

Trends in Uncompensated Care At Minnesota's Hospitals

This issue brief analyzes trends in uncompensated care and its components – charity care and bad debt – for Minnesota community hospitals from 1998 to 2008. The Minnesota Department of Health studies uncompensated care for three main reasons: (1) Trends in uncompensated care can serve as an indicator of the degree to which hospital patients are uninsured or are unable to afford their deductibles or coinsurance; (2) charity care, one component of uncompensated care, is an important measure of how hospitals meet their obligations as tax exempt health care organizations; and (3) trends in uncompensated care illustrate how the financial burden associated with providing free and discounted care is spread across hospitals and how this is changing over time.

This analysis focuses on hospitals, because hospitals account for the majority of uncompensated care provided by health care organizations. National estimates indicate that as much as 60 percent of total uncompensated care is provided by hospitals.¹

Overview

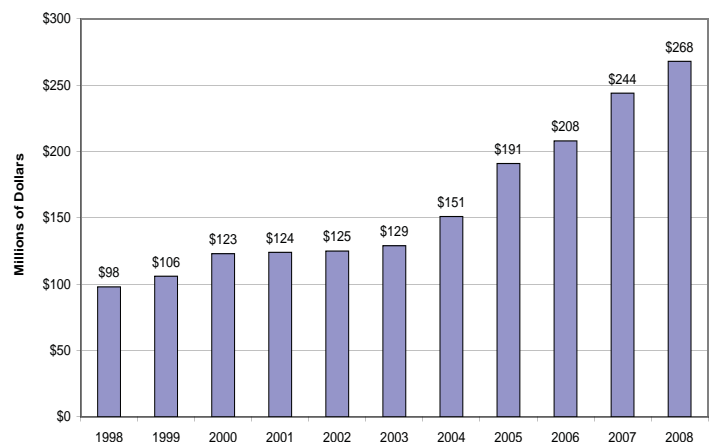
In 2008, Minnesota hospitals incurred \$268.4 million in uncompensated care costs,² an increase of almost 10 percent compared to 2007 (see Figure 1). As Figure 1 illustrates, hospital uncompensated care costs have been increasing rapidly in the past few years. Between 2004 and 2008 uncompensated care grew at an average annual rate of 15 percent, in contrast to the overall stability in uncompensated care between 2000 and 2003.

Although statewide hospital uncompensated care has grown in aggregate every year since 1995, uncompensated care relative to hospitals' overall operating activity has fluctuated somewhat over time. As shown in Figure 2, uncompensated care as a percent of operat-

ing expenses declined between 2000 and 2003 (from 2.0 percent to 1.6 percent). Since 2003, the ratio of uncompensated care to operating expenses has steadily grown, reaching approximately 2.2 percent in 2007 and 2008.

Figure 1

Uncompensated Care in Minnesota Hospitals, 1998 to 2008



Source: MDH, Health Care Cost Information System

The financial burden that uncompensated care places on hospitals in Minnesota has consistently been lower than the national average. This is likely due in large part to Minnesota's lower uninsurance rate, which has historically been about half the national average.³ In 2008, uncompensated care spending accounted for 5.8 percent of hospital operating expenses for the nation as a whole, more than 2.6 times the level for Minnesota hospitals.

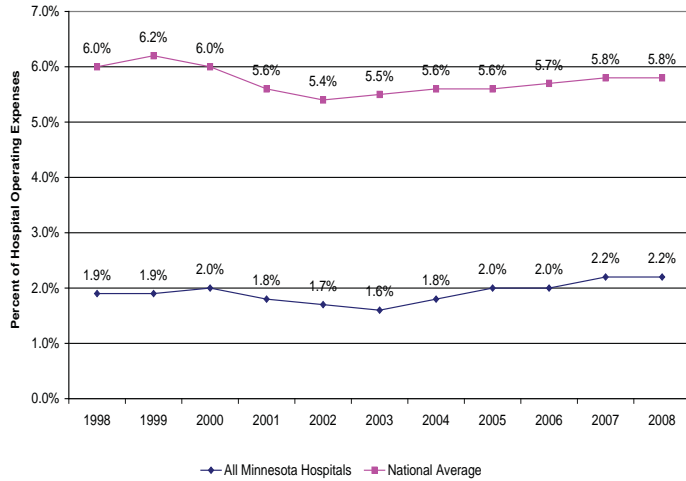
Historically, the burden of uncompensated care in Minnesota has been higher for urban hospitals than rural ones. For instance, in 1998 uncompensated care was 1.5 percent of operating expenses for rural hospitals and 1.9 percent for urban hospitals. This difference has narrowed over the years and for the first time in 2008 uncompen-

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sated care as a percent of expenditures was higher at rural than at urban hospitals (see Figure 3).

Figure 2

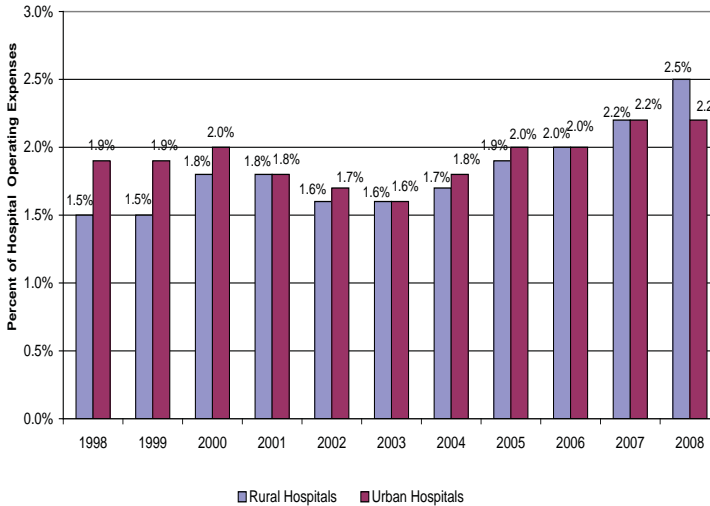
Uncompensated Care as a Percent of Hospital Operating Expenses, 1998 to 2008



Source: MDH, Health Care Cost Information System

Figure 3

Uncompensated Care as a Percent of Hospital Operating Expenses, 1998 to 2008



Source: MDH, Health Care Cost Information System

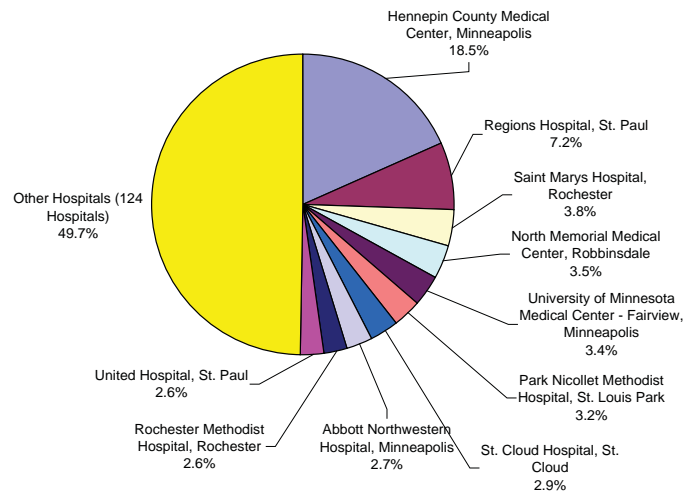
In 2008, uncompensated care at rural hospitals grew at double the rate of operating expenses (21.5 percent compared to 9.9 percent) while the growth at urban hospitals for these measures was more comparable. However, urban hospitals continued to account for a

large majority of overall compensated care in the state (79 percent).

Uncompensated care in Minnesota is unevenly distributed across hospitals, with the majority of spending occurring at large hospitals in metropolitan areas. As illustrated in Figure 4, the ten largest providers of hospital uncompensated care in Minnesota accounted for over half (50.3 percent) of total uncompensated care provided in the state in 2008. Although these ten hospitals account for a disproportionate amount of the total uncompensated care, only two of them had higher than average uncompensated care as a share of operating expenses (see Figure 5).

Figure 4

Distribution of Uncompensated Care by Hospital, 2008



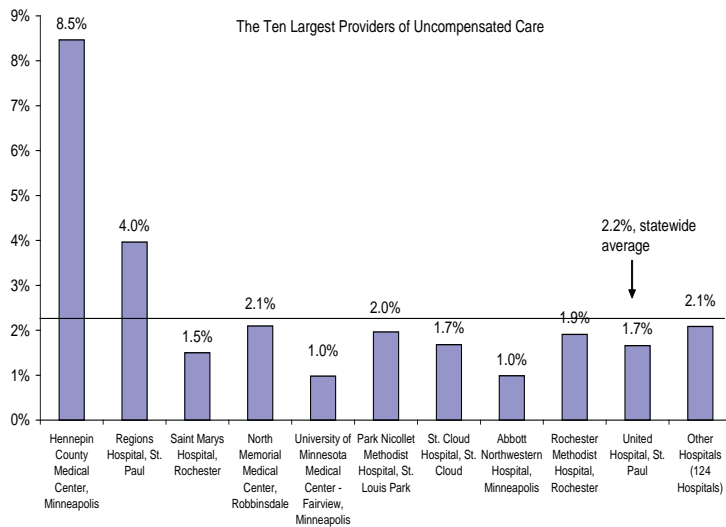
Source: MDH, Health Care Cost Information System

Since the beginning of this decade, the state's two primary safety net hospitals – Hennepin County Medical Center in Minneapolis and Regions Hospital in St. Paul – have provided an increasing share of the total hospital uncompensated care in Minnesota.

In 2000, these two hospitals accounted for a combined 21.7 percent of the state's total uncompensated care (17.3 percent and 4.4 percent, respectively); by 2008, their combined share had risen to 25.7 percent (18.5 percent and 7.2 percent, respectively). Historically, these two facilities have also had the highest ratios of uncompensated care to operating expenses.

Figure 5

Uncompensated Care as Share of Operating Expenses, 2008



Source: MDH, Health Care Cost Information System

Components of Uncompensated Care

While uncompensated care serves as a useful aggregate measure of care that is provided without payment, analyzing the components of uncompensated care allows one to distinguish between cases for which hospitals never expected payment (charity care) and cases where hospitals anticipated, but did not receive full payment or an agreed upon share of total payment (bad debt).

Charity care includes services that are provided to patients free of charge or at a discount because of patients' demonstrated inability to pay. To evaluate patients for charity care eligibility, hospitals generally rely on criteria established in formal charity care policies.

Although hospitals' charity care policies vary substantially across the state, there are similarities in the factors that hospitals take into account when determining eligibility.

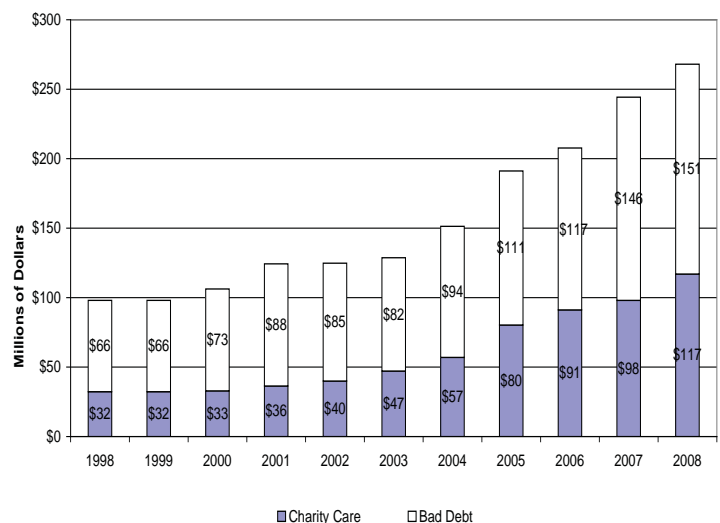
These factors typically include family income, assets, and ineligibility for public assistance. In contrast to charity care, bad debt reflects the cost of care for which a hospital expected, but did not receive payment from patients.⁴

In 2008, Minnesota hospitals incurred \$117 million in charity care cost and \$151 million in bad debt, or about 1.3 times as much bad debt as charity care (see Figure 6). Although the volume of bad debt has historically exceeded that of charity care, charity care has recently been growing faster than bad debt, particularly since the beginning of this decade. Between 2000 and 2008, charity care grew by 17.2 percent per year, compared to 9.4 percent for bad debt.

It is unclear what specific factors are responsible for the faster rise in charity care compared to bad debt. On the one hand, the change may be driven by changes in charity care policies or changes in screening for charity care eligibility. On the other hand, it could be due to an increase in the numbers of people eligible for charity care. In addition, higher cost sharing requirements may also be a contributing factor, if people cannot afford their deductible or coinsurance.

Figure 6

Charity Care and Bad Debt for Minnesota Hospitals, 1998 to 2008



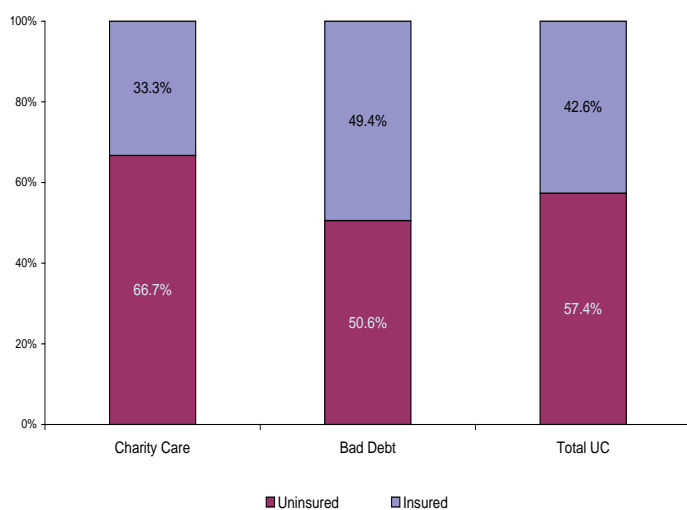
Source: MDH, Health Care Cost Information System

Since 2007, the Minnesota Department of Health (MDH) has collected additional detail on charity care and bad debt to distinguish between care provided to uninsured and insured patients, and to better understand what portion of charity care is written off in part or in total.

Although charity care is often thought of only as care for the uninsured, Figure 7 illustrates that insured patients are also recipients of charity care. In 2008, hospitals reported that 33.3 percent of charity care was provided to patients with insurance coverage. In addition, insured patients accounted for almost half of hospitals' bad debt (about 49.4 percent).

Figure 7

Charity Care and Bad Debt by Patients' Insurance Status, 2008



Source: MDH, Health Care Cost Information System

When writing off payments for services as charity care, hospitals may forgive the entire bill or just a portion of it. Of the \$78 million in charity care that Minnesota hospitals reported providing in 2008 to uninsured patients,⁵ about 80 percent was for costs that were written off in their entirety; only a small portion of total hospital care, 20 percent, resulted from partial charity care discounts. Many of the state's largest hospitals contributed to this outcome, by primarily delivering charity care as a complete write off to uninsured patients.

In addition to writing off care for individuals eligible under hospitals' charity care policies, under an agreement between the Minnesota Attorney General and Minnesota hospitals, hospitals provide discounts to uninsured patients who have incomes below \$125,000 but do not qualify for charity care.⁶ These discounts reduce hospital costs for eligible uninsured patients to levels equivalent to those paid by insurance companies that provided individual hospitals with the most rev-

enue in the previous year. In 2008, hospitals reported providing these discounts to uninsured patients at a value of about \$200 million, which represented a median discount of 15 percent (ranging from 2 percent to 60 percent).

Discussion

The analysis shows that Minnesota hospitals continue to experience high rates of growth in their cost of unreimbursed or discounted care. It is likely that the pressure on hospitals to provide uncompensated care has not diminished noticeably since 2008. A recent study documents that as a result of the economic downturn, more Minnesotans in 2009 were without health insurance coverage,⁷ potentially making more individuals eligible for free and discounted hospital care or responsible for hospital bad debt. Further, the trend towards insurance products with higher enrollee cost sharing shows little sign of abating,⁸ potentially resulting in an additional increase in the number of people who find themselves unable to afford their share of the cost of hospital care. However, activities by safety-net hospitals to triage patients to lower-cost care alternatives may somewhat mitigate future uncompensated care growth.

Endnotes

¹ Hadley, Jack and Holahan, John. "How Much Medical Care do the Uninsured Use, And Who Pays For it?" Health Affairs. Web exclusive: February 12, 2003.

² Throughout this issue brief, uncompensated care, charity care and bad are reported on a cost basis, meaning that hospital charges are adjusted by a cost-to-charge ratio to approximate the actual cost of providing this care.

³ U.S. Census Bureau, Current Population Survey, 2006 to 2008 Annual Social and Economic Supplements.

⁴ To the extent that hospitals at times are unable to positively identify a patient's capacity to pay, either because of the patient's lack of cooperation or administrative barriers, bad debt could contain a portion of the cost of care for patients who might have qualified for charity care.

⁵ This data is only collected for uninsured patients based on the assumption that, by definition, charity care for insured patients amounts to a partial write-off beyond what health insurance covered.

⁶ Minnesota hospitals initially entered into two-year agreements with the Attorney General in 2005. These agreements, which also cover debt collection practices, were renewed in 2007 for an additional five years. Under section 9007 of the federal Patient Protection and Affordable Care Act enacted in March, 2010, non-profit hospitals will be required to limit charges to those who qualify for financial assistance to the lowest amount charged to insured patients. These discounts are not considered uncompensated care.

⁷ Minnesota Department of Health, Health Economics Program and University of Minnesota School of Public Health, "Health Insurance Coverage in Minnesota, Early Results from the 2009 Minnesota Health Access Survey;" Fact Sheet, Feb. 2010.

⁸ Minnesota Department of Health, Health Economics Program, "Trends in Health Care Premiums and Cost Drivers, 2008;" Issue Brief, Nov. 2009.

The Health Economics Program conducts research and applied policy analysis to monitor changes in the health care marketplace; to understand factors influencing health care cost, quality and access; and to provide technical assistance in the development of state health care policy.

For more information, contact the Health Economics Program at (651) 201-3550. This issue brief, as well as other Health Economics Program publications, can be found on our website at <http://www.health.state.mn.us/healthconomics>.

**Minnesota Department of Health
Health Economics Program
85 East Seventh Place, PO Box 64882
St. Paul, MN 55164-0882
(651) 201-3550**

