outpatient charges associated with bad debt.¹⁰ A summary provided each year by DSHS reports these uncompensated amounts in full charges, as is discussed above. This figure has grown from \$5.5 billion in 2002 to \$15.1 billion in 2009 (preliminary data).¹¹ Slightly more than half of this measure of uncompensated care (56 percent) is reported as charity care, that is care for which hospitals expect no reimbursement.

Charges are not the best data point upon which to make comparisons between hospitals.¹² When the Department of State Health Services publishes the results of the survey for the state, it does not use an RCC to convert charges to cost, although other data elements in the Annual Hospital Survey could be used to calculate one.¹³ To provide a basis for comparison between hospitals, charges must be converted to costs since charges do not reflect the actual impact on a hospital from providing uncompensated care.

Disproportionate Share Hospital Program–Uninsured costs and Hospital Specific Limit

One of the most significant sources of funding available to provide payment to hospitals related to uncompensated care is the Disproportionate Share Hospital Program (DSH), a component of the state-federal Medicaid program. DSH is a capped federal program that provides about \$1.5 billion in funding to approximately 170 hospitals that are more extensively utilized by Medicaid clients and other low income persons. In the DSH program, each hospital's payment is based on a Hospital Specific Limit (HSL) that is the sum of its Medicaid shortfall¹⁴ and uninsured costs. The DSH program defines uninsured costs as the charges for care for patients with no source of payment for the care they receive. These charges are converted to costs using an “all-payer”

¹⁰ The survey also collects some community benefit information, but these amounts are not included in the reported uncompensated care charges.

¹¹ A note on 2009 Annual Hospital Survey data: HHSC is required to submit a biennial report on uncompensated care costs. To incorporate two years of data that include new questions added to calculate residual uncompensated care required using preliminary 2009 data. DSHS conducts a thorough verification and validation process with hospitals that continues throughout the fall. The data from the 2009 survey used in this report was compiled as of October 8, 2010. Some changes are likely but they are expected to be relatively minor when dealing with statewide totals.

¹² When AHA prepares an annual assessment of uncompensated care, they convert the charges to costs stating “Uncompensated care data are sometimes expressed in terms of hospital charges, but charge data can be misleading, particularly when comparisons are being made among types of hospitals, or hospitals with very different payer mixes.” American Hospital Association, *Uncompensated Hospital Care Cost Fact Sheet* November 2009, <http://www.aha.org/aha/content/2009/pdf/09uncompensatedcare.pdf>

¹³ The AHA converts charges to cost with a ratio of total expenses (excluding bad debt) over the sum of gross patient revenue and other operating revenue. One difficulty in using this RCC, especially for comparisons of hospitals, is that the AHS data is not always complete for every hospital. To address this issue, statistical methods were used to estimate missing values for hospitals. Those methods are discussed further in the appendix.

¹⁴ A Medicaid shortfall is the difference between the allowable costs to a hospital for providing services to Medicaid clients and the Medicaid payments received by that hospital.

RCC,¹⁵ and from these costs any payments made by or on behalf of those individuals are subtracted.

For the purpose of identifying reimbursable costs, only payments directly tied to the patient are used to offset the reported cost. If the hospital received a local tax appropriation for the general purpose of offsetting the hospital's uncompensated care this payment does not show up in the reporting of DSH. So what is considered uninsured costs in the DSH program may not necessarily be unreimbursed costs from a broader policy perspective.

Trauma—uncompensated trauma care

The Texas Legislature has provided state funding for hospitals to help address the costs of the uncompensated trauma care they provide.¹⁶ Uncompensated trauma care is defined as the sum of the unreimbursed costs of bad debt and charity care provided on an inpatient or emergency room basis. By rule, the reported trauma charges are converted to cost using the all-payer RCC calculated from hospital Medicare/Medicaid cost reports submitted to the state's Medicaid fiscal intermediary. Information on charges is collected on a separate survey instrument for the trauma program on a calendar year basis. Charges for trauma patients must exclude any ambulance charges.

While limited to specific diagnosis codes, the charges associated with trauma care are a subset of uncompensated care and could easily be reported in both the DSH program and the trauma program.

Tobacco settlement—unreimbursed health expenditures

Texas' master settlement with the tobacco companies provided for units of local government to be compensated for their health care expenditures. The court settlement specifies that hospital districts and public hospitals be awarded a pro rata distribution of funds based on their unreimbursed health care expenditures. Rather than have hospitals report those expenditures, the settlement defines unreimbursed costs as the amount of tax revenues collected by hospital districts and public hospitals. Tax collections in effect serve as a proxy for unreimbursed costs.

Since tax revenues serve as the state match for DSH and the Upper Payment Limit supplemental payment programs and they are the *de facto* basis for allocating tobacco settlement revenues, essentially the same dollars serve as the basis to draw uncompensated care funding across different programs.

County governments are also eligible for funding from the settlement. However, counties are required to provide a more detailed accounting of the actual expenditures classified as

¹⁵ The "all-payer" RCC used to convert charges to costs is calculated from the hospital's cost report. The Medicaid program has specific rules for determining allowable costs that do not allow hospitals to include all of their operational costs in the reporting and it can be argued that a Medicaid RCC may understate a hospital's costs. The all-payer RCC allows a higher percentage of charges to convert to costs than a Medicaid ratio, which is limited to the costs that Medicaid program rules allow.

¹⁶ Trauma funding is principally from drivers' license surcharges and from court fines.

unreimbursed. Reporting requirements related to distribution of funds from the settlement do not involve an RCC.

While this funding stream is based on “unreimbursed health costs,” political subdivisions are not required to use the funds for health related purposes. There is an incentive for counties to use their tobacco settlement proceeds for health care since expenditures that are financed by the tobacco settlement proceeds may be counted as unreimbursed expenditures in the next reporting period.

Upper Payment Limit–uninsured costs

While not contributing to the varying array of definitions related to uncompensated care, Medicaid’s Upper Payment Limit (UPL) program provides a major source of uncompensated care reimbursement for participating hospitals. The UPL program makes supplemental payments to offset the difference between what Medicare would pay for services and actual Medicaid payments. However, for hospitals that receive DSH payments (discussed above), the hospital specific limit (HSL) is carried over to UPL. For example, a hospital that had an HSL for Medicaid shortfall and uninsured costs of \$20 million and received \$15 million in DSH payments could be eligible for \$5 million in UPL payments.

Acting as a cap on UPL payments for hospitals that participate in both the DSH and UPL programs, the HSL indirectly brings uninsured costs into the UPL program and therefore transforms the UPL program into a major funding stream for the uncompensated care of hospitals.¹⁷

Timing issues

Reporting of uncompensated care, regardless of the instrument, presents a series of timing issues. Surveys or reports of uncompensated care, by their nature, deal with a single point in time. The information systems associated with patient care, however, are a series of feedback loops and evolving data.

Patients with a single source of third party payment can be reported on with relative ease. For the uninsured, hospitals face additional steps trying to secure some sort of payment, typically a governmental program. This can be hampered by incomplete or inaccurate information provided by the patient. Frequently, the patient has long since left the hospital’s care when all of the determinations have been made.

Similarly, once the patient’s financial responsibility is known, there is additional time and effort devoted to collections. Some patients arrange payment plans that can extend the time their accounts are kept open.

¹⁷ In fiscal 2008, close to \$3 billion was paid to hospitals via the DSH and UPL programs. This makes up just over half of total Medicaid funding provided to hospitals. These programs that were initially intended as supplements and funding enhancements now match traditional payments but little is known about the care provided to justify the payments or the quality of services provided.

While imperfect, time boundaries are set to allow for collection of data and subsequent analysis. Some care reported as bad debt or charity care, may eventually be covered to a degree by patient or third party payments.

Data sources

In adopting the residual uncompensated care methodology, HHSC elected to use the Annual Hospital Survey as the principal source of data since it has data for all hospitals. To advance the methodology for calculating residual uncompensated care, new questions were added to the survey in 2008. The response rates have been generally high, although the new questions are not universally answered.

It should also be noted that the AHS data is self-reported. Hospitals are asked, but not required to use audited financial statements to prepare their responses. Due to timing issues, this is not always possible. For example, the AHS is typically sent to hospitals around March and hospitals are to report based on their hospital fiscal year that ended in the previous calendar year.

Timing issues can limit the effectiveness of comparisons between hospitals. For example, two hospitals in the same community but different hospital fiscal years would not necessarily have the same number of months of a spike in activity (i.e. flu epidemic or disaster response) in their reported AHS data.

Except where noted, all data used in this report are from the Annual Hospital Survey from 2008 and 2009. Because the 2009 data are still in the verification process, this report will largely focus on 2008 data.

Analysis of Charity Care and Bad Debt Charges

As mentioned earlier, uncompensated care has typically referred to the sum of charity care and bad debt charges. While it is not the best measure of the impact on hospitals, it is still useful to analyze the uncompensated care charges more fully before looking at hospitals' costs. Table 1 demonstrates that charity care charges account for just over half of all uncompensated care charges. Inpatient care is slightly over half of the care uncompensated care provided, with inpatient care charity care representing the largest share of reported uncompensated care charges.

Table 1: 2008 Description of Uncompensated Care Charges

	Charity Care Charges		Bad Debt Charges		Uncompensated Care Charges	
Inpatient	\$4,062,250,341	56%	\$3,015,698,597	52%	\$7,077,948,939	54%
Outpatient	\$3,238,856,084	44%	\$2,831,086,951	48%	\$6,069,942,036	46%
Total	\$7,301,106,425		\$5,846,785,548		\$13,147,890,975	
Percent of UCC	56%		44%			

Note: These amounts differ slightly from others used elsewhere in this report since a subset of hospitals did not report charity care and bad debt broken out by inpatient and outpatient.

It is also useful to understand which types of hospitals are providing uncompensated care. What is interesting is the distribution of uncompensated care between charity care and bad debt varies

significantly by hospital type, as shown in Table 2. Whereas charity care is the majority of public hospitals' uncompensated care, bad debt is the majority of for profit hospitals' uncompensated care.

Table 2: 2008 Charity Care Charges and Bad Debt Charges by Hospital Type

	For Profit Hospitals (n=278)	Nonprofit Hospitals (n=166)	Public Hospitals (n=135)	All Hospitals (n=579)
Charity Care Charges	\$ 1,084,445,960	\$ 3,454,104,637	\$ 2,958,324,252	\$ 7,496,874,849
	36%	58%	65%	55%
Bad Debt Charges	1,949,754,477	2,494,403,872	1,614,480,864	6,058,639,213
	64%	42%	35%	45%
Subtotal	\$ 3,034,200,437	\$ 5,948,508,509	\$ 4,572,805,116	\$ 13,555,514,062

There can be fluctuations in reported uncompensated care charges from year to year. Total uncompensated care charges increased about \$1.5 billion between 2008 and 2009. Table 3 shows the amounts reported for 2009 using preliminary data.

Table 3: 2009 Charity Care Charges and Bad Debt Charges by Hospital Type (preliminary data)

	For Profit Hospitals	Nonprofit Hospitals	Public Hospitals	All Hospitals
Charity Care Charges	\$ 1,250,622,021	\$ 3,983,614,390	\$ 3,293,034,656	\$ 8,527,271,067
Bad Debt Charges	2,169,209,646	2,572,523,845	1,833,018,701	6,574,752,192
Subtotal	\$ 3,419,831,667	\$ 6,556,138,234	\$ 5,126,053,357	\$ 15,102,023,258

Each hospital type saw growth in both charity care and bad debt charges from 2008 to 2009, with the bulk of the growth in charges occurring at nonprofit and public hospitals. Reported charity charges increased approximately \$1 billion from 2008 to 2009. About one-third of the total growth of uncompensated care charges stemmed from charity care charges at nonprofit hospitals. The growth at for profit and public hospitals was more evenly split between charity and bad debt, roughly in proportion to the levels provided in 2008.

To provide some additional context to uncompensated care charges, it is useful to compare them to gross charges¹⁸ for all patients. Texas' nonprofit hospitals have the most uncompensated care charges in absolute terms, but Table 4 shows that this is logical given that they have the most gross charges as well. For profit hospitals have lower amounts of uncompensated care charges, while it appears the safety net mission of Texas' public hospitals is reflected in their greater percentage of their services devoted to uncompensated care.

¹⁸ Gross charges, also referred to as gross patient revenue, are hospitals' full established rates for services rendered to patients.

Table 4: 2008 Gross Charges by Hospital Type and Relative Charity Care and Bad Debt

	For Profit Hospitals	Nonprofit Hospitals	Public Hospitals	All Hospitals
Gross Charges	\$59,359,633,191	\$67,558,303,620	\$21,267,752,602	\$148,185,689,413
Charity Care Charges as a Percent of Gross Charges	2%	5%	14%	5%
Bad Debt Charges as a Percent of Gross Charges	3%	4%	8%	4%

Analyzing charges by type of service provided (inpatient vs. outpatient) demonstrates some further differences in the uncompensated care by hospital type. For profit hospitals have the largest share of their uncompensated care services as inpatient services from bad debt. Nonprofit hospitals have the largest portion of their uncompensated care charges related to inpatient charity care. In contrast, outpatient charity care charges are the largest share of public hospitals' uncompensated care.

Table 5 indicates that not only is there a difference between charity care and bad debt by hospital type in general, but also by the services provided (inpatient vs. outpatient). Strategies to reduce uncompensated care may thus have varying effects on hospitals. Public hospitals would benefit from strategies to fund outpatient services, while for profit and nonprofit hospitals would benefit more from strategies to provide funding for inpatient services.

Table 5: 2008 Inpatient and Outpatient Uncompensated Care Charges by Hospital Type

	For Profit Hospitals	% UCC Charges	Nonprofit Hospitals	% UCC Charges	Public Hospitals	% UCC Charges	All Hospitals	% UCC Charges
Inpatient Charity Charges	\$721,123,395	26%	\$2,226,321,657	38%	\$1,114,805,289	25%	\$4,062,250,342	31%
Outpatient Charity Charges	206,830,966	8%	1,208,946,369	21%	1,823,078,749	40%	3,238,856,084	25%
Inpatient Bad Debt Charges	1,043,571,723	38%	1,135,196,949	19%	836,929,925	18%	3,015,698,598	23%
Outpatient Bad Debt Charges	774,939,170	28%	1,295,374,910	22%	760,771,871	17%	2,831,085,952	22%
Subtotal	\$2,746,465,254		\$5,865,839,885		\$4,535,585,834		\$13,147,890,975	

Note: These amounts differ slightly from others used elsewhere in this report since a subset of hospitals did not report charity care and bad debt broken out by inpatient and outpatient.

Converting charges to cost

The previous tables provided detail to the aggregate reporting of uncompensated care. However, charges are not the best measure of uncompensated care since charges can vary widely between hospitals.

For the rest of this report, uncompensated care will be discussed in terms of costs. While not a perfect method, analysis of hospital costs relies on the conversion of charges to costs through the use of a ratio of costs to charges.

In this analysis, the ratio of cost to charges was calculated from financial information reported in the AHS, using the methodology that the American Hospital Association (AHA) uses in its reports. The AHA converts charges to cost with a ratio of total expenses (excluding bad debt) over the sum of gross patient revenue and other operating revenue. Because the AHS data is not complete for every hospital, statistical methods were used to estimate missing values for hospitals. Those methods are discussed further in Appendix A.

Table 6 shows estimated charity care and bad debt costs using the RCC computed from financial data in the AHS. The \$13.5 billion reported in charity care and bad debt charges is converted to \$4.7 billion in costs.

Table 6: 2008 Estimated Charity Care and Bad Debt Costs by Hospital Type

	For Profit Hospitals		Nonprofit Hospitals		Public Hospitals		All Hospitals	
Charity Costs	\$ 257,957,342	37%	\$ 1,013,460,577	57%	\$ 1,452,288,823	67%	\$ 2,723,706,743	59%
Bad Debt Costs	447,152,740	63%	758,340,306	43%	725,192,016	33%	1,930,685,062	41%
Subtotal of UCC Costs	\$ 705,110,082		\$ 1,771,800,884		\$ 2,177,480,839		\$ 4,654,391,805	
Total Expenses, excluding bad debt	\$ 13,887,906,499		\$20,980,372,274		\$10,917,871,905		\$45,786,150,678	
Subtotal as a percent of Total Expenses, excluding bad debt	5.1%		8.4%		19.9%		10.2%	

Similar to Table 2 which showed charges by hospital type, this table demonstrates that charity care and bad debt *costs* are not evenly distributed among hospital types. Total expenses (excluding bad debt) also are shown to provide a sense of scale.

It is also interesting to compare the relative amounts of charity care and bad debt by hospital type. Where charity care is more than two-thirds of public hospitals uncompensated care, bad debt is the major component of for profit hospital uncompensated care. These relative portions are comparable to those outlined in Table 2.

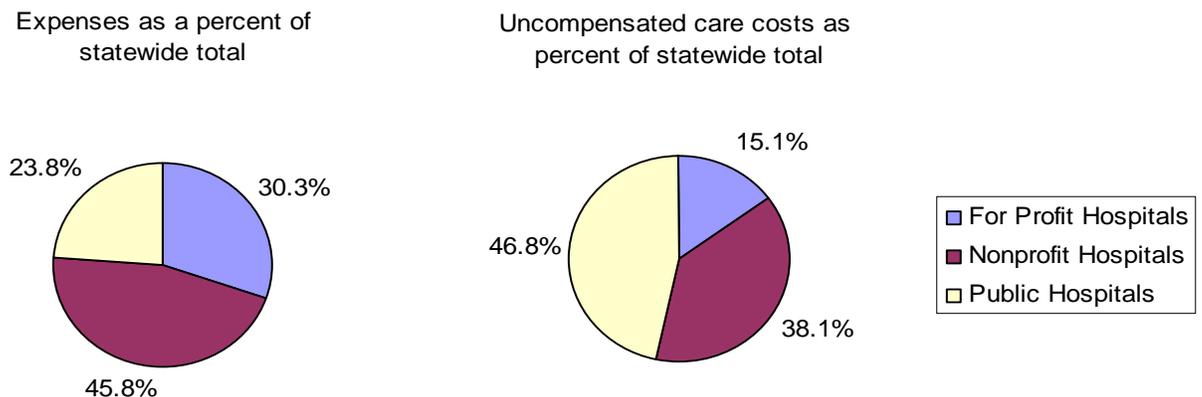
While charity care and bad debt charges grew by about \$1.5 billion between 2008 and 2009, there was smaller growth when 2008 and 2009 charity care and bad debt costs are compared. It appears that charges grew at a faster rate than hospital costs. The estimated UCC costs for 2009 are shown in Table 7. Total charity care and bad debt costs grew by about \$270 million, of which almost 90 percent is charity care. Most of that growth was seen at nonprofit hospitals.

Table 7, 2009 Estimated Charity Care and Bad Debt Costs by Hospital Type (preliminary data)

	For Profit Hospitals		Nonprofit Hospitals		Public Hospitals		All Hospitals	
Charity Costs	\$ 261,065,778	37%	\$ 1,179,737,642	60%	\$ 1,521,070,548	68%	\$ 2,961,873,968	60%
Bad Debt Costs	449,162,954	63%	798,710,760	40%	714,399,777	32%	1,962,273,490	40%
Subtotal of UCC Costs	\$ 710,228,732		\$ 1,978,448,402		\$ 2,235,470,325		\$ 4,924,147,458	
Total Expenses, excluding bad debt	\$13,894,957,065		\$22,093,883,181		\$10,755,546,630		\$46,744,386,876	
Subtotal as a percent of Total Expenses, excluding bad debt	5.1%		9.0%		20.8%		10.5%	

Figure 1 demonstrates that the relative contributions toward uncompensated care costs are not necessarily proportional to each hospital type share of Texas hospital services. Hospital expenses (excluding bad debt) can be used to assess the amount of services provided to all patients by hospital type. While for profit hospitals have about 30 percent of Texas hospitals total expenses (excluding bad debt), they have 15 percent of uncompensated care costs. Conversely, public hospitals have about 24 percent of total expenses, but almost 47 percent of uncompensated care costs. This makes sense given the safety net mission of most public hospitals.

Figure 1: 2008 Expenses and Uncompensated Care Costs by Hospital Type



Bad debt from uninsured and partially insured patients

In the 2008 Annual Hospital Survey, questions were added to get more information on the nature of bad debt. Hospital industry representatives have raised a concern that insurance coverage has been giving patients additional financial responsibility via higher deductibles, co-pays and co-insurance. While this might allow Texans to keep their insurance via lower premiums, the logic is that those insured patients may not be able to afford their share of their hospital bills. The unpaid patient payments likely would be classified by hospitals as bad debt.

The new questions asked hospitals to identify bad debt from uninsured patients and bad debt from partially insured patients. Partially insured is also sometimes referred to as underinsured. These amounts are shown in Table 8.

Table 8: 2008 Bad Debt Costs from Uninsured and Partially Insured

	Bad Debt Costs from the Uninsured	Bad Debt Costs from the Partially Insured	All Bad Debt Costs
Amount	\$1,040,134,781	\$463,233,605	\$ 1,930,685,062
Percent of Total	53.9	24.0	
Number of hospitals reporting	514	502	579
Hospital response rate	88.8	86.7	

Note: Table does not add across since a subset of hospitals did not supply responses to the survey questions.

On the 2008 Annual Hospital Survey, bad debt costs were estimated to be \$1.9 billion. Roughly 89 percent of the respondents provided additional detail on bad debt from the uninsured and the partially insured. The estimated bad debt costs for those that responded totaled \$1.5 billion, or about 78 percent of total bad debt costs. Bad debt from partially insured patients was \$463 million, or about 24 percent of all bad debt costs. Based on the preliminary data available from the 2009 AHS, shown in Table 9, it does not appear the bad debt from partially insured patients grew. However, two years of data is insufficient to determine a trend.

Table 9: 2009 Bad Debt Costs from Uninsured and Partially Insured (preliminary data)

	Bad Debt Costs from the Uninsured	Bad Debt Costs from the Partially Insured	All Bad Debt Costs
Amount	\$1,295,051,994	\$392,348,125	\$1,962,273,490
Percent of Total	66.0	20.0	

Note: Table does not add across since a subset of hospitals did not supply responses to the survey questions.

This survey element can be monitored over time to determine if “bad insurance” is becoming a larger component of uncompensated care. This is an area where the requirements of federal health care reform could have an impact as the requirements for higher medical loss ratios and limitations on out of pocket costs take effect.

Funding offsets

Having estimated hospitals uncompensated care costs, it is necessary to consider the funding available to hospitals to offset these costs. There are patient specific funding associated with some charity and bad debt as shown in Table 10. While the amounts are dwarfed by the overall costs of providing the care (less than 10 percent), they should be recognized nonetheless. For example, patients could have third party payments (auto insurance, workers’ compensation) that

defray some of the costs of their charity care and still be eligible for charity care according to the hospital's eligibility system.

Table 10: 2008 Patient Specific Funding for Charity Care Costs by Hospital Type

	For Profit Hospitals	Nonprofit Hospitals	Public Hospitals	All Hospitals
Estimated charity care costs	\$ 257,957,342	\$1,013,460,577	\$1,452,288,823	\$2,723,706,743
State government payments	\$ 2,030,080	\$ 5,438,088	\$ 3,501,734	\$ 10,969,902
Local government payments	4,604,552	2,943,374	7,858,227	15,406,153
Private insurance payments	2,693,680	52,243,379	3,250,337	58,187,396
Patient payments	1,480,898	20,054,986	25,335,154	46,871,038
Other third party payments	2,122,193	40,461,374	22,016,139	64,599,706
Subtotal of patient funding	\$ 12,931,403	\$ 121,141,201	\$ 61,961,591	\$ 196,034,195
Charity costs after patient specific funding	\$ 245,025,939	\$ 892,319,376	\$1,390,327,232	\$2,527,672,548

Similar questions were asked on the survey regarding payments associated with bad debt charges. These amounts are summarized in the Appendix Table B3, but it was not clear that hospitals hadn't already deducted those amounts from reported bad debt. Rather than overstate the amounts received by hospitals, these amounts were excluded from the main analysis.

While there are patient specific funding streams available to hospitals, there are also a series of lump sum payments that hospitals receive that are not necessarily associated to specific patients. These amounts are shown in Table 11. Amounts required as intergovernmental transfers to support DSH and UPL are shown as negative so avoid duplicating revenues.

Table 11: 2008 Lump sum funding offsets, as reported in AHS

Medicare supplemental payments	\$ 244,957,923
Medicaid Disproportionate Share Hospital (DSH)	918,435,858
Medicaid Upper Payment Limit (UPL)	1,115,437,028
State trauma	59,416,083
Tobacco settlement	69,889,895
Federal grants	826,988,839
Other state government funding	25,935,519
Donations	271,432,913
Local government funding	1,199,970,645
Tax revenue	1,266,285,036
Intergovernmental transfers for DSH	(360,427,983)
Intergovernmental transfers for UPL	(282,991,740)
Other IGTs for Medicaid	(49,496,833)
Collections from patients previously reported as uncompensated	60,088,071
Subtotal of lump sum funding	\$ 5,365,921,254

Care must be taken to avoid double counting revenues available to hospitals. It is likely that some of the lump sum amounts reported in Table 11 were included in the patient specific

payments reported with government programs (discussed later). As such, Table 12 represents a modified amount of lump sum payments to minimize duplication.

Table 12: 2008 Selected Lump Sum Funding Offsets

Upper Payment Limit (UPL)	\$ 1,115,437,028
State trauma, other state funding	74,381,700
Tobacco settlement	69,889,895
Federal grants	826,988,839
Donations	271,432,913
Tax revenue	1,266,285,036
Intergovernmental transfers for DSH	(360,427,983)
Intergovernmental transfers for UPL	(282,991,740)
Other IGTs for Medicaid	(49,496,833)
Collections from patients previously reported as uncompensated	<u>60,088,071</u>
Subtotal of lump sum funding	\$ 2,991,586,926

Although DSH is a source of lump sum revenue available to some hospitals, the AHS specifically instructs hospitals to include DSH in Medicaid net patient revenue. This analysis assumes that DSH was already included in Medicaid payments discussed in the next section of the report. UPL is another lump sum revenue source. Since the 2008 survey was silent on the treatment of UPL, it is assumed that in 2008 hospitals did not report it along with other Medicaid payments.¹⁹ Other adjustments were made to avoid duplicating state and local government program revenues discussed later.

With these modifications to lump sum revenue reported in Table 12, there appears to be close to \$3.0 billion in non-patient specific revenue available to offset the \$4.7 billion costs of uncompensated care summarized in Table 6. This results in unreimbursed charity and bad debt costs of just under \$1.5 billion as shown in Table 13. After considering the lump sum revenues, nonprofit and public hospitals appear to have roughly the same amount of unreimbursed charity and bad debt costs. As noted earlier, while the amounts may be similar, these costs are a larger share of public hospitals services.

¹⁹ AHA has added separate data fields for DSH and other non-DSH supplemental payments (largely UPL) in the main portion of the AHS for 2009. As hospitals become familiar with reporting in this fashion, a more thorough analysis of the effect of these supplemental payments will be possible. Given the differences between reported amounts in 2008 and 2009, it was assumed that hospitals did not include UPL in net patient revenue in 2008, but did in the 2009 survey. The 2009 survey instructs hospitals to report payments minus any provider taxes or assessments, which can assumed to be net of IGTs needed to support the program.

Table 13, 2008 UCC Costs After Funding Offsets

	For Profit Hospitals	Nonprofit Hospitals	Public Hospitals	All Hospitals
UCC Costs	\$705,110,082	\$1,771,800,884	\$2,177,480,839	\$4,654,391,805
Patient Specific Payments	12,931,403	121,141,201	61,961,591	196,034,195
Lump Sum Funding	412,160,438	1,054,839,453	1,524,587,035	2,991,586,926
Unreimbursed UCC Costs	\$280,018,241	\$595,820,230	\$590,932,213	\$1,466,770,684

Government program shortfalls

The Senate Bill 10 Uncompensated Care Work Group advised HHSC that hospitals' participation in government indigent care programs influence the amount of charity care and bad debt they can absorb. Hospital representatives point to payment rates in these programs lagging behind private insurance payments, and sometimes behind hospitals costs. When payments are less than the cost of providing care, this is referred to a "shortfall."

There are a variety of governmental health programs, most of which are designed to serve people with specific health conditions or of specific income levels. These include Medicaid, Children's Health Insurance Program (CHIP), Kidney Health Care, and Children with Special Health Care needs. Sometimes, Medicare, the federal health insurance program for the elderly, also can be considered a source of hospital shortfalls.

To gain a more comprehensive understanding of the impact of unreimbursed care on hospitals, HHSC considered these shortfalls in its assessment of residual uncompensated care.

Medicaid Shortfall

Hospitals frequently express concern about Medicaid payment rates. The DSH and UPL programs serve to enhance the regular Medicaid payments received. What began as supplemental payments are gaining parity with regular hospital payments.

Table 14: Hospital Funding, Fiscal Year 2008

	Amount (millions)	Percent
Inpatient payments	\$ 3,087.0	
Outpatient payments	1,425.3	
<i>Subtotal of payments</i>	<i>4,512.3</i>	<i>59%</i>
UPL	1,659.3	
DSH	1,464.8	
<i>Subtotal of supplemental payments</i>	<i>3,124.1</i>	<i>41%</i>
Total*	\$ 7,636.4	

*About \$300 million in outpatient services not related to hospitals (home health, DME, FQHCs, RHCs, etc.) are excluded.

Source: Health and Human Services Commission, <http://www.hhsc.state.tx.us/news/presentations/2010/082710-House-Border.pdf>

Based on the AHS, Medicaid costs exceeded Medicaid net patient revenue by \$475 million, as shown in Table 15. Medicaid underpayments are a particular concern to hospitals that treat a higher proportion of Medicaid patients. This concern can be compounded because these same hospitals may also treat a greater portion of the uninsured. As the proportion of unpaid and unreimbursed care gets higher, it is harder for hospitals to recoup those costs from other paying patients.

Table 15: Medicaid Shortfall Calculated from 2008 Annual Hospital Survey

Medicaid Charges	\$ 20,134,821,866
Medicaid Costs, using AHA derived ratio of cost to charges	6,291,171,056
Medicaid net patient revenue	5,815,770,111
Remaining costs, or shortfall	\$ 475,400,945

The amounts reported in Table 15 are from the Annual Hospital Survey. They may differ from other amounts reported by HHSC in that they are self-reported data. There may also be differences in the reporting periods used (state fiscal year versus hospital fiscal year). Hospitals are instructed in the survey to include DSH payments, but it is not clear that all hospitals do so. It is also unclear whether hospitals that transfer local funds to match federal funds report the full payment, or deduct the local funds.

Other Government Program shortfalls

To provide a comprehensive view of the impact of unreimbursed care on hospitals, it is necessary to consider other state programs for the indigent or those with specific health conditions. These may include such as the Children’s Health Insurance Program (CHIP) and Kidney Health program. Questions were added to the AHS to gather data on these programs. These amounts are reported in Table 16. Based on the responses to the survey, it appears that payments from the state cover a large portion of the costs of these programs. However, only a limited number of hospitals (132 out of 579) responded to these questions so result should not be interpreted broadly.

Table 16, Other Governmental Program Shortfalls from the 2008 Annual Hospital Survey

	Charges	Estimated Costs	Payments	Remaining Costs, or Shortfall
State Governmental Health Programs	\$ 3,822,661,035	\$ 1,450,756,848	\$ 1,363,929,947	\$ 86,826,901
Local Governmental Health Programs	506,485,500	155,326,057	140,294,226	15,031,831
Medicare	40,000,415,645	10,914,061,730	9,563,337,885	1,350,723,845

In a similar fashion, questions were added to the AHS in 2008 to gather data on the charges and payments associated with local indigent health care programs. This could include County Indigent Health Care payments to hospitals, as well as any programs unique to a local area. Given the small amounts reported and the relatively low response rate (178 out of 579 hospitals), like state government shortfall, this finding should not be interpreted broadly.

Medicare is a major source of third party payments for most hospitals. Even so, many hospitals argue that the payments are not sufficient to cover their costs. Covering those remaining costs can also influence how much a hospital can participate in state and local programs, and how much charity care and bad debt hospitals can absorb. To provide a comprehensive view of the impact of government programs and care for the indigent, Medicare shortfalls are included in this analysis. However, a case could also be made that state policy makers should not be responsible for offsetting federal program shortfalls.

Unreimbursed costs after patient specific payments

Having reviewed the individual programs that comprise uncompensated or unreimbursed care, these components can now be viewed together to provide a broad picture of the impact on hospitals. These costs and payments are summarized in Table 17 for all hospitals. Table 17 shows the breadth for uncompensated or unreimbursed costs, prior to consideration of lump sum payments.

Table 17: 2008 Uncompensated Care Costs and Government Program Shortfall Costs after Patient Specific Revenue

	Uncompensated Care Costs		Government Program Shortfall Costs			Total
	Charity	Bad Debt	Medicaid	State, local government programs	Medicare	
Charges	\$7,496,874,849	\$6,058,639,213	\$20,134,821,866	\$4,329,146,535	\$40,000,415,645	\$78,019,898,108
Estimated Costs	2,723,706,743	1,930,685,062	6,291,171,056	1,606,082,905	10,914,061,730	23,465,707,496
Medicaid payments			5,815,770,111			5,815,770,111
State/local government payments	26,376,055	na ²⁰		1,483,143,124		1,509,519,179
Medicare					9,012,227,471	9,012,227,471
Private insurance	58,187,396	na		10,725,143	321,119,122	390,031,661
Patient payments	46,871,038	na		2,041,080	131,118,458	180,030,576
Other third party payments	64,599,706	na		8,314,826	98,872,834	171,787,366
Subtotal of payments	\$196,034,195	na	\$5,815,770,111	\$1,504,224,173	\$9,563,337,885	\$17,079,366,364
Subtotal of cost after patient specific funding	\$2,527,672,548	\$1,930,685,062	\$475,400,945	\$101,858,732	\$1,350,723,845	\$ 6,386,341,132

²⁰ Questions were added to the AHS to capture information on payments associated bad debt. However, the data indicated that many hospitals had already considered these payments before reporting bad debt charges. To not skew the analysis with too much offsetting revenue, these items were dropped from consideration here. The reported amounts are available in the appendix.

The bulk of the costs remaining after patient specific funding are found at nonprofit and public hospitals. For profit hospitals account for less than 10 percent of the \$6.4 billion costs remaining after patient specific funding. Appendix Tables B7, B8 and B9 show costs after patient specific funding by hospital type.

Putting it all together

After converting charity, bad debt and government programs charges to costs and considering all both patient specific and lump sum funding available to hospitals, an estimated \$3.1 billion in unreimbursed uncompensated costs remain as shown in Table 18. This table differs from Table 13 in that lump sum revenues are applied to charity and bad debt costs, as well as government program shortfalls.

Table 18: 2008 Estimates of Residual Uncompensated Care Costs

	For Profit Hospitals	Nonprofit Hospitals	Public Hospitals	All Hospitals
Uncompensated Care and Government Program Charges	\$27,474,407,101	\$39,398,328,772	\$13,003,940,246	\$79,876,676,119
Estimated Costs	\$5,763,070,804	\$12,188,026,712	\$5,332,150,426	\$23,465,707,496
Subtotal patient specific funding	\$5,483,850,399	\$8,857,873,280	\$2,870,242,194	\$17,069,736,625
Subtotal of costs after patient specific funding	\$603,909,207	\$3,330,153,432	\$2,461,908,232	\$6,395,970,871
Subtotal of lump sum funding ²¹	\$ 427,724,481	\$1,093,649,425	\$1,715,170,943	\$3,236,544,849
Residual unreimbursed uncompensated care costs	\$176,184,726	\$2,236,504,007	\$746,737,289	\$3,149,796,283

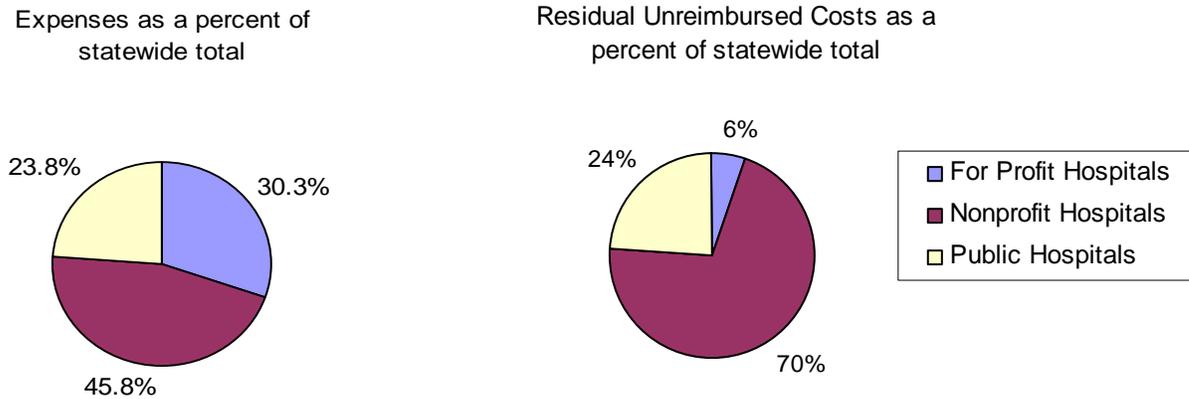
Residual unreimbursed uncompensated care costs seem largely concentrated at nonprofit hospitals. As was outlined earlier in the report, this type of hospitals has the largest amount of activity, both in terms of gross charges and total expenses. While it is difficult to estimate, nonprofit hospitals have an offset to their costs in the form of exemption from taxes that allows them to absorb more uncompensated and unreimbursed costs. How to value this tax exemption “offset” warrants further consideration.

²¹ These lump sum amounts differ from those discussed in Tables 12 and 13. Medicare supplemental payments (\$245 million) were excluded there, but are appropriate for including here as an offset to the Medicare shortfall.

While public hospitals have a greater portion of their services related to care for the uninsured, much of the cost of that care is financed by the taxpayers in those local communities.

To better understand these costs, Figure 2 shows the share of statewide expenses and residual costs by hospital type. Nonprofit hospitals have about 46 percent of expenses (excluding bad debt), but 70 percent of residual costs.

Figure 2: 2008 Expenses and Residual Unreimbursed Care Costs by Hospital Type



Although it is preliminary data, a comparable table for 2009 is shown in Table 19. One change is that Table 19 assumes that UPL payments were reported by hospitals along with Medicaid net patient revenue. This shows up in a smaller amount of lump sum revenue in Table 19. In Table 19, it appears that residual costs are more evenly distributed among hospital types.

Table 19: 2009 Estimates of Residual Uncompensated Care Costs (preliminary data)

	For Profit Hospitals	Nonprofit Hospitals	Public Hospitals	All Hospitals
Uncompensated Care and Government Program Charges	\$33,136,229,221	\$43,879,766,446	\$14,524,123,846	\$91,540,119,513
Estimated Costs	\$6,857,064,619	\$13,516,260,782	\$6,284,045,518	\$26,657,370,919
Subtotal patient specific funding	\$5,875,561,348	\$10,499,739,535	\$3,569,616,244	\$19,944,917,127
Subtotal of costs after patient specific funding	\$981,503,271	\$3,016,521,247	\$2,714,429,274	\$6,712,453,792
Subtotal of lump sum funding	\$129,432,492	\$568,052,438	\$1,616,795,823	\$2,314,280,753
Residual unreimbursed uncompensated care	\$852,070,779	\$2,448,468,809	\$1,097,633,451	\$4,398,173,039

Considerations of federal health care implementation

The results of this analysis can help inform an understanding of the residual impact on hospitals of care for the uninsured and those covered by governmental programs. However, if federal health care reform is fully implemented, the landscape for hospitals may change dramatically. Patients who did not pay for their care, or only paid limited amounts, may have Medicaid coverage or subsidies to purchase private insurance. Charity care should be dramatically reduced. A large portion of those charges will be shifted to the Medicaid program, either due to Medicaid expansion or due to growth of emergency Medicaid for noncitizens. The newly covered may also seek care outside of hospital settings.

Bad debt, especially from the partially insured, should be reduced as health insurance plans are required to cover more of the costs of care. Provisions scaling patient co-pays and setting cost sharing limits may serve to make these amounts more within the ability of patients to pay. Of course a major unknown from the hospitals' perspective is the rates that the private insurance plans supported by federal subsidies will pay for hospital services.

Medicaid shortfall amounts may increase due to an increase in the number of Texans covered by Medicaid. At the same time, the state's allotment of DSH funds will be reduced. This may

prompt consideration about where to target a reduced allotment, or whether to continue a pro rata distribution.

The amounts of care provided by other state and local governmental programs should decrease, as more of these Texans become eligible for Medicaid or receive subsidies to purchase private insurance. This may free up local resources that were previously used to support the safety net function of public hospitals.

Summary and key findings

Texas hospitals make significant contributions toward the care for the uninsured and the indigent. This effort can be measured in uncompensated care costs and government program shortfalls. Rather than consider these amounts as statewide totals, it is important to consider that different hospital types contribute in varying ways. Future policy considerations may need to take into account the relative efforts of hospitals, as well as the variety of funding offsets available to hospitals.

Key Findings:

- Nonprofit and public hospitals have the bulk of their uncompensated care in the form of charity care charges, where for profit hospitals uncompensated care is concentrated in bad debt. (Table 2)
- Public hospitals have a substantially higher amount of their gross charges related to uncompensated care. (Table 4)
- There are differences in the source of uncompensated care charges. For profit hospitals have their largest share of uncompensated care from inpatient bad debt charges; nonprofit hospitals are their largest share from inpatient charity charges; public hospitals have their largest share of uncompensated care from outpatient charity charges. (Table 5)
- After converting to costs, public hospitals have a significantly higher portion of their activity related to uncompensated care, almost twice the statewide average. (Table 6 and Figure 1)
- There is about \$3 billion of lump sum revenue available to offset charity and bad debt costs. (Table 12)
- Hospitals have \$1.5 billion in unreimbursed charity care and bad debt costs after considering lump sum funding. (Table 13)
- Government program shortfalls amount to about \$1.9 billion in unreimbursed costs to hospitals. (Table 17)
- When lump sum revenues are considered as offsets to both charity and bad debt costs, as well as government program shortfalls, hospitals have \$3.1 billion in residual unreimbursed costs. (Table 18)

Appendix A

Calculation of grouped means to substitute for missing values

The steps for calculation of missing values are as follows:

1. Data were sorted by rural and urban and then by small (< 100 beds) and large (100+ beds) hospitals.
2. Weighted means were calculated for four separate categories -- small rural, large rural, small urban, and large urban categories.
3. Seven variables needed for our calculation had missing values. The weighted means were used to estimate the missing values of these variables namely, Total bad debt charges (I1C), Total charity care charges (I2C), Bad debt expense (D5A1), Other Operating Revenue (D3C), Total expenses (Payroll plus all non-payroll expenses, including bad debt) (D3J), Total gross patient revenue (D4C), and Bad debt expenses including bad debt (D5A). Later on this was revised because Hospital Survey Unit informed us that if the answer to the question whether bad debt was included in bad debt expenses was missing it meant “yes”. (Per AHA item 5, if D3k1 is missing, they assume bad debt is included in total expense). Therefore only six variables required weighted means to replace missing values.
4. The weighted means were calculated by the summing each of these seven variables and dividing each sum by the total number of beds of all the hospitals in that category. This gave a per bed value for each variable in each of the four categories.
5. Before summing, negative values were dropped.
6. The values for missing and negative cells were calculated by multiplying the number of beds in the hospitals that had missing or negative values by the per bed (mean) value as calculated under 4 above.
7. There were no missing values for rural hospitals with 100+ beds for bad debt, charity care charges, and bad debt expense.
8. Values of 0 (zero) were not replaced.

Means for computing missing values

Annual Hospital Survey 2008

	I1C	I2C	D3C1	D3J1	D4C1	D3K1
Urban small						
Mean per bed	30523.4	16034.5	4657.8	407947.3	1181831.0	408694.2
Urban large						
Mean per bed	79188.9	108444.7	35262.6	655460.2	1957465.6	669927.1
Rural small						
Mean per bed	78565.1	29565.3	9870.5	406682.2	843988.6	420007.2
Rural Large						
Mean per bed	*	*	4455.9	*	*	*

*Not calculated because there were no missing values

I1C	Bad debt charges
I2C	Charity care charges
D3C1	Other operating revenue
D3J1	Total expenses
D4C1	Total gross patient revenue
D3K1	Bad debt expense

The mean values were multiplied by the number of beds in the hospital that had missing values to obtain the weighted means.

Appendix B Additional Data Analysis Tables

It is also useful to consider where this uncompensated care is provided. The following table demonstrates uncompensated care by Public Health Region. The regions with the largest metropolitan areas, not surprisingly, account for the bulk of the uncompensated care. This reflects Texas' urbanized population, as well as people travelling to major hospitals for more specialized care.

Table B1: 2008 Uncompensated Care Charges by Public Health Region

	Charity Care Charges	Bad Debt Charges	Total Uncompensated Care Charges
High Plains	\$ 297,591,384	\$ 249,505,711	\$ 547,097,096
Northwest Texas	180,948,425	126,194,960	307,143,385
Metroplex	2,044,122,099	1,683,962,823	3,728,084,922
Upper East Texas	445,944,304	445,826,386	891,770,689
Southeast Texas	185,116,155	201,353,007	386,469,161
Gulf Coast	1,928,177,852	1,553,453,638	3,481,631,490
Central Texas	853,097,127	462,470,529	1,315,567,656
Upper South Texas	661,207,888	445,420,079	1,106,627,966
West Texas	77,762,529	206,509,642	284,272,172
Upper Rio Grande	151,526,666	223,628,954	375,155,620
Lower South Texas	671,380,420	460,313,485	1,131,693,905
Total	\$ 7,496,874,849	\$ 6,058,639,213	\$ 13,555,514,062

To provide some additional context to uncompensated care charges, it is useful to compare them to gross charges for all patients. Table B2 demonstrates uncompensated care charges by region but also provides the context of gross charges. It is interesting to note that the similar regions may have different levels of uncompensated care charges. For example, the Metroplex and Gulf Coast are similar urban regions but have variation in the uncompensated care as a percent of gross charges.

Table B2: 2008 Uncompensated Care Charges and Gross Charges by Public Health Region

	Total Uncompensated Care Charges	Total Gross Charges	UCC as a % of Gross Charges	Number of hospitals
High Plains	\$547,097,096	\$6,650,236,156	0.082	42
Northwest Texas	307,143,385	2,998,140,386	0.102	39
Metroplex	3,728,084,922	37,059,531,777	0.101	128
Upper East Texas	891,770,689	8,440,092,580	0.106	40
Southeast Texas	386,469,161	4,954,680,309	0.078	25
Gulf Coast	3,481,631,490	41,206,825,393	0.084	107
Central Texas	1,315,567,656	12,694,723,360	0.104	64
Upper South Texas	1,106,627,966	12,848,406,245	0.086	51
West Texas	284,272,172	2,836,047,473	0.100	32
Upper Rio Grande	375,155,620	5,743,488,818	0.065	17
Lower South Texas	1,131,693,905	12,753,516,916	0.089	34
Total	\$13,555,514,062	\$148,185,689,413	0.091	579

As mentioned in the main report, there questions added to the AHS to gather information on payments received on care that was reported as bad debt. These were greater than those associated with charity care. Hospitals' charity care policies typically mean that no payment is expected from those patients, where as bad debt occurs when hospitals expect but do not receive payments, or complete payments. Reported bad debt charges were converted to cost and the patient specific funding sources are also shown. However, it became clear that there was variability in how these questions were answered. It appears that some of these payments may have already been considered before hospitals reported their bad debt amounts.

Table B3: 2008 Patient Specific Funding for Bad Debt Costs by Hospital Type

	For Profit Hospitals	Nonprofit Hospitals	Public Hospitals	All Hospitals
Estimated bad debt costs	\$ 447,152,740	\$ 758,340,306	\$ 725,192,016	\$ 1,930,685,062
State government payments	1,866,846	11,507,268	24,898,840	38,272,954
Local government payments	1,198,683	10,421,079	502,409	12,122,171
Patient payments	58,949,293	224,822,527	76,867,078	360,638,898
Other third party payments	80,214,426	43,413,694	270,861,438	394,489,558
Subtotal of patient funding	\$ 142,229,248	\$ 290,164,568	\$ 373,129,765	\$ 805,523,581
Bad debt costs after patient specific funding	\$ 304,923,491.62	\$ 468,175,738.49	\$ 352,062,251.14	\$ 1,125,161,481.26

In the main report, governmental program shortfalls were reported in a summary fashion. Because the amounts for local shortfalls were so small, they were combined with state government program shortfalls. They are shown here separately.

Table B4: Other State Program Shortfalls

State Governmental Health Program Charges	\$ 3,822,661,035
State Governmental Health Program Costs	1,450,756,848
State Government Payments	1,346,332,805
Private Insurance Payments	9,540,870
Patient Payments	1,284,625
Other third party payments	6,771,647
Subtotal of Payments	\$ 1,363,929,947
State Governmental Health Programs Remaining Costs	\$ 86,826,901

Table B5: Other Local Program Shortfalls

Local Governmental Health Program Charges	\$ 506,485,500
Local Governmental Health Program Costs	155,326,057
Local Government Payments	136,810,319
Private Insurance Payments	1,184,273
Patient Payments	756,455
Other third party payments	1,543,179
Subtotal of Payments	\$ 140,294,226
Local Governmental Health Programs Remaining Costs	\$ 15,031,831

Table B6: Medicare Program Shortfalls

Medicare Charges	\$ 41,214,181,441
Medicare Costs	10,914,061,730
Medicare Payments	9,012,227,471
Private Insurance Payments	321,119,122
Patient Payments	131,118,458
Other third party payments	98,872,834
Subtotal of Payments	\$ 9,563,337,885
Medicare Remaining Costs	\$ 1,350,723,845

Tables B7, B8 and B9 show uncompensated care costs and governmental program costs for profit, nonprofit and public hospitals separately.

Table B7: For Profit Hospitals 2008 Uncompensated Care Costs and Government Program Costs after Patient Specific Revenue

	Uncompensated Care Costs		Government Program Shortfall Costs			Total
	Charity	Bad Debt	Medicaid	State, local government programs	Medicare	
Charges	\$1,250,622,021	\$2,169,209,646	\$7,357,944,713	\$622,754,166	\$16,073,876,555	\$27,474,407,101
Estimated Costs	257,957,342	447,152,740	1,588,917,667	129,270,249	3,522,232,360	5,945,530,358

Medicaid payments			1,647,017,532			1,647,017,532
State/local government payments	6,634,632	na		121,610,590		128,245,222
Medicare					3,375,198,751	3,375,198,751
Private insurance	2,693,680	na		199,548	117,964,442	120,857,670
Patient payments	1,480,898	na		409,084	40,828,996	42,718,978
Other third party payments	2,122,193	na			25,460,805	27,582,998
Subtotal of payments	\$12,931,403	na	\$1,647,017,532	\$122,219,222	\$3,559,452,994	\$5,341,621,151

Subtotal of cost after patient specific funding	\$ 245,025,939	\$ 447,152,740	\$ (58,099,865)	\$ 7,051,027	\$ (37,220,634)	\$ 603,909,207
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Table B8: Nonprofit Hospitals 2008 Uncompensated Care Costs and Government Program Costs after Patient Specific Revenue

	Uncompensated Care Costs		Government Program Shortfall Costs			Total
	Charity	Bad Debt	Medicaid	State, local government programs	Medicare	
Charges	\$3,435,268,026	\$2,572,523,845	\$9,480,510,725	\$3,309,903,330	\$14,830,144,623	\$33,628,350,549
Estimated Costs	1,013,460,577	758,340,306	3,164,561,044	1,285,522,157	5,966,142,627	12,188,026,712
Medicaid payments			2,839,945,075			2,839,945,075
State/local government payments	8,381,462	na		1,221,973,827		1,230,355,289
Medicare					4,447,956,049	4,447,956,049
Private insurance	52,243,379	na			131,594,007	183,837,386
Patient payments	20,054,986	na			71,703,914	91,758,900
Other third party payments	40,461,374	na			23,559,207	64,020,581
Subtotal of payments	\$121,141,201	na	\$2,839,945,075	\$1,221,973,827	\$4,674,813,177	\$ 8,857,873,280
Subtotal of cost after patient specific funding	\$892,319,376	\$758,340,306	\$324,615,969	\$63,548,330	\$1,291,329,450	\$ 3,330,153,432

Table B9: Public Hospitals 2008 Uncompensated Care Costs and Government Program Costs after Patient Specific Revenue

	Uncompensated Care Costs		Government Program Shortfall Costs			Total
	Charity	Bad Debt	Medicaid	State, local government programs	Medicare	
Charges	\$2,937,884,038	\$1,833,018,701	\$3,296,366,428	\$396,489,039	\$4,540,182,040	\$13,003,940,246
Estimated Costs	1,452,288,823	725,192,016	1,537,692,346	191,290,499	1,425,686,742	5,332,150,426

Medicaid payments			1,328,807,504			1,328,807,504
State/local government payments	11,359,961	na		139,558,707		150,918,668
Medicare					1,189,072,671	1,189,072,671
Private insurance	3,250,337	na		2,603,776	71,560,673	77,414,786
Patient payments	25,335,154	na		971,039	18,585,548	44,891,741
Other third party payments	22,016,139	na		7,267,863	49,852,822	79,136,824
Subtotal	\$61,961,591	\$725,192,016	\$1,328,807,504	\$150,401,385	\$1,329,071,714	\$ 2,870,242,194

Subtotal of cost after patient specific funding	\$1,390,327,232	\$352,062,251	\$208,884,842	\$40,889,114	\$96,615,028	\$ 2,461,908,232
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Table B10 shows lump sum funding, broken out by hospital type. It is clear from this table that not all hospitals have the same level of lump sum funding available to them. These are the amounts as reported in the survey, although there is some question of the validity of tax revenue reported by for profit and nonprofit hospitals. Likewise, according to federal requirements, for profit and nonprofit hospitals may not supply intergovernmental transfers, as they are not public entities. This table shows the lump sum amounts as reported in the AHS, without reductions to minimize duplication.

Table B10: 2008 Lump Sum Funding Offsets by Hospital Type, as reported in AHS

	For Profit Hospitals	Nonprofit Hospitals	Public Hospitals
Medicare supplemental payments	\$ 15,564,043	\$ 38,809,972	\$ 190,583,908
Medicaid Disproportionate Share Hospital (DSH)	169,447,837	259,789,919	489,198,102
Medicaid Upper Payment Limit (UPL)	295,783,409	321,701,762	497,951,857
State trauma	8,178,834	23,937,888	27,299,361
Tobacco settlement	76,253	1,851,568	67,962,074
Federal grants, including Section 1011	146,971,246	656,423,199	23,594,394
Other state government funding	3,567,633	12,689,302	9,678,584
Donations	39,523,385	112,069,380	119,840,148
Local government funding	93,956,695	74,023,564	1,031,990,386
Tax revenue	15,693,008	752,925	1,249,839,103
Intergovernmental transfers for DSH	(34,704,651)	(70,879,433)	(254,843,899)
Intergovernmental transfers for UPL	(59,473,111)	(41,072,594)	(182,446,035)
Other IGTs for Medicaid	(3,147,266)	(2,455,799)	(43,893,768)
Collections from patients previously reported as uncompensated	1,721,778	45,259,343	13,106,950
Subtotal of lump sum funding	\$ 693,159,093	\$ 1,432,900,996	\$ 3,239,861,165

As discussed in the body of the report, modifications were made to avoid duplicating revenues available to offset the cost of care. Table B11 demonstrates how the lump sum amounts discussed in the analysis were reported by hospital type. Clearly tax revenue is the majority of the funding available to public hospitals.

Table B11: 2008 Selected Lump Sum Funding Offsets by Hospital Type

	For Profit Hospitals	Nonprofit Hospitals	Public Hospitals
Upper Payment Limit	\$ 295,783,409	\$ 321,701,762	\$ 497,951,857
State trauma, other state funding	9,716,387	31,189,102	33,476,211
Tobacco settlement	76,253	1,851,568	67,962,074
Federal grants	146,971,246	656,423,199	23,594,394
Donations	39,523,385	112,069,380	119,840,148
Tax revenue	15,693,008	752,925	1,249,839,103
Intergovernmental transfers for DSH	(34,704,651)	(70,879,433)	(254,843,899)
Intergovernmental transfers for UPL	(59,473,111)	(41,072,594)	(182,446,035)
Other IGTs for Medicaid	(3,147,266)	(2,455,799)	(43,893,768)
Collections from patients previously reported as uncompensated	1,721,778	45,259,343	13,106,950
Subtotal of lump sum funding	\$412,160,438	\$1,054,839,453	\$1,524,587,035

DSH uninsured compared to AHS

One of the complexities of uncompensated care reporting is that different programs and reporting instruments summarize similar numbers. The amounts may be similar, or vastly different. Table B11 compares amounts used in the DSH program and amounts reported in the AHS.

Table B12: Comparison of DSH and Annual Hospital Survey Values

Year	DSH Program Calculations	
	Uninsured Cost, All Medicaid Hospitals	Medicaid Shortfall, All Medicaid Hospitals

2008	\$3,031,499,305	\$1,015,820,395
2009	\$3,291,296,641	\$1,213,642,399

Year	Annual Hospital Survey Calculations	
	Charity Costs	Medicaid Shortfall
2008	\$2,723,706,743	\$475,400,945
2009	\$2,961,873,968	-\$499,917,074

Some of the reasons these amounts vary:

- The Charity Care Law limits charity reporting to 200 percent FPL and lower. Many hospitals have lower FPL levels for eligibility.
- In the DSH program, the criteria is uninsured costs. There is no income limit.
- In the DSH program, the Medicaid shortfall is calculated using regular Medicaid payments.
- In the survey, Medicaid net patient revenue (used to offset Medicaid costs) includes DSH. In the 2009, Medicaid net patient revenue also includes UPL. Net patient revenue is used to offset Medicaid costs.
- The ratio of cost to charges differs. DSH uses RCCs computed from the cost reports and this report used financial data from the AHS to compute each hospital's RCC.

Appendix C

Review of the residual uncompensated care methodology

Ratio of cost to charges

The methodology originally envisioned using the “all-payer” ratio of cost to charges that is calculated by HHSC’s Hospital Rate Analysis staff from cost report data. The lack of automation on the process meant that there wouldn’t be up-to-date ratios for all hospitals in the survey data set. It was therefore decided to use a ratio calculated from financial data in the hospital survey. In this way, all hospitals would be treated comparably. In a few instances, hospitals did not answer all of the relevant survey questions needed to calculate a ratio of cost to charges. In those cases, statistical methods were used to provide substitute data through comparison to similar hospitals.

Using an RCC to convert charges to costs provides an estimate of hospitals’ costs. Actual costs for a type of service could be higher or lower. In this analysis, when estimating missing variables, the guiding principle was to err on the side of increasing hospitals costs.

Medicaid shortfall

Similarly, the methodology assumed that the Medicaid shortfall as calculated by HHSC’s Hospital Rate Analysis would be included in the calculation of residual uncompensated care. Hospital Rate Analysis has focused their calculations of Medicaid shortfall to the hospitals that apply for the Disproportionate Share Hospital program. Since this data would not be available for all hospitals in the survey, survey data was used to estimate the Medicaid shortfall so that all hospitals could be treated comparably.

It should be noted that there are particular CMS criteria for calculating the Medicaid shortfall for the DSH program. Amounts included in this report are not likely to match the DSH Medicaid shortfall calculations.

Data limitations

With close to 600 hospitals in the data set, there will be error in the data. Significant effort is made to verify the information reported. However, there will be “error” from hospitals have different interpretations of the same question.

Response rates for new questions are high, but not 100 percent. The assumption has to be made that those hospitals that do respond reflect the industry as a whole.

Survey refinements

A few of the questions did not yield data as expected. For example, the detailed questions added on bad debt for the partially insured asked for information on the private insurance payments for these individuals. In 2008, hospitals reported \$2 billion. The charges for Bad Debt from the underinsured were reported as \$1.6 billion. It is illogical that there would be bad debt if private insurance paid that much. Some possible scenarios include:

- Some portion of hospitals report bad debt charges after accounting for insurance payments, instead of gross bad debt charges.

- The \$2 billion may be some other private insurance revenue, not necessarily associated with patient files reported as bad debt.

To avoid overstating the amounts received by hospitals, these responses were dropped from consideration for this analysis of patient specific revenue streams.

In 2009, the American Hospital Association added questions to the survey that request separate reporting of Medicaid net patient revenue by fee for service, managed care, DSH and non-DSH supplemental payments. In future years, this break out should allow for additional verification that hospitals are including all of these supplemental payments.

Given the responses to the tax revenue and intergovernmental transfers survey questions by nonprofit and for profit hospitals, which likely should not have these responses, clarification of the survey definitions may be necessary.

Since the AHS is conducted online, there are technical methods of requiring hospitals to enter data in the fields that are required for calculating ratios of cost to charges. While the statistical methods used in this report are valid, it is preferable to use actual hospital data rather than computed estimates. Additions should be made to the survey software so that hospitals cannot have missing values in fields required for calculating the ratio of cost to charges.