



Follow the Money: What Hospitals May Not Be Telling You

Non-profit hospitals are important assets in our health care system. Classified as charities, they are exempted from paying local, state, and federal taxes. In return, they are expected to provide a sufficient amount of **community benefit** through free or subsidized goods, services, and resources that address unmet needs in their communities. Since resources are often limited, hospitals are generally encouraged—and, in some instances, required—to tailor community benefit programs to serve vulnerable populations in their neighborhoods.

Evaluating a hospital's finances can help the public understand whether the hospital is fulfilling these responsibilities to the broader community. But state and federal reporting standards, as well as hospitals' internal strategies for calculating and administering community benefit, vary. While a recent push to create across-the-board *federal* reporting standards has made more standardized information about non-profit hospitals available than ever before, it has not precluded some hospitals and trade associations from issuing independent reports that inflate their annual investments in community benefit. This obscures key information necessary to determine whether hospitals are responding appropriately to the needs of the communities they serve.

Knowing what's behind the numbers hospitals report is essential for determining when to take them at face value and when to dig deeper. Here are three key concepts to keep in mind.

Bad Debt vs. Charity Care: Yes, the Distinction Matters

Non-profit hospitals can provide tangible help to communities by connecting financially strapped patients to medical care. **Charity care (financial assistance)** is free or reduced-cost care offered to patients who cannot afford to pay all or part of their out-of-pocket costs. Hospitals typically award financial assistance based on income, although some consider additional factors—insurance status, available assets, medical indigency, housing status—that may impact a patient's ability to pay. When the process works well, hospitals proactively inform, screen, and help patients apply for financial assistance and public programs. Hospitals do not expect payment for charity care/financial assistance services. As a result, the patient's account is typically not advanced through the collections process, and the amount is written off as a legitimate community benefit.

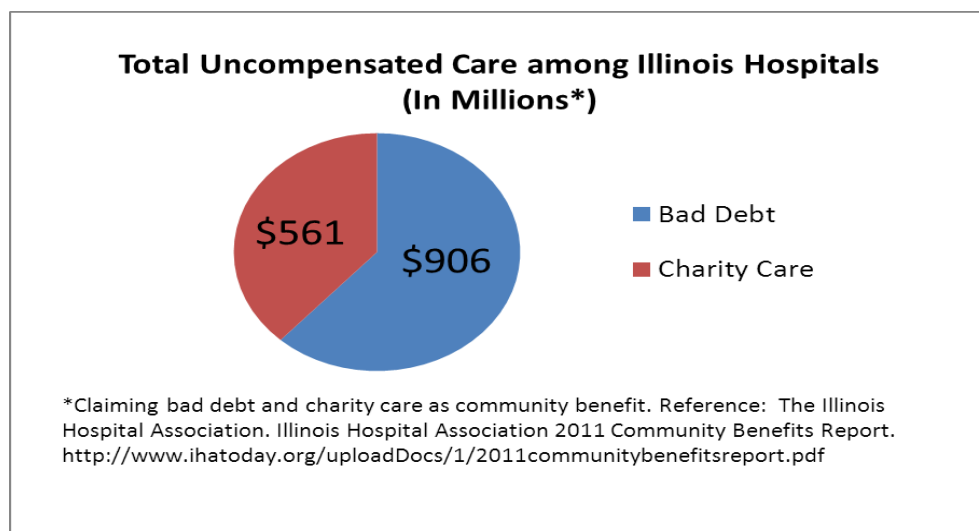
By contrast, **bad debt** is money owed for hospital services for which the hospital expected but never received payment. Bad debt arises from several sources, including unpaid insurance claims. Importantly, it may also be attributable to patients who cannot afford to pay for care but who were never informed about financial assistance or did not qualify under the terms of the hospital's policy.

Like charity care, hospitals routinely write off bad debt. But from a patient's perspective, the consequences of having an account classified as bad debt are long-lasting since bad debt accounts are typically pursued aggressively through the collections process. Depending on the hospital's collection policies and legal safeguards available in a given state, patients may face

long-lasting consequences: a damaged credit rating, unaffordable payment plans, wage garnishment, liens, or even bankruptcy.

Despite the very different consequences felt by patients, some hospitals and trade associations routinely combine their bad debt and charity care data and report both numbers together as **uncompensated care**. They then use the total amount of uncompensated care—not charity care—as a proxy to show their commitment to the underserved (see Figure One). This practice artificially inflates hospital spending on community benefit. It is also short-sighted. By claiming the derailment of low- and moderate-income families’ financial security as community benefit, non-profit hospitals leave themselves more susceptible to public censure about their role in promoting, rather than alleviating, medical debt.

Figure One: Sample Illinois Hospital Data



Costs vs. Charges: Self-Pay Patients Get Stuck with the Bill

In general, hospital **charges** for services (a charge is the “sticker price” for a service or supply) are significantly higher than the **cost** hospitals incur to provide services. Hospitals face few legal constraints when determining charges, and information that allows pricing comparisons among hospitals is usually not publicly available. Still, most payers—Medicare, Medicaid, and private insurers—can use their market clout to bargain down a lower price than what the hospital initially charges.¹ These practices have implications for hospital reporting. For example,

¹ The exception, of course, are self-pay patients—including the uninsured and underinsured—who lack bargaining power and are routinely billed full freight for care. In practice, self-pay patients are generally held to be financially responsible for services at rates that far exceed what insurers and public programs pay. For example, one [Health Affairs study](#) found that self-pay patients were charged 250 percent more than private insurers paid and 300 percent more than what Medicare allowed. See Anderson, G. “From ‘Soak the Rich’ to ‘Soak the Poor’: Recent Trends in Hospital Pricing,” *Health Affairs* (published online May 11, 2007). This is doubly concerning given [recent research](#) indicating most low- and middle-income uninsured patients can ill afford to pay what hospitals charge. “The Value of Health Insurance: Few of the Uninsured Have Adequate Resources to Pay Hospital Bills,” Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services (May 2011).

hospitals that report charity care by **charge** will, on the surface, appear to have provided much more community benefit than hospitals that report the same data by **cost**.

To address this, the Internal Revenue Service now requires non-profit hospitals to report their charity care and community benefit expenses **at cost**, rather than at the inflated charge rate. Policymakers and the public interested in “apples-to-apples” comparisons should make sure that hospitals are providing cost-based data.²

Reimbursements from Public Programs

Hospitals may claim underpayments—or **shortfalls**—from public insurance programs, such as Medicare or Medicaid, as community benefit. Shortfalls arise when hospitals are paid less than the cost of the care they provided for patients with public coverage.

Medicaid shortfall describes underpayments from state governments for Medicaid beneficiaries who received care. Medicaid, like the State Children’s Health Insurance Program (SCHIP) and other programs for the medically indigent, is a means-tested program. Medicaid payments are usually driven by what state governments decide they can afford to pay, which often is less than the cost of care. Because of this—and to incentivize hospitals to participate in public programs that serve low-income patients—shortfalls from Medicaid and other means-tested public programs are almost uniformly recognized as community benefit.

By contrast, neither the Internal Revenue Service nor the Catholic Health Association recognize **Medicare shortfall** as community benefit. Unlike means-tested public programs, Medicare beneficiaries generally qualify based on their age rather than financial need. In addition, the Medicare Payment Advisory Commission (MedPAC), an independent agency that advises Congress on issues affecting the Medicare program, found in their [March 2011 report](#) that Medicare payments are adequate for efficient providers. According to MedPAC, hospitals claiming Medicare shortfall are either inefficient or operating in markets that allow them to charge fairly high rates to private payers.

Further Resources

- A Community Leader’s Guide to Hospital Finance, The Access Project. http://www.accessproject.org/downloads/Hospital_Finance.pdf
- Free Care Compendium, Community Catalyst. http://www.communitycatalyst.org/projects/hap/free_care
- What Counts As Community Benefit: Community Benefit Categories and Standard Definitions-Hospitals. Catholic Health Association. http://www.chausa.org/Pages/Our_Work/Community_Benefit/What_Counts/What_Counts_Q_and_A/Categories/.

² See IRS Form 990, [Schedule H](#) and [Instructions](#) for Tax Year 2011.